I: State Information

State Information

Plan Year

Start Year:

End Year:

State DUNS Number

Number
809045594

Extension

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

Agency Name
Department of Health and Human Services

Organizational Unit
Office of Adult Mental Health Services

Mailing Address
SHS 11

City
Augusta

Zip Code
04333-0011

II. Contact Person for the Grantee of the Block Grant

First Name
Sheldon

Last Name
Wheeler

Agency Name
Office of Adult Mental Health Services

Mailing Address
11 SHS

City
Augusta

Zip Code
04333-0011

Telephone
207-287-4243

Fax
207-287-1022

Email Address
sheldon.wheeler@maine.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
10/1/2011

To
6/30/2013

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
Cynthia

Last Name
McPherson

Telephone
207-287-4243

Fax
207-287-1022

Email Address
cynthia.mcpherson@maine.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	William Boeschenstein
Title	Chief Operating Officer
Organization	Health and Human Services

Signature: _____ Date: _____

Footnotes:

Signature for Assurances-Non Contruction Program can be found in the Attachments.

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications 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).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

Name	William Boeschenstein
Title	Chief Operating Officer
Organization	Health and Human Services

Signature: _____ Date: _____

Footnotes:

Signature for Certifications can be found in the Attachments

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Maine agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Paul R. LePage
Title	Governor
Organization	State of Maine

Signature: _____ Date: _____

Footnotes:

The Govenors signature can be found in the Attachments Section.

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

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, intermediate 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, 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 youth who are often underserved.

Footnotes:

Office of Adult Mental Health Services

Overview
Maine's Department of Health and Human Services (DHHS), Office of Adult Mental Health Services (OAMHS) is the designated State Public Mental Health Authority. OAMHS is responsible for assuring the quality of services and supports to individuals with severe and persistent mental illness and the integration of mental health service into healthcare generally and through specific public health initiatives. OAMHS, in collaboration with its community partners, develops, monitors and improves adult mental health treatment, services and supports for individuals 18 years and older who have SPMI. Treatment, services and supports include crisis services, inpatient treatment, outpatient treatment, community integration services, ACT, peer support, medication management, housing, vocational and outreach services.

OAMHS works within DHHS to incorporate mental health into Maine's Homeland Security and Disaster Response Plan and in the state's health plan.

OAMHS is committed to ensuring that a full array of treatment, supports and services are available and equitably accessible throughout the state to sustain and enhance the quality of life for adults with SPMI.

Criteria 1:
OAMHS provides statewide leadership in defining, measuring and improving the quality of services and supports to adults with serious mental illness. Administratively, this function is accomplished through a Central Office, the Office of Adult Mental Health Services, two state- operated psychiatric inpatient facilities as well as state forensic services.

OAMHS contracts with community-based agencies for the provision of: tenant based supported housing, residential treatment supports and services, medication management, crisis services, 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.

Based on a future needs analysis of block grant services we will incorporate the national best practice model that will utilize peers in the provision of services. Our target will include 25% utilization of peer based services and future contracts will see an increase of this percentage in years to come. This will be achieved through the Request for Proposal (RFP) process, which will be informed by the needs analysis mentioned above.

In addition to the two state-operated psychiatric facilities, six private hospitals with dedicated psychiatric units and two private psychiatric hospitals partner with OAMHS to provide inpatient treatment as close to an individual's home community as possible. The primary goal of inpatient treatment is to stabilize the person's psychiatric symptoms, resolve imminent issues and restore his or her capacity to resume life in the community.

Monthly webinars are conducted by leadership of OAMH to the provider community to provide an opportunity for bi-directional communication and establish uniform consistency of programs and applications.

Mental health service and support contracts are performance based and include:
• Assertive Community Treatment (ACT)
• Community integration, daily living supports and skill development;
• Crisis services, which include telephone support, mobile assessments and residential stabilization services and peer crisis supports
• Tenant based supported housing as well residential treatment programs
• Outpatient therapy
• Medication management
• Peer support services, including peer centers and social clubs, peer operated "warm lines," peer support in emergency departments, peer conferences, certified peer training, and support of the Consumer Council of Maine.
• Inpatient hospital care and treatment
• Vocational services and supports

DHHS/OAMHS contracts with APS HealthCare to serve as its Administrative Services Organization for prior authorization and continued stay reviews for certain services.

OAMHS provides Intensive Case Management (ICM) services to individuals with mental illness who are in jail or in homeless shelters. ICM services focus on those individuals who are homeless within the identified population who have historically experienced difficulty connecting with and maintaining other community services. The goal is to provide outreach, engagement and referral to mainstream resources. For those in jails, the ICMs focus on service linkage upon release.

Over the last few years OAMHS has incorporated national best practices of linking Substance Abuse and Mental Health Treatment into the contracting process with providers. Now, our standard rider language specifically includes the following language: "Co-occurring Mental Health and Substance Abuse Disorders. In support of the DHHS statewide initiative to create a system welcoming to clients with co-occurring mental health and substance abuse disorders, the Provider agrees to the following:
1.The Provider shall not deny services to any individual solely on the basis of the individual's having a known substance use/abuse disorder in addition to their mental illness;
2.The Provider shall maintain a written protocol or policy that describes its service approach to individuals with a co-occurring mental health and substance abuse disorder; etc.

Criteria 2:
The development of quality improvement and information systems, including data/information systems, monitoring, peer review, consumer satisfaction and

evaluation processes, is based on the commitment of all those involved with the provision of mental health services at every level. The responsiveness and effectiveness of Maine's mental health system can only be guaranteed by the collaborative input of consumers, families, the DHHS/OAMHS, other involved State departments, and all community providers.

As mental health services move toward increased community inclusion and increased consumer and family involvement, there is a need to better integrate information systems. With the additional impact of the Bates v. DHHS consent decree, the Mental Health Statistics Improvement Program (MHSIP), the U.S. Supreme Court's "Olmstead decision", statutorily mandated performance contracting, and other state and federal requirements, the development of a comprehensive information system that can capture client identifiable instances of service, assessments, and other demographic data is essential.

The Offices of Information Services and Quality Improvement efforts have focused on systems integration and restructuring, performance measures/indicators, and consent decree/settlement mandates. They play a significant role in the identification of needs and outcomes in the planning of mental health services and the service delivery system. Of significant note, OAMHS, CBHS and the Office of Quality Improvement, in conjunction with the QIC and other consumer and family representative organizations are rolling out the statewide implementation of the OQ® Measurement system.

Criteria 3: See Children's Section

Criteria 4: Homeless

Homelessness is a national problem affecting people from all walks of life; individuals with SPMI are no exception and are among the most vulnerable to the effects of being homeless. OAMHS recognizes the need for housing as well as the need for related supports and services as essential to recovery and successful community integration.

Independent housing vouchers represent a foundation of recovery and hope. To the greatest extent practicable, we 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. 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.

Despite the challenges presented by economic recession, OAMHS continues to adhere

to a “housing first” philosophy and to maintain a recovery-oriented infrastructure that seeks to ensure successful community integration. The Bridging Rental Assistance Program (BRAP), Shelter-Plus Care (SPC) and the Project for Assistance in Transition from Homelessness (PATH) are examples of OAMHS successful housing programs. Although individuals with SPMI who are homeless or at risk of homelessness are given priority for assistance, OAMHS remains cognizant of the fact that the need for safe, adequate housing exceeds currently available funding. OAMHS continues to advocate strongly for additional funding for housing resources. We are pleased to announce that OAMHS has received a 30 % increase in its state funded Bridging Rental Assistance Program and more than $1,000,000 in new Shelter Plus Care grants from HUD for FY12.

The OAMHS reorganization has re-dedicated resources to Policy Development which includes persons dedicated to coordinating and developing housing resources, including the Bridging Rental Assistance Program ($4,000,000 state funded) and the Shelter Plus Care program ($11,000,000 HUD funded). Maine’s housing programs are becoming evidence based best practice models and have been presented at local, regional, and national conferences. Our administrative and management systems provide for clear lines of accountability, efficiency, and transparency. These systems and models have been duplicated in several other states. Our program manuals have been utilized by the U.S. Department of Housing and Urban Development in their creation of HUD’s Shelter Plus Care Resource Manual.

Intensive Case Management services are available for individuals with SPMI who are homeless or at risk of homelessness. ICM services include comprehensive outreach and service linkage and maintenance. Services include assistance in obtaining housing, often utilizing Shelter Plus Care (SPC), the Bridging Rental Assistance Program (BRAP) and/or the Project for Assistance in Transition from Homelessness (PATH). The immediate goal for any identified homeless consumer is housing and stability.

OAMHS is a recent recipient of a SOAR (SSI/SSDI Outreach, Access and Recovery) grant. We anticipate this will further enhance the effectiveness of engagement of homeless persons into mainstream benefit programs for which they are eligible. Our two pilot sites include the City of Bangor and our ICM program. We are also incorporating SOAR into our PATH program as well. There is a need for sustainability of the SOAR program and the Block Grant may serve this purpose.

Having a safe and decent place one can call home is a core element of recovery. However, housing in and of itself for individuals with SPMI, is often insufficient to successfully integrate into the community. Services and supports, as directed by the consumer, lead to stability and recovery. Combined housing and services are a essential to the recovery process. OAMHS has a long and very successful history of linking housing and services, as directed by the consumer. We have been using a ‘housing first’ model in our rental assistance programs (BRAP and Shelter Pus Care) before there was a best practice known as ‘housing first.”

Criteria 4: Rural
Maine is a predominately rural state with many of the issues and challenges inherent in the provision of mental health supports and services to persons with SPMI across a large geographic expanse. If expectations remain constant across service regions, service provision becomes problematic. Time, distance, smaller pools of service providers (particularly for individualized special needs) and fewer individuals needing specific services are problematic throughout rural Maine. Widespread and entrenched poverty, lack of reliable transportation in remote regions and regional/cultural attitudinal differences regarding acceptance of treatment, supports and services for individuals with SPMI all factor into the challenge of service and support provision in rural areas.

Many national issues also exist in Maine and can have a profound effect on rural mental health service delivery. These include:

- The national and global recession, which is exacerbating to the decline of Maine's rural economy;
- Increasing stress on communities, families and individuals resulting from the soaring costs of basic needs – food, gas, heating oil, etc.
- A growing rate of unemployment in rural areas;
- A lack of decent, affordable housing options which has been impacted by the recession and age of Maine's housing stock (the 5th oldest in the country)

With at least half of the State of Maine consisting of unincorporated territories, some mental health service areas are highly rural and isolated. In response, all mental health agencies operate branch offices in their regions. In addition, a variety of discrete programs and services are not readily available to rural areas, such as social clubs and supported employment. OAMHS is examining options for noncenter based peer services and uses for technology and cyberspace to link people. This includes telemedicine.

Through monthly statewide webinars hosted by the Office of Adult Mental Health, providers and consumers are able to form alliances to identify regionally specific problems and respond to challenges. Teleconferencing and tele-health are other strategies that continue to grow in serving rural areas. The QIC is actively seeking to expand its membership representing rural areas, tribal representation, and the Consumer Council System has worked diligently to develop and strengthen its local councils in all areas, including rural Maine.

Criteria 4: Elderly
The Department of Health and Human Services makes treatment and support services available to elder persons who have a mental illness or who experience cognitive and physical disabilities or substance addictions/abuse. However, circumstances associated with aging such as isolation, denial, and shame, impaired mobility, and diminished social supports present unique challenges to delivering effective services.

DHHS provides services to older adults with SPMI, utilizing a responsive, flexible approach that is specifically designed to meet individual needs, and with recognition that for many older consumers, traditional delivery models are neither appropriate nor efficacious. We have incorporated into contracts with several mental health agencies specific terms and expectations for effective outreach to elderly persons with SPMI. OAMHS and the Office of Elder Services continue to jointly pilot a project under the auspices of an AOA/CMS grant to develop Aging and Disability Resource Centers (ARDC). This project explores and develops creative methods of disseminating information about and providing access to long term supports and other resources of benefit to both consumers and providers. The project supports community coalitions to test methods to coordinate the connection of consumers with information about the full range of long-term supports available to adults of all ages and income levels. The information provided includes how best to leverage local resources to assist individuals who do not qualify for publically funded programs. The project also works to eliminate duplicative efforts and strives for efficient, high quality service availability and delivery. Each project site has an active local Community Coalition which provides project staff with a well rounded sense of the community's needs and available resources. Community specific knowledge further informs outreach efforts, allowing staff to initiate and maintain contact with stake holders and build collaborative relationships with area providers.

OAMHS utilization review nurses conduct regular reviews of the treatment, services and supports provided to individuals in specialized psychiatric nursing facilities, assuring the appropriate levels and quality of care.

OAMHS provides both general funds as well as Medicaid for home based services for outpatient therapy and medication management and is working with the Office of Elder Services to improve the integration of these services.

The Office of Elder Services offers comprehensive services and supports to meet the needs of older adults, their family members and their caregivers/providers. Other adult service programs in DHHS provide comprehensive supports to meet the needs of adults with mental illness, cognitive disabilities, brain injury and/or substance addictions/abuse. The services and supports within both these offices are individualized and person-directed. However, their services are not necessarily responsive to or effective in meeting the needs of older adults whose needs cross over both systems of service delivery. The older adult service system encounters difficulties addressing symptoms and challenging behaviors presented by those older adults who have mental illness, cognitive and physical disabilities, brain injury or substance addictions/abuse. Likewise, the integrated support service system is challenged in addressing issues encountered by older adults such as community isolation, living alone without supports, non-recognition or denial about diagnosis or service needs, shame about diagnosis, impaired physical or cognitive functioning, diminished social supports, and dual disorders. Older adults who may need the supports provided by the existing service systems include:

1. Individuals with chronic or long term conditions who are 60 and older and have aging issues that complicate symptoms of existing diagnosis. They may also have dementia in addition to existing diagnosis.
2. Caregivers who are older adults and who are caring for adult children with mental illness, developmental disabilities, brain injury, and/or substance addictions/abuse. They may now have mental health issues such as depression and anxiety disorders associated with their own aging and/or care-giving.
3. Older adults who have not accessed mental health, cognitive disability, brain injury and/or substance addictions/abuse services prior to 60 years old, but are now older adults seeking and needing to access services. They may have had chronic conditions that were undiagnosed throughout their lifetime or they may have newly emerging conditions resulting from medical conditions or issues as they age.

The Aging and Disability Resource Centers (ADRCs) implemented by area agencies on aging in three of the five regions of the state offer a point of information dissemination, resource identification, and service referral for adults, their caregivers, and community providers. OAMHS created two positions to address persons with complex needs and their service needs. Staff from Elder Services, Mental Health, Cognitive and Physical Disabilities, and Substance Abuse meet weekly to develop individual plans and pool resources.

Two members from Policy Management Division and Quality Management Division within OAMHS has been appointed the Maine Elder Death Analysis Review Team (MEDART). MEDART was established by the Maine Legislature under the auspices of the Maine Office of the Attorney General. 5 M.R.S.A. § 200-H. MEDART is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly or vulnerable adults. MEDART meets monthly to review selected cases. MEDART's membership includes representation from state, local, and county law enforcement, prosecutors, victim services, licensing and regulatory services, medical examiner services, adult protective services, long-term care ombudsman, mental health, emergency medical services, physicians, and healthcare crimes enforcement. The purpose of the review is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future. MEDART was chosen early on as one of four "elder fatality review teams" in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the Commission on Law and Aging of the American Bar Association. The goal of the pilot program was to expand the fatality review team concept, and to develop and disseminate a replication and best practices guide. In August 2008, the Maine Elder Death Analysis Review Team was recognized at the National Adult Protective Services Association annual conference. The Team's annual reports, procedures, recommendations, findings, enabling legislation, membership, and case reviews were discussed during a session that highlighted national promising practices and programs. Several communities across the country have contacted the Maine Team as they begin to develop new Elder Death Analysis Review Teams.

Criteria 5:
The Office of Adult Mental Health has reorganized to better align with changing state and federal priorities. This reorganization makes efficient use of existing staff and organizes work flow and arranges staff to align with areas of specialty and expertise. One essential element of this reorganization is enhanced communication by, between, and among our own workgroups. Leadership meets on a weekly basis as does program units which ensure bi-directional flow of information and direction. Attached is an organizational chart highlighting these significant elements, "Planning Steps_1 Org Chart_Adult MH".

Mental health service providers receive funding through a variety mechanisms, primarily state general funds and Medicaid. General funds are allocated through Maine's biennial budget process. The budget process is inclusive, in that OAMHS actively seeks provider, consumer, family and other public input in budget planning and development. The budget document presented to the Maine Legislature reflects the needs of consumers of mental health services based on the best data and information available. The legislative process is open and public comment is welcomed and listened to. OAMHS' budget is presented to the legislature within the context of the DHHS overall budget. In FY2012 the OAMHS budget received a $5.4 million dollar increase targeting Consent Decree Clients and the Bridging Rental Assistance Program mentioned earlier.

APS HealthCare, as the DHHS/OAMHS administrative service organization acts to ensure that funds are efficiently allocated and that supports and services provided are appropriate to the documented needs of consumers and of a consistently high quality. All contracted mental health service providers are enrolled with APS HealthCare. OAMHS provides, directly or through contract, training and technical assistance to mental health service providers statewide. Training initiatives are coordinated by OAMHS' Training and Best Practices Coordinator. The University of Southern Maine, Muskie School of Public Service provides data, research and technical assistance through a cooperative agreement. Tuition support is available for direct service staff for certification.

Examples of training provided include:
• Competency based certification training for Mental Health Rehabilitation Technicians including crisis certification
• Competency based certification training for Intentional Peer Support Specialists
• Competency based certification training for Mental Health Support Specialists
• Best Practice training for OAMHS medical staff, including utilization review nurses
• Specialized training in employment

OAMHS also sponsors statewide "summits" on domestic violence, criminal justice, forensic grand rounds and an annual consumer "Hope Conference." OAMHS provides technical assistance to providers and consumers on an as requested basis.

The correctional system has undergone a merger between the county and state systems and the Office is deeply involved in the design of the mental health and substance abuse delivery system. Protocols are being developed to ensure diversion whenever possible and quality services while incarcerated as well as a detailed re-entry plan.

Maintenance of Effort (MOE) Report:

It should be noted for FY12, The Department of Health and Human Services requested, and the legislature approved, an additional $5.6 million (representing nearly 20% of our allocation of general funds) to principally serve persons with Mental Illness who are currently not receiving services and/or who are uninsured.

Actual FY08	Actual FY09	Actual FY 10	Estimate FY11
$135,474,171.	$123,352,714.	$107,725,676.	TBD

The relevant factors that SAMHSA considers in making a recommendation
To the Secretary include: 1) whether the State maintained service levels,
2) The State's mental health expenditure history, and 3) the State's future
commitment to funding mental health services.

OAMHS will be conducting a thorough needs analysis of the MH Service system in the coming months. As mentioned previously our intent is to develop an RFP based on this assessment.

Currently we have a need regarding IT systems. Although we can collect client identifiable data from the Medicaid records we are having difficulty discreetly identifying individual clients served by particular grants funds including the Block Grant resources. The solution may be as simple as adding a modifier to existing data sets or as complex as examining entire IT systems.

Children's Behavioral Health Services

Application and Plan FY12/13

STEP 1: ASSESS THE STRENGHTS AND NEEDS OF THE SERVICES SYSTEM TO ADDRESS SPECIFIC POPULATIONS

CRITERION 1: COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM FOR CHILDREN

Focal Point of Responsibility for Children's Mental Health: The State mental health authority is the Department of Health & Human Services. The focal point for children's mental health is the Division of Children's Behavioral Health Services within the Office of Child and Family Services, 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 supports 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.

Children's Services 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 Population: The Children's Behavioral Health Services Division 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.

Children's Behavioral Health Services Program - Current Operations

Number Served (FY'10) Source: Year End Contract Reports from Community Providers; MaineCare claims data from MECSM and clinical authorizations from Clinical Care Specialists: 51,136 total services provided to children and families; estimated unduplicated number of

children served 22,727; expenditures (FY11) $32,681,123 in State General Funds, including $15,543,097 state seed dollars for federal Medicaid (MaineCare) matching funds. Budget (FY12) $29,453,949 in State General Funds, including $15,546,457 state seed dollars for matching federal Medicaid (MaineCare) funds.

Children's Mental Health Services: CBHS Mental Health Program Coordinators and Resource Coordinators oversee regional program development; facilitate interagency collaboration provide information, referral and case advocacy and offer education and public awareness activities for children and families who are affected by neurobiological and other serious emotional disorders, and for their service providers. The Division of Children's Behavioral Health Services contracts with private community-based agencies to provide: case management; crisis services; individual planning fund administration, information and referral, clinical home and community based behavioral health treatment; rehabilitate community support services; infant mental health services; outpatient counseling and therapies; respite services, family support services, children's ACT services, medication management; early intervention services, therapeutic recreational services, homeless outreach, and short term, intensive residential treatment services.

Early Childhood, Intellectual Disability, and Autism Services: CBHS Regional Supervisors oversee staff that performs referral, prior authorization, utilization review, program oversight and overall quality improvement functions for community based contracted agencies. The contracted agencies provide home and community based identification and assessment; rehabilitative services; personal supports; case management; crisis services; medication management; early intervention services for infants/toddlers; preschool integrated support; short-term residential treatment ,individual planning funds, recreational programming and respite for children with developmental delay, autism spectrum disorders and intellectual disabilities.

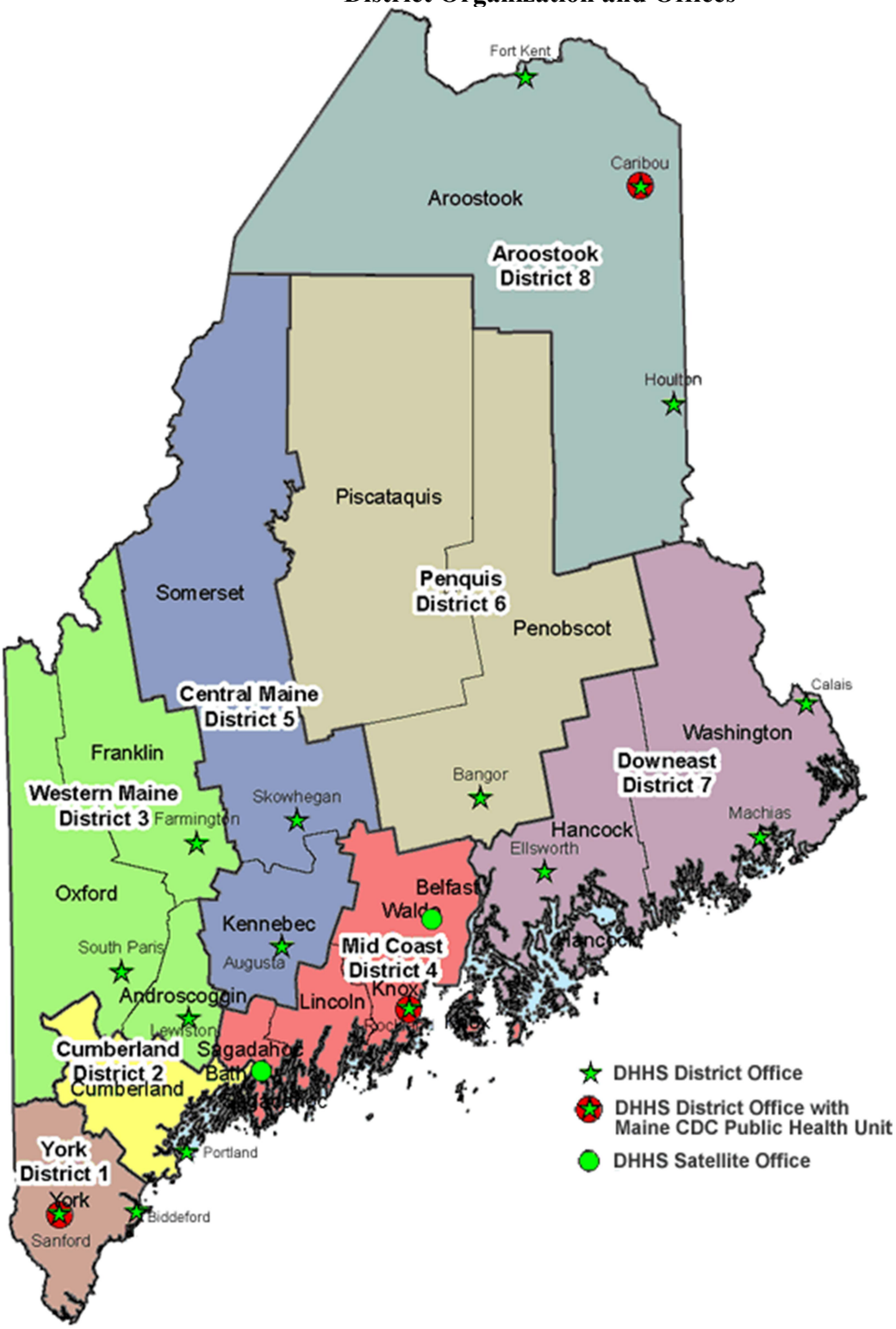
State/Local Administrative Structure: The integration of Children's Behavioral Health Services into the Office of Child & Family Services has fostered a common, integrated approach to the Department's local administrative structure. In FY08 CBHS began the transition from a regionally based construct to a district configuration that is compatible with other Offices within the Department of Health & Human Services. In 2007, the CBHS central office co-located with Early Childhood Services and Child Welfare Services in the main administrative office of the Office of Child & Family Services in Augusta. The operational integration of CBHS field personnel at the district level has been a CBHS Priority in FY10 and continues to be a key element of CBHS/ OCFS Integration.

CBHS Local Administrative Structure by DHHS District

District 1	York County	Formerly Region I
District 2	Cumberland County	Formerly Region I
District 3	Androscoggin, Franklin and Oxford Counties	Formerly Region II
District 4	Sagadahoc, Lincoln, Waldo and Knox Counties	Formerly Region II
District 5	Kennebec and Somerset Counties	Formerly Region II
District 6	Piscataquis and Penobscot Counties	Formerly Region III
District 7	Hancock and Washington Counties	Formerly Region III
District 8	Aroostook County	Formerly Region III

Maine Department of Health and Human Services
Office of Child & Family Services

District Organization and Offices



State Mental Health Agency and Other State Agencies

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) program unit within the Department of Health & Human Services, Office of Child & Family Services (OCFS). Children's Behavioral Health Services central office 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. CBHS is authorized 57.5 FTE positions which consist of the following personnel:

Children's Behavioral Health Services Central Operations

The Director of Children's Behavioral Health Services oversees all operations of Children's Behavioral Health Services from the central office level, and is responsible for financial oversight of the CBHS budget, develops and implements policies relevant to the mental health system of care for children, represents the Department on issues affecting Children's Behavioral Health Services to include strategic planning and work with the Maine legislature, oversee contract development, provides leadership within the CBHS program and directs staff within the central office operations and the regional Children's Team Leaders. These staff includes the following:

Children's Systems Manager, responsible for planning, policy development, and resource coordination of Department activities and program implementation for Children's Behavioral Health Services at the state and regional levels. Represents the Department on state level interagency/departmental committees to promote coordination and collaboration across child-serving state agencies and contracted local provider agencies.

Medical Director of Children's Behavioral Health 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 Children's Behavioral Health Services Clinical 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.

Other personnel include a **Quality Manager**, who is the liaison to the DHHS Office of Quality Improvement and responsible for implementing the Children's Quality Improvement Plan, overseeing the staff training and certification process required for behavioral health services and rehabilitative services, and is the CBHS representative to the Lean Management Team. A **Program Specialist** responsible for preparation of reports required by federal, legislative or departmental personnel, analysis of non-clinical data and information, and preparation of the federal Children's Mental Health Block Grant application and the federal Thrive System of Care

Initiative, and the Healthy Transitions Initiative. **An Information Systems Manager** responsible for liaison and communication between CBHS and the Office of Information Services, and who is the lead team member overseeing the implementation of the Enterprise Information System, specifically as that system will support the needs of Children's Behavioral Health Services. A **Behavioral Health Services Manager** responsible for the implementation of the delivery of mental health services to youth in the two Department of Corrections Youth Development facilities and Juvenile Services Regional offices. A **Social Services Program Specialist** performing interdepartmental collaborative work with other child serving agencies on the design and implementation of new and existing programs and services for children with behavioral health needs, including MaineCare policy and development of a federal Home and Community Based Waiver for children with intellectual disabilities and Autism Spectrum Disorder. A **Project Manager** responsible for the Healthy Transition federal grant initiative. A **Manager of Clinical Services** responsible for monitoring and coordination of the prior authorization of all children being considered for residential treatment and implementing any necessary changes. Other tasks include quality improvement monitoring, assisting in coordinating the integration of hospital and community services and assisting in coordinating the integration of residential treatment with community services. This position is also a liaison between the Division of CBHS and Child Welfare, as well as between OCFS and the managed care entity, APS Healthcare.

Children's Behavioral Health Services Field Operations

Mental health services for children are delivered at the local level through a regional/ district structure overseen by the Director of Children's Behavioral Health Services. **The Children's Behavioral Health Services Team Leader** manages all activities in the region pertaining to the development and delivery of behavioral health and rehabilitative services for children and their families, supervises all regional staff, and actively participates as a member of the Children's Systems Management Team.

Mental Health Program Coordinators 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**.** **Resource Coordinators** 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. **Clinical Care Specialists** track utilization of services of children placed out of state and children placed in residential treatment settings within the state. They are involved in the prior authorization of children being considered for residential treatment as, well as clinical reviews and clinical consultations with mental health treatment providers, families, Child Welfare, Department of Corrections and others. The purpose of these reviews is to assure that children receive the most appropriate and effective treatment in the least restrictive, medically necessary level of care. Clinical Care Specialists routinely monitor the quality of treatment provided within residential treatment settings and respond to urgent situations when necessary. **Regional Supervisors** are involved in daily district operations, engage in issue/problem solving, participate in community meetings and select, orient and supervise the following front line staff**:** **Enrollment Specialists** are responsible for documenting individual access to community services, manage the collection of information from community agencies regarding children

receiving services and track information for accuracy, completeness and utilization of services. **Quality Improvement Specialists** 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. **Family Information Specialists** are 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 in the region. Family Information Specialists are trained parent employees who are knowledgeable of the local service area and have a child with a disability.

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. Three (3) **Mental Health Program Coordinators** are co-located in Juvenile Services field offices. The MHPCs screen all caseloads of the Juvenile Community Correctional Officers (JCCOs) to identify youth in need of mental health services. In addition a **Social Services Manager** and two (2)**Psychiatric Social Workers** are located the Long Creek Youth Development Center in South Portland and a **Mental Health Program Coordinator**, and a **Psychiatric Social Worker** are located at the 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.

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 4 child-serving state agencies.

Six core mental health service components were identified and are 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, and 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. In Maine, these services are funded by the General Fund, MaineCare EPSDT, Part B-IDEA, and School Based Health and Mental Health Services.

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 home, school 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. In Maine, these services are funded by the General Fund, MaineCare - Crisis Services, MaineCare - Outpatient Services and the Community Mental Health Block Grant.

Individual Planning/Case Management Services consist of screening and assessment, individual service planning, homeless youth outreach and targeted case management. This core service is further described in a following section of this plan. In Maine, these services are funded by the General Fund, MaineCare-Targeted Case Management, Part B-IDEA, School Based Mental Health Services, and the PATH Grant (Homeless Outreach).

Family and Child Supports include respite care, parent and peer support services, information & referral services, flexible funds and social & 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 care giving, and support for each care giver's problem-solving, communication skills, behavioral interventions and advocacy. In Maine, these services are funded by the General Fund, Community Mental Health Block Grant, School Linked Mental Health Services, and Part B-IDEA.

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 & family counseling, special education and other support services geared specifically to support the child or youth in the school environment. In Maine, these services are funded by the General Fund, MaineCare, School Based Health and Mental Health Services, Substance Abuse Block Grant and Part B-IDEA.

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. Children's Behavioral Health Services provide short term, intensive temporary out of home treatment services (ITRTS) that are described in a following section. In Maine, these services are funded by the General Fund, MaineCare-PNMI, Title IV-E, Substance Abuse Block Grant, Local Educational Administrations (educational costs), and Part B-IDEA.

Maine's Plan for Children's Mental Health Services presented data on the capacity of these services, drawing from actual utilization information obtained from all child-serving state agencies in the summer of 1997. The Plan measured current capacity against estimates of children needing services on a statewide basis. This comparison revealed core services needing additional capacity and core services that were at excess capacity. A Five Year service development schedule was constructed based on this data. The Department's annual and supplemental budget requests over the past 10 years have reflected high priority service development needs that were based on the System of Care Capacity and Sizing Summary in the 5 Year Plan.

Expansion of Core Services : The Department has annually prepared information about its progress in developing the system of care, and specifically with regard to growth in services for children and families over the previous 11 years. This time frame coincided with planning efforts and program information gathered for the Plan for Children's Mental Health during the summer of 1997; therefore, the baseline data was taken from that report and compared with Year End contracting report data for FY10. The results are shown in the table below:

*

Children's Behavioral Health Services – Core Services – Numbers Served FY98 - FY10				
Service Area	**FY 98**	**FY 10**	**Increase**	**% Increase**
Crisis Intervention	2,144	5,546	3,402	158.7%
Outpatient Services*	6,949	19,088	12,139	174.7%
In-Home: Behavioral Health Treatment /Rehabilitative Community Services	90	4,323	4,233	4,703.3%
Case Management	1,532	9,696	8,164	532.9%
Respite Care	1,514	1,667	153	10.1%
Totals	**12,229**	**40,320**	**28,091**	**229.7%**

*Includes Medication Management

The expansion that has occurred over this twelve year period was driven in part by the demand for specific MaineCare services and by pre-Risinger litigation that emphasized the need for timely access to in-home behavioral health treatment services and rehabilitative community services and supports. Targeted case management services were also considered an integral service that would increase family access to the entire system of care, and was, therefore, a third service that increased prior to and following the Risinger Settlement Agreement.

A second factor in the expansion of core and other services is the growth in the number of service providers that offer these services. Prior to 1997 when the Plan for Children's Mental Health was under development, the vast majority of services were being provided by a relatively small number of providers consisting of Maine's established community mental health centers. Moreover, this expansion has not been limited to the greater population centers; rather it has been throughout all areas in Maine, including rural areas.

By FY11 the profile of the original Core Services had changed significantly. Children's Behavioral Health Services contracted with sixty-two (62) Targeted Case Management provider agencies; eighty-two (82) Outpatient Services providers, of which twenty (20) also provide Medication Management; fifty-one (51) Rehabilitation and Community Services providers that offer In-Home Supports; forty-four (44) Children's Home and Community Based Treatment Services providers of home-based behavioral health treatment services; nine (9) Crisis Services providers; nine (9) Homeless Outreach Services providers and eleven (11) Family Support Services providers that include Respite Care, Parent and Peer Support groups and Information and Referral Services. Many of these agencies serve more than one Region. A regional update of available services by CBHS Region for FY2011 appears in Criterion 4.

Case Management Services for Children : 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. An individual service plan is built on the results of assessment, taking into account child and family strengths, needs, and preferences. Plans reflect services to be secured, with measurable goals and time frames, natural supports and service providers.

An individual plan is developed through a child and family centered wraparound planning process, with a Child and Family Team. Agencies and programs already involved with the child and/or family are included in the planning process, as are persons whom the child and family prefer to be included as natural supports. Case management involves brokering services, advocacy, insuring that a quality treatment plan is developed and implemented, and reviewing the child's progress. Case management involves aggressive outreach on behalf of the child and family and working with a wide range of community agencies and resources.

In Maine, mental health case management services for children are funded by MaineCare Targeted Case Management, Part B-IDEA, and PATH Grant (Homeless Outreach).

Children's Behavioral Health Services case management services are provided through contracts with local service providers. Case management services for children with behavioral health needs did undergo a major redesign that recognizes the need for uniform screening and assessment tools that are used to help determine the level of care or intensity of service that the child needs. 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.

Nearly all Maine children receiving case management services are eligible for MaineCare, and are served through CBHS Targeted Case Management services under that funding mechanism. Eight years ago when CBHS staff assumed non-direct service responsibilities, case management services for children with intellectual disability and autism were transferred to community provider agencies. This change, coupled with a high demand for case management services from families who had not previously been served, resulted in a dramatic expansion of both provider agencies and numbers of children served in the MaineCare funded program.

The utilization of Targeted Case Management services has been under review in the past year with important adjustments and MaineCare policy changes under way. These proposed changes were part of the Department's Strategic Plan to implement a single case management system in FY10. Under a key Budget Initiative for FY10-11, the Department established measurable criteria to assist in the case management process by determining whether case management continues to be medically necessary on a case by case assessment for individual children and youth.

Inpatient Services and Hospital Capacity As of July 2011 the number of beds for children and adolescents at Maine in inpatient psychiatric hospitals totaled 99 and were allocated as follows:

Provider	Location	Service Type + amount	Total
Spring Harbor	Westbrook	Child=14, Adolescent=14 MR/DD/Autism Unit = 12	Total= 40
St. Mary's	Lewiston	Child/ Adolescent = 20	Total= 20
Northern Maine Medical Center	Fort Kent	Serves age range from 4-17	Total= 7
Acadia (Bangor)	Bangor	Child=16, Adolescent=16	Total = 32
Maine Inpatient Psychiatric Beds			Total =99

Maine has two free standing psychiatric facilities, one in Bangor with a child and adolescent unit with 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 a 20 bed unit in central Maine (Lewiston).

Children in Out of State Placement For a number of years Maine, like many other states, placed children and adolescents with behavioral health or habilitation needs in out-of-state residential programs or hospitals for behavioral health treatment services. This practice reflected a lack of appropriate in-state treatment programs and inpatient psychiatric capacity to meet the needs of these children. Both families and their children do far better when they are able to stay connected with each other during hospitalization or while in a temporary out-of-home treatment setting. Out-of-state placements typically mean that parents are separated from their children for extensive periods of time. This causes additional emotional stress on siblings and financial hardship that impacts the entire family.
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. The legislation references a Memorandum of Agreement between the former BDS and the Department of Human Services. This document establishes a priority for returning children

who are in out-of-state hospital and residential placements, as well as children who could be diverted from unnecessary placement out of state.

CBHS 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 served out of state in July, 2010 was 26 and the census of children receiving treatment out of state in July, 2011 was 20, resulting in a net change of (-6) children during the 12 month period.

- The census in out of state program in July, 2011, was 4 for Child Welfare Services, which has responsibility for children in state custody, and 16 youth for Children's Behavioral Health Services, which has responsibility for children in parental custody or are their own guardian.

- The census over the past seven years represents a steady reduction in the utilization of out of state treatment programs and inpatient psychiatric care , decreasing from 68 in 2003 to 20 in 2011. Shortly after the passage of Chapter 790 in April, 1998, the census out of state was 260 children. Over the past 13 years the census has been reduced by 92% percent of that total, or by 239 children.

- The current census by facility type is Residential Treatment, 18 children or 86% and Hospital setting, 2 children or 14%.

- Of the 21 youth currently in out of state facilities, all reside in New England programs, either in Massachusetts or New Hampshire.

- Of the 18 youth currently in out of state residential programs, 6 (29%) are 18-21 years old, and are awaiting openings in Adult Waiver Services for individuals with Cognitive & Physical Disabilities.

Over the last several years there has been greater availability of in-state resources such as intensive home and community behavioral treatment services, intensive temporary out-of-home residential treatment programs, and other specialized treatment options developed in Maine where none existed in earlier years. These factors have had a positive effect on decreasing out of state placements over time.

Systems Access Program and Utilization Review

Much of the reduction in out of state placements during this period can be attributed to collaboration among the state's child-serving state agencies, and especially between Children's Behavioral Health Services and Child Welfare Services.

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 Children's Behavioral Health Services Clinical 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.

In FY10, MaineCare eligibility criteria was amended for residential treatment which established a two level system of need. (Mental Health I & II and Intellectual Disability/Pervasive Developmental Disorders I & II). The determination of a Level I (moderate behavior) or Level II (severe behavior) is dependent upon the child's presenting unsafe behaviors and the clinical intervention necessary to meet the needs of the presenting behaviors. The use of this two level system has continued throughout FY11.

Intensive behavioral treatment is provided in order to address the specific unsafe behaviors that necessitated the child needing to leave the home. Once the behaviors that were unsafe have decreased, the child will return to his/her own home and continue treatment as necessary with community based treatment services. Research has clearly indicated that the longer a child is out of the home, the more difficult it is for the child to successfully transition back into his/her home and community. The focal treatment approach of ITRTS should minimize the time that the child is physically out of the home. A basic premise of this program is the requirement of active caregiver involvement in the child's treatment, so that new skills acquired by both the child and the caregiver can be practiced together leading to better success in generalizing these skills in the home upon discharge.

Formal prior authorization and continued stay processes for residential treatment is required for all children regardless of custody status. 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 a Clinical Review Team.

In FY11, the Clinical Review Team composition was changed from a team made up of multiple staff from both CBHS and Child Welfare (CW) to a team of two that includes the CBHS Mental Health Program Coordinator and CBHS Clinical Care Specialist. The CBHS Medical Director is involved as necessary. This change was in relation to efficiency of the Prior Authorization process and the direction of the State in regard to managed care. The Clinical Review Team receives and reviews documentation for each request for residential treatment, determines if the child meets the level of care for this service, determines Level I or II if the child meets the level of care for residential treatment, reviews the initial treatment plan submitted from a prospective provider, and authorizes admission to a residential treatment program.

Once a child is admitted into a residential treatment program, any requests for continued stay are submitted by the residential provider to the state's Administrative Service Organization, APS Healthcare. 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. Training continues for Child Welfare staff, community case managers, Guardian Ad Litems, AAG's and other service providers about residential treatment and the prior authorization/utilization review process.

ITRTS residential data reflects all children who have received residential treatment regardless of custody status. In FY11, a total of 650 children received residential treatment services. Of this number, 167 were in state's custody (Child Welfare Services). In FY11, CBHS served 483 children and youth in 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.

Overall 58 fewer children received out of state treatment services decreased by 8.2%
Number of CWS children who received out of state treatment services decreased by 39.5%
Number of CBHS children who received out of state treatment services increased by 11.8 %

Office of Substance Abuse: 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 & Human Services through the Office of Substance Abuse.

OSA reports in FY 11 that a total of 1,115(unduplicated) admissions for services were provided to children and adolescents, up to age 20 years**.** Of those admissions 530 (o 47.5%) were identified as children with dual diagnoses, specifically with substance abuse and mental health needs. Specific unduplicated services provided to this population were; Outpatient (357); Intensive Outpatient (63); Evaluation (18); Detoxification (10); Residential (64); Methadone (13) and Shelter (5).

The following agencies have specific programs for youth that are funded through OSA 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.

The Co-occurring State Integration Initiative is a grant- funded project designed to help DHHS develop infrastructure as well as clinical capacity to provide integrated care to those with co-occurring mental health and substance use disorders. The Co-occurring State Incentive Grant (COSIG) was awarded to Maine by SAMHSA in 2005 and will be extended through 2011. The grant addresses the needs of both adults and children.

Since 2005, the project has overseen the development of a Department-wide policy on integration of care applicable to all providers, has helped to write and implement new licensing regulations related to co-occurring care, has written contract language requiring co-occurring capability for all providers, and has implemented a standardized state-wide screening tool that has a specific child version. A set of clinical standards and guidelines for co-occurring practice has been published and will be made available to all providers. A new code for integrated services has been added to the outpatient mental health MaineCare regulations. Finally, at least four of 30 pilot sites engaged with the project are specifically child-serving agencies. Data was collected from these sites, along with date from both juvenile detention facilities, providing a small sampling of outcomes and demographic characteristics for these children. Maine has been able to make small inroads into new clinical approaches for children who have mental health as well as substance abuse disorders and will work over the coming year to sustain and advance these achievements.

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. Children's Services regional offices maintain an informal list of dental providers who are willing to take children with MaineCare insurance. Children's Services 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. Children's Behavioral Health Services 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 is the umbrella term in use in the State of Maine to collectively refer to all benefits provided under previously separate program names such as Medicaid, SCHIP, CubCare, etc. The name change (a Legislative mandate) is administrative in nature and represents no change in benefits or rights of beneficiaries. MaineCare is administered by the Department of Health and Human Services, Office of MaineCare Services.

MaineCare, with Title XIX funding, provides coverage to children from birth to 12 months of age in families with income through 185% of the federal poverty level (FPL), children ages 1 through 5 in families with income through 133% FPL, and children ages 6 through 18 in families with income through 125% FPL. With Title XXI funding, (under MaineCare expansion), MaineCare provides coverage to children ages 1 through 18 in families with income from 133%/125% through 150% 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 186% through 200% of the FPL, and to children ages 1 through 18 in families with income from 151% through 200% of FPL

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. Over the course of FY11, the CHIP caseload averaged 10,291 children per month.

Rehabilitation and Employment Services

Children's Behavioral Health Services 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 Adult Cognitive and Physical Disabilities (OACPD) to begin early collaborative planning for young people at age 16 so that the adult service system can begin resource planning for future needs. In addition a unique aspect of this agreement allows a young person who is age 18 to receive needed supports and services from either system or both systems as circumstances require and allow. As part of that agreement training was provided to Children's Behavioral Health Services contracted case managers. Training included such topics as vocational rehabilitation, guardianship issues and consumer perspective. In FY09 CBHS collaborated with the Office of Adult Mental Health Services and produced a formal Memorandum of Understanding around transition of youth from children's service to adult services, described in Criterion 3, Children's Services.

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 9 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. The December, 2010 census for this selected group of students shows a decrease of 742 children or 0.5% from 2009. These categories, with child count data are listed as follows:

Department of Education - Special Education - Child Count Data
December, 2010

Disability/Exceptionality	Age 3-5 CDS	Age 6-21 School Age	Total	% of All Child Count
Intellectual disability	12	710	722	2.24
Emotional Disability	748	2,512	2,560	7.94
Specific Learning Disability	*	**	9,311	28.93
Multiple Disabilities	78	2,088	2,878	8.92
Developmentally Delayed	745	49	794	2.46
Autism	405	2,241	2,646	8.20
TOTALS	**1,288**	**7,600**	**18,911**	**58.69**

* DOE suppresses numbers for confidentiality purposes when number is less than 10.
** Suppressed to avoid mathematical exposure

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 FY11 showed a census of about 5.353 children. In the IDEA Part C program for children ages 0-2, the total count of active children was 1,253. 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 379 of Part C children. The rest, 874 children, had qualified and had an Individual Family Service Plan (IFSP).

Part B –619 the program for children ages 3-5, accounted for 4,100 of the children in the system, 641 had been referred and were being evaluated to determine if they qualified for services. 3,459 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 5.353 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, 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 & 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.

Managed Care Initiative

Administrative Services Organization/ APS Healthcare : In September, 2007, the state entered a two-year contract with APS Healthcare (since, extended to four years) to act as an Administrative Services Organization and provide managed care services for adult and child mental health and substance abuse services. APS provides prior authorization and/or utilization review for children's mental health services, including Targeted Case Management, Outpatient Services, Home and Community-Based Treatment, Children's Assertive Community Treatment, Crisis Services, Residential and Inpatient Psychiatric Services. Children's Behavioral Health Services and APS work on collaborative models of utilization management, care management, provider relations and quality improvement that emphasize community partnership, training and technical assistance

Maine continues in to work on developing a managed care system. The particular model of managed care has not been selected as of this date. The decision as to the model and the RFP and start-up of the managed care entity is anticipated to occur by July 2012.

The Managed Care Design Management Committee (DMC) met for the first time in mid-August 2010. The DMC is responsible for overseeing the Managed Care initiative; interfacing with the Stakeholder Advisory Committee; developing overall design of the program; articulating goals and objectives; directing assignments to, and coordinating various subcommittees. CBHS staff will actively participate on these subcommittees, which will cover issues such as quality care, operations, financial and special topics/populations.

Children's Behavioral Health successfully advocated for active youth and family involvement within the formal Stakeholders Advisory Committee (SAC). There is a representative from Youth MOVE Maine, a youth representative from the Child Welfare Services' Youth Leadership Advisory Team, a family representative from the GEAR Parent Network, which is the Maine chapter of the Federation of Families for Children's Mental Health, from the Autism Society of Maine and NAMI Maine. As directed by the legislature, this committee will provide guidance to the Director of MaineCare Services during both the initial design and then the implementation phase for the Managed MaineCare program.

In preparation for this effort in FY11, CBHS developed a document related to the Outcomes and Processes to be Specified in the Managed Care Contract, which will be a helpful guide to assure that we continue to keep child, youth and family related issues in the forefront of this work as the services/benefit options are developed in the coming year. This work is a major systemic change in the oversight and management of services and supports for all Medicaid populations. This direction will have a major impact on the roles & responsibilities of Children's Behavioral Health Services staff at both the local and central office levels.

The CBHS Director is a member of the Managed Care Design Management Committee (DMC), which reports directly to the Commissioner's Office.

This year the Department of Health and Human Services (DHHS) has developed a four-pronged value-based purchasing strategy to achieve target savings and improve health outcomes. Value-based purchasing means holding providers accountable for both the quality and cost of care, through:

- increased transparency of cost and quality outcomes,
- rewards for performance, and
- payment reform.

Below are the proved health outcomes:

1. Emergency Department Collaborative Care Management Initiative

Over the past year, MaineCare conducted a collaborative care management pilot with Maine General to reduce non-urgent use of their Emergency Department (ED) by MaineCare members. The pilot saved an estimated $100,000 in reduced ED costs just from working with approximately 35 members. MaineCare has decided to expand the pilot statewide in the face of increasing ED costs and an expressed interest from hospitals in increased care management capacity. This summer, MaineCare has met with all of Maine's hospitals to discuss the initiative and to assess the care management capacity of their respective hospital systems, the members' primary care provider offices or patient centered medical home, and community care teams, where available. MaineCare will utilize the identified care management resources as the first line and, where care management services are not available; MaineCare will provide the care management resources.

2. Transition toward risk-based contracting with qualified providers; exploration of global and/or bundled payments.

MaineCare will build off its work with hospital EDs to enter into risk-based agreements with capable providers for the care management of their members. In exchange for a per member per month administrative fee, providers will collaborate with hospitals and EDs, primary care providers, specialists and other entities to achieve quality outcomes and cost savings. MaineCare will explore the possibility of phasing in alternative payment modes such as shared savings, bundled episode of care payments, or global payments

3. Leveraging and/or expansion of current initiatives and federal opportunities

Pay for Performance: MaineCare is conducting an analysis of its Primary Care Case Management (PCCM) and Primary Care Provider Incentive Payment (PCPIP) to identify opportunities to better incent providers to deliver quality, cost efficient care. Reforms under consideration include a more stringent baseline for providers to qualify for incentive payments, and increased payments for providers who do qualify. We are also looking at shifting the emphasis on payment criteria on which the payments are made from access, where significant progress has already been made, to reduced ED utilization, attainment of clinical quality benchmarks, and the provision of cost efficient care

Transparency & Reporting: MaineCare will continue to provide quality and utilization reports to its PCCM providers. In addition, MaineCare plans to learn from the efforts of the State Employee Health Commission, the Maine Health Management Coalition and Quality Counts! to develop provider rankings to share with MaineCare members and the public.

4. Targeting Individuals with Dual Medicaid and Medicare Eligibility, Chronic or Complex conditions:

MaineCare currently has 26 multi-payer Patient Centered Medical Homes (PCMH), initiatives which have gained national recognition for the "promising trends" they show on cost and quality, as well as "greatly improved access to care."[i] Medicare is joining the PCMH Pilot in October 2011 under the Medicare Multi-Payer Advanced Primary care practice (MAPCP) demonstration, at which point Community Health Teams (CHT) will be introduced as a strategy to improve care and reduce avoidable costs for PCMH patients, especially those with complex or chronic conditions. MaineCare plans to leverage the PCMH and CHT partnership to take advantage of the Affordable Care Act's (ACA) Health Homes option for enrollees with chronic conditions. Implementation of the State Health Homes Option will enable Maine to receive an enhanced 90/10 federal match for the first eight quarters of the initiative. This enhanced match could in turn fund the expansion of PCMH beyond the current 26 practices.

In addition, the Centers for Medicare and Medicaid (CMS) Innovation Center is testing new payment and service delivery models to achieve cost reductions and quality care for Medicare-Medicaid enrollees. MaineCare plans to pursue a model under which they could receive retrospective performance payments for achieving target Medicare savings through improved care coordination for Medicare-Medicaid enrollees under Health Homes or other primary care delivery models.

CRITERION 2: 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. "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 Mental Health Block Grant State Plan.

Maine Estimates of SED Population

In this year's Block Grant Application estimates of the number of children with SED are allocated within the Office of Child & Family Services local District Office structure that is comprised of one or more of Maine's 16 counties. County population information is from the Bureau of the Census (2010) for all children ages 0-17. The estimated State SED population (URS Table 2) was used to estimate the District SED population.

CMHS Data Infrastructure Plan Maine Population Estimate for Children Under Age 18 with SED		
Office of Child & Family Services - Districts	**All Children Ages 0-17 Years 2010 Estimated**	**Estimate of SED Population (yr.2010)**
Aroostook – District 8	14,384	1,030
Downeast – District 7	16,541	1,184
Penquis- District 6	33,720	2,414
Central Maine – District 5	36,484	2,612
Mid-Coast Coast District 4	29,747	2,130
Western Maine – District 3	42,672	3,055
Cumberland District 2	58,894	4,217
York District 1	42,091	3,014
STATE TOTAL (7.16%)	**274,533**	**19,664**

Sources of Data and Information in this Application

Because the FY12 Block Grant Application and Plan rely on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plan, it is useful to state at the beginning of Criterion 2 the specific data sources that Maine employs for these purposes in the current application.

Year End Contract Reports Children's Behavioral Health Services (CBHS) 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 (yearend) reports are a major source of data used by the Department, and are referenced in this Application. Yearend reports are not always available in August of the previous full fiscal year; which is the case for State Fiscal Year 2011. Because Year End Contract Reports for FY10 are complete for all services covered, this is the base year available for inclusion in the current Plan. 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. This system came on-line in September, 2009. 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) This is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children's Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children's Home and Community Based Treatment and Children's Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08 . An updated version of this system became operational on July 1,2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. 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 FY10 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health & Human Services for children, through the Division of Children's Behavioral Health Services and for adults, through the Office of Adult 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 in Part B, Section 3. of the Mental Health Block Grant Application and Plan.

Children Receiving Publicly Funded Services

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 FY10, using information reported to CBHS field personnel, Purchased Services Agreement 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 CBHS, paid through the CBHS budgeted Room & Board account and reported by CBHS Clinical Care Specialists.

Children's Behavioral Health Services
Children Served, by Program Type
Under Community Provider Contract FY10*

Type of Service	#Served	Type of Service	#Served
Case Management	9,696	Outpatient Services	14,664
Crisis Services	5,546	Medication Management	4,444
Early Intervention (0-5)	3,814	Parent Self-Help/Support	4,359
Assertive Community Treatment	505	Sibling/Peer Support	474
Homeless Services	2,506	Residential Treatment	650
Respite Services	1,667	Rehabilitative Community Support	1,492
Flexible Funded Services	2,179	Home&Community Based Treatmt	2,774
Functional Family Therapy (FFT)*	310	MultiSystemic Therapy (MST)*	415

*** Evidence Based Practice**

TOTAL SERVICES PROVIDED to CHILDREN 51,136 (FY10)

Estimation of Unduplicated Count of Children Served

Individual service categories reported above provide an unduplicated count of all children who received that service during FY10. 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. Children's Behavioral Health Services has employed a planning assumption that children and families in Maine receive an average of 2.25 different types of service over a year. Based on that assumption, then **it is estimated that the unduplicated count of children served was 22,727 in FY10**.

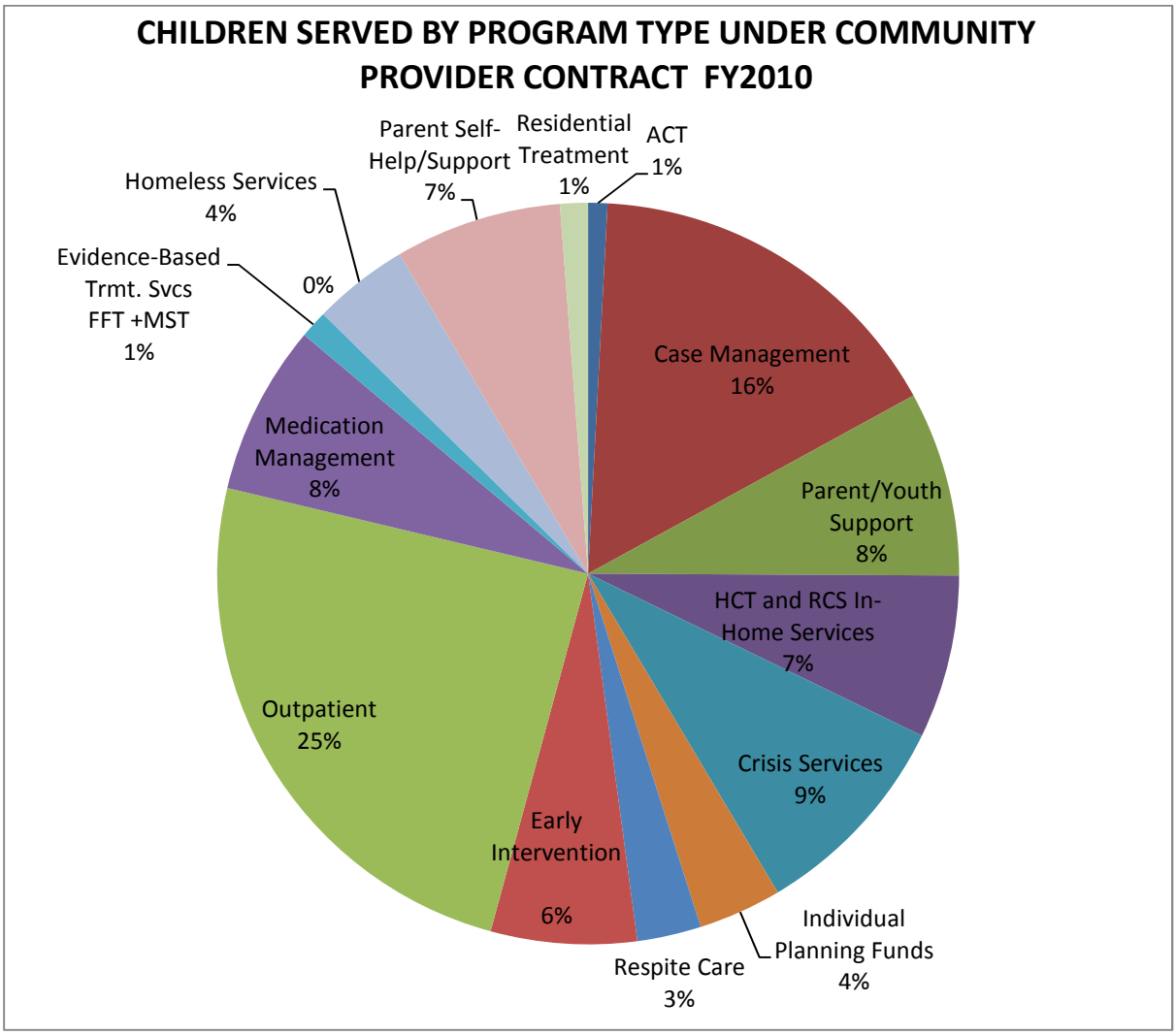
Target for Criterion 2 In addition to the National Outcome Measure (NOM), URS Basic Table 2A which measures increased access to services for children and youth who receive MaineCare behavioral health services, the Department and CBHS also monitor estimates of the total number of children that are served in the fiscal year.

The total unduplicated estimate for FY10 above includes children and their families who are receiving both MaineCare and non-MaineCare covered services such as respite, flexible funded services and/or other family support services. This population also includes children whose service needs are not specifically behavioral health, such as children with intellectual disability who are receiving Rehabilitative and Community Support services, young children with developmental needs who are receiving Early Intervention Services or children whose needs require Therapeutic Recreation/ Socialization activities in the community, provided through Flexible Funds.

The estimated unduplicated count for all children being served in FY10 was 22,727 and the MaineCare behavioral health count (NOM URS Basic Table 2A) was 18,664 (82.2%), leaving

an estimated 4,063 (17.8%) children whose primary diagnoses are likely to include intellectual disability, autism or early childhood developmental delay.

While CBHS does not set a state performance indicator similar to the federal NOM for all services delivered in a fiscal year, the total number served in any fiscal year is critical to track because it is one of the most frequently asked questions directed to the Department. Total children served, by program, are meaningful statistics to program administrators, Departmental officials, the Executive Department and Governor, the public at large and members of the Maine Legislature's Joint Standing Committee on Health & Human Services and the Joint Standing Committee on Appropriations and Financial Affairs.



CRITERION 3: INTEGRATION OF CHILDREN'S SERVICES

Children's Behavioral Health Services has developed strong and viable relationships with other child-serving state agencies, notably the Department of Corrections, Juvenile Services; the Department of Education, the DHHS Office of Substance Abuse and within the Office of Child & Family Services, the Divisions of Child Welfare Services and Early Childhood Services.

These relationships are nurtured and strengthened through active collaboration within the system of care. Collaboration and partnerships are developed at the regional and district levels 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. CBHS 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.

The Division of Children's Behavioral Health Services 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 way stations for some youth as they begin to age out of the children's service system. These agencies include the Office of Adult Mental Health Services which may be a provider for young adults with Serious Mental Illness (SMI) and the Office of Adults with Cognitive and Physical Disabilities 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.

Children's Behavioral Health Services 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 CBHS and they have been long standing partners in key areas within the children's behavioral health services program.

OMS continues to be a valued partner by collaborating with CBHS in writing Medicaid (MaineCare) rules for high quality and essential behavioral health services that incorporate promising, proven and evidence based practices. The MCDC has been supportive in promoting the integration of mental health services with physical health policy as well as other important work with CBHS on the Maine Youth Suicide Prevention Committee's Steering and Action Committees. The OQI has been instrumental in collecting and evaluating data on client outcomes related to specific behavioral health services, and reporting performance indicators for contracted programs that are an important element of the data included in the Mental Health Block Grant Application.

System of Integrated Services

This section of the FY12/13 application focuses on the development of relationships between Children's Behavioral Health Services and the other child-serving agencies that are essential partners in Maine's comprehensive system of care. This section documents the identification of CBHS as the mental health authority in the State of Maine via legislative act, Chapter 790, Public Law 1997.

Historically, many positive steps have been taken leading toward increased integration of behavioral health services within and throughout public and private entities providing behavioral health services to children and youth in Maine. These steps include legislative activity with resulting mandates, memoranda of agreement amongst several state agencies, and between

services divisions within state Departments, and emergence of operational processes that, over time, have strengthened integration as the model of service delivery replacing the more compartmentalized system existing prior to the passage of Chapter 790.

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, the statute covering the former Department of Behavioral and Developmental Services, by adding Chapter 15, Children's Mental Health Services. The legislation does not change the existing Children's Behavioral Health Services statute under Title 34-B, which includes children who have developmental disabilities, intellectual disability, autism, or mental health treatment needs, and their families. The law also does not change the responsibilities of the other 3 child-serving agencies relative to their services, entitlements or benefits that are already in place.

Rather, 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 Children's Behavioral Health 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. There is paramount consideration given for the safety of the child, followed by mental health, emotional,

social, educational and physical needs that are to be addressed in the least restrictive, most normative environment.

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 Children's Behavioral Health Services 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 Department's respective responsibilities.

DHHS Children's Behavioral Health 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. CBHS has this capacity within the Office of Child and Family Services through the integration of CBHS, Early Childhood Services and Child Welfare Services 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, region, care provided 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. Over the first 6 years of the legislation the Departments generated reports on a regular basis at the direction of the committee. These reports included specific topics of interest concerning Juvenile Services, Education, Child Welfare and Children's Behavioral Health Services. All child-serving Departments continue to provide information to their legislative committees of jurisdiction, such as the Joint Standing Committee on Health & Human Services

that oversees DHHS Office of Child & Family Services' Child Welfare Services, Early Childhood Services and Children's Behavioral Health Services. Other committees of jurisdiction include the Joint Standing Committees on Education & 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. Children's Behavioral Health Services 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 3 child-serving state agencies, has promoted a high level of interdepartmental collaboration since that time. Because these partnerships began prior to the merger of the Department of Behavioral and Developmental Services (BDS) and the Department of Human Services (DHS), the original Departments are cited in the discussion below.
These collaborative efforts are summarized as follows:

Children's Behavioral Health Services/ Office of MaineCare Services

In pre-merger years, both Departments have worked closely on a number of initiatives. Now that the unification of the former DHS and BDS has occurred, Children's Behavioral Health Services and the Office of MaineCare Services, in accordance with their previous Memoranda of Agreement, jointly share responsibility for the development of policies for behavioral health care for children and adolescents. Once developed, these policies are formally promulgated by OMS, the state Medicaid authority. Public informational meetings with providers following the release of a MaineCare policy change also include representatives from the Department of Education and Department of Corrections. Providers have indicated they find these meetings to be very helpful, which is both indicative of and reflective of the excellent working relationships between the state agencies.

Significant changes have been made or are presently undergoing formal rulemaking that directly impact the children's system of care. Representative provider agencies participate in the process for proposed changes to MaineCare policies. One of the very important changes occurred over the last two years with the development of MaineCare rules establishing the Children's Home and Community Based Treatment Services, including evidence-based practices such as MultiSystemic Therapy and Functional Family Therapy.

Other Medicaid policy areas underwent revision and resulted in the consolidation of many individual treatment services that are now incorporated in a single section of policy under

Children's Mental Health Services (MaineCare Section 65). Currently there are major policy changes focused on Targeted Case Management services and Residential Treatment services.

Interdepartmental MOU for Assisting Children At Risk

The goal of this protocol was to establish a clear framework and process for meeting the behavioral health needs of children effectively and efficiently. This approach is one of collaborative and joint problem solving. The primary focus is to include and support parents in their efforts to continue nurturing their child and participating in their child's treatment in and out of the child's home. Children's Behavioral Health Services and Child Welfare Services expected all providers to have active family involvement components in their treatment programs and to encourage families to continue to actively participate in all aspects of their child's care and treatment in order to expedite the child's successful transition to their home and community.

Interdepartmental MOU for Assisting Children At Risk -Post Adoption Addendum

Providing a home for children adopted from the child welfare system has a set of challenges and rewards that can differ from raising birth children. This addendum clearly identified the shared responsibility in supporting adopted children and their families when it is apparent that a possible out-of-home placement may be necessary.

This agreement provides for information sharing between DHHS/ Child Welfare Services Adoption Program and Children's Behavioral Health Services, regarding children receiving adoption assistance who also access CBHS grant funds for residential treatment. Both CWS and CBHS facilitate coordination of resources to maximize utilization of appropriate funding and prevent duplication.

Adoptive parents applying for residential services (Intensive Temporary Residential Treatment Services) are informed of CWS and CBHS coordination regarding children receiving Adoption Assistance through Child Welfare Services. Families receiving post-adoption assistance, who have children with special needs, are encouraged by CBHS and its contracted providers to access appropriate services available through the CWS Post-Adoption Support Program. Families receiving post-adoption assistance, who have children with special needs, will be encouraged by the CWS Post-Adoption Support program to access assistance available through Children's Behavioral Health Services and its contracted providers. Both CBHS and CWS recognize there is a shared responsibility to provide adoptive families the most appropriate services that are supportive of their children's needs in a continuum of community-based services. This amendment was finalized in June, 2004.

CBHS Partnership with Maine Center for Disease Control

Project LAUNCH: Linking Actions for Unmet Needs in Children's Health is the most recent illustration of close and successful intra-departmental relationships that CBHS has established with its peers in Maine's Department of Health & Human Services. The Maine Center for Disease Control, Division of Maternal and Child Health, in collaboration with the Office of Child and Family Services, including CBHS, was awarded one of six SAMHSA grants funded

for five years at $916,000 per year to promote wellness for children birth to 8 years of age. Wellness is defined as a state of positive physical, emotional, social and behavioral health. The goal is to create a shared vision for the wellness of young children that drives the development of Federal, State, Territorial, tribal and locally based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed. Project LAUNCH is grounded in the public health approach, working towards coordinated programs that take a comprehensive view of health, addressing the physical, emotional, social and behavioral aspects of wellness

The Community Caring Collaborative (CCC) in Washington County implemented Project LAUNCH. CBHS has had a continuing relationship with this collaborative prior to this current initiative, providing Children's Mental Health Block Grant support for an infant mental health specialist position to develop a curriculum for working with new parents with substance abuse issues. The CCC is comprised of community members, child-serving agencies and tribal entities. The CCC has developed three groups to advance its collaborative efforts. A work group of front-line workers and family members define areas of concern and needs. The Executive Council includes heads of agencies or tribal organizations and family members develops policies and procedures for the collaborative. The State Agency Advisory group explores policy and program issues that require state action and inclusion. The children to be served under Project LAUNCH include those born affected with substances or are at risk due to a variety of other issues and their families and older siblings through age eight. Currently, approximately 100 infants are born a year within this at risk population. Including siblings and parents or caregivers the total population to be served is 300.

CBHS Collaboration with Early Childhood Care and Education

The National Early Childhood Technical Assistance Center (NECTAC) in collaboration with the Office of Special Education Programs (OSEP) is supporting 11 states that are establishing a statewide framework to strengthen families and support a continuum of inclusive community-based early care and education opportunities. Children's Behavioral Health Services is a member of the expanded cross-systems team known as Maine's Expanding Inclusive Opportunities Initiative that is ensuring that children birth through 5 and their families have increased access to high quality community based inclusive early care and education. The team works collaboratively and transparently across sectors and systems both locally and statewide to promote interagency understanding and support of this inclusive initiative.

Assistance to CMS Long Term Services and Supports

Maine is participating in a two-year grant sponsored by the Center for Medicare & Medicaid Services (CMS). Phase I requires the development of a state profile tool that identifies the current long term services and supports system, describes the administration of these services and supports and includes demographic and utilization data. In Phase 2 Maine will work with a National Balancing Indicator Consultant (NBIC) to develop common measures across states for measuring the balance between home and community based services and institutional services. The Office of Child and Family Services is contributing to this project by providing vital

information on children with long term service and supports needs. Central office personnel supporting this work include the CBHS Quality Assurance and Training Manager and the CBHS Information Systems Manager.

Department of Corrections - Juvenile Services/Children's Behavioral Health

CBHS/DOC Summary for FY11

The following narrative summarizes the work of Children's Behavioral Health Services staff assigned to support the Department of Corrections (DOC), Juvenile Services, in all 4 DOC regional offices and in the 2 Youth Development Centers in Fiscal Year 2011.

The collaborative integration of behavioral health services within the juvenile justice system is managed by a CBHS Social Services Manager who oversees the behavioral health services provided within juvenile facilities and by CBHS Team Leaders who supervise Mental Health Program Coordinators attached to the community-based system in DOC regional offices.

The original Memorandum of Agreement beginning this collaboration and the placement of children's mental health staff in Juvenile Youth Development Centers and co-location DOC field offices was signed in 2002 between CBHS and Juvenile Services and was updated in 2007. In the early days of this collaboration, most of the CBHS staffs' efforts were on educating their counterparts within juvenile services that some of the youth on their caseloads were in need of behavioral health treatment. These efforts centered on helping staff have a basic understanding of mental illness and then on removing barriers in order that youth and their families would get the treatment and support that they needed. Over several years this relationship has matured to the point where today the work of staff involved with this program fall into two broad categories: individual consultation, assessment, treatment and advocacy, and system integration and improvement. Those efforts are described below.

Individual Consultation, Assessment, Treatment, Advocacy

Initial Mental Health Assessment- Long Creek and Mountain View Youth Development Centers have worked hard to implement a system to assure that each youth entering the facility has a mental health assessment. Both facilities administer the Massachusetts Youth Screening Inventory-2 (MAYSI-2) to each youth upon admission. The results are given to nursing personnel who further assesses the youth. If a youth scores in the critical area of suicide they are immediately put on a "watch" and further assessed by the Suicide Prevention Protocol. Results of the MAYSI are then given to the CBHS clinical social worker who then completes an additional mental health assessment. These results inform staff about the level of support that youth may need while in the facility, and help inform their teams on mental health symptoms that may need to be treated once they leave the facility. Prior to this system, CBHS clinicians relied on client's self referring, staff observation or on reports from outside providers to signal that a youth may need mental health support. The MAYSI assessment tool and process now provides an objective and systematic way to screen for mental health needs and has been especially helpful in detecting youth with internalizing behaviors.

Aggression Replacement Therapy "ART" This is a multimodal therapy designed to help reduce aggressive behavior in chronically aggressive youth. CBHS staff at Mt. View have co-lead this group therapy with DOC staff.

Trauma Affect Regulation: Guide for Education and Therapy--"Target"- This is a psycho-educational program which teaches youth to manage the symptoms of complex trauma. While some clinicians at Long Creek and Mt. View are trained in the TF-CBT model of trauma treatment, DOC chose to implement Target as it has been designated a promising practice by National Child Traumatic Stress Network, for use with youth in the juvenile justice system. It is basic enough that non-clinical staff are able to help implement it and because it does not require exposure therapy, it is anticipated that this model will be better suited to the sometimes re-traumatizing correctional setting. CBHS staff from Long Creek attended an intensive training and co-facilitated Target groups for girls in the facility. CBHS Mental Health Coordinators will also be attending this training to better understand which youth can benefit from this model.
Team meetings- Mental Health Coordinators spend the bulk of their time in team meetings on individual youth. This provides the opportunity to educate teams on how the youth's mental illness may be interfering with their functioning and on treatment that is matched to their needs. Many of the youth are connected with community mental health case managers, but even in this situation, having a person who understands the complexities between correctional and mental health needs is valuable. It offers someone who is not deeply involved in the day to day challenges of the case to be able to ask questions, and can most often help the team reframe some of their thinking and give hope to parents that their child and family's functioning can improve.

Systems Collaboration/Integration

Youth with Complex Needs- This meeting of Child Welfare, DOC and CBHS Central Office staff and DOC facility staff was initiated because of concern over a number of youth with serious emotional disorders and developmental disabilities who had been detained. These youth did pose a high risk to the community because of aggressive behaviors, but treatment within a correctional system could have the unwanted effect of increasing their criminal risk. This collaborative problem-solving group has been instrumental in developing a systematic approach in considering youth under these circumstances, to include:

Interagency Protocol for Detained Youth - This approach calls for a multidisciplinary team meeting on all detained youth with a joint recommendation to the court in order that the youth can be detained. It outlines steps to move the case to higher administrative levels when a joint agreement cannot be reached. Even with this improvement in the process, monitoring and enforcing a multi-departmental protocol has proved difficult, highlighting the differences in management styles and expectations between the agencies.

Interagency Case Review – Problematic cases are presented, dissected and reviewed with recommendation given for future changes in process.

Jurisdictional Team Planning- JTP involves regional groups of multidisciplinary providers including attorneys, judges, mental health providers and correctional providers who meet on a regular basis to develop ways to avoid the use of secure detention and to increase evidence based practices. Efforts have been extremely fruitful, resulting in a significant decrease in the number

of youth being detained and the length of time they are detained. Other tangible outcomes from this working model have included:

- Resource Guide for parents who have youth in the Juvenile Justice System
- Formal training protocol given to law enforcement officers at the Police Academy to educate them on responding to a crisis
- Formal protocol for police responding to juvenile crisis to document and refer cases to crisis services for follow-up
- Developing a multi-system case review system for families with complex needs and who are involved with multiple providers and services.
- Developing a case review system to address family/ youth situations where multiple police responses have occurred. This is an off shoot of the juvenile reporting form and training that a local police officer spearheaded this past summer.
- Participating in workshop for families who have youth heading toward the JJ system—designed to help them understand modalities that are available to help and designed to get families to be more involved in the development of resources in their communities.
- Redesigning the initial juvenile intake form to identify natural supports and assets early in a youth's involvement with Corrections as a way to begin effective case planning, crisis planning and diversion.

Juvenile Justice Task Force- In April 2009, Chief Justice Saufley, First Lady Karen Baldacci, and Dean Pitegoff of the Maine School of Law convened this task force of state agencies, branches of government and sectors of the non-profit agencies to reform the Juvenile Justice system. Goals included, "increasing educational attainment, access to community-based services, correctional practices, resource allocation and organizational structure and development." While similar to other initiatives such as JTP, Regional Children's Cabinets, the Juvenile Justice Advisory Group and Regional Wraparound Maine Advisory Board, the Juvenile Justice Task force has the advantage of coming from the Governor's office and has been able to actively bring the Departments of Education and Labor to the table.

On April 7th, 2010, Governor Baldacci signed LD 1703 into law – Resolve, To Implement the Recommendations of the Juvenile Justice Task Force – Reinforces the Juvenile Justice Task Force report from March 2010 that called on the state to make major changes to how it treats at-risk or troubled teenagers, proposing a list of goals aimed at keeping youth in school and out of correctional facilities. Since that time, the state has been divided into 8 geographical districts with each district inviting professional providers along with community members to develop a strategic plan for their district on how they will achieve the goals outlined.

Intensive Temporary Residential Treatment "ITRT"- CBHS staff present and review youth to determine level of care, when this is a treatment option that is being considered

Sexual Behavior Treatment- CBHS staff, along with DOC staff present cases to consultant Dr. Sue Righthand to insure youth get appropriate levels of treatment

Girls Case Management- CBHS staff are working with DOC staff to develop and implement gender specific case management guidelines for girls in the correctional system. Currently there are two Juvenile Community Corrections Officers (JCCO's) who have all girls caseloads and are slowly implementing these practices. The group is also working on how to screen girls early in the process to identify mental health needs.

Substance Abuse Collaborative—Mental Health Coordinators are members of this collaborative, aimed at improving system delivery to youth with substance abuse problems. The focus statewide of substance abuse treatment has been to have all providers capable in treating substance abuse in a co-occurring model

Aggressive Youth in Residential Treatment-CBHS and DOC staff work together to ensure that residential treatment facilities respond appropriately when youth with dual mental health and correctional involvement become violent.

Mt. View Facility and Community Collaborative - Monthly meeting where mental health staff from DOC and CBHS who work in the facility are joined by their counterparts in the community to help identify and plan for youth who are transitioning out of the Mt. View facility.

Education on Evidence Based Treatment/Promising Practices-Mental Health Coordinators in each region meet with providers and corrections frequently to disseminate information about evidence based treatment and connect people with the agencies providing these treatment modalities. MST, FFT, Multidimensional Treatment Foster Care, TF-CBT, and Wraparound Maine have all been promoted in this population. Due to needs identified, in part by the Mental Health Coordinators, Kennebec Behavioral Health expanded their MST services several years ago to include a Sexual Behavior Specialty.

Enterprise Information System (EIS)- Mental Health Coordinators are beginning to use this electronic record system to better document, track and share information on the youth they work with.

Continuous Quality Improvement (CQI)- Mental Health Coordinators are working alongside the other Clinical Staff and families, youth and providers to develop an effective tool to measure the quality of services that CBHS contracted providers deliver.

Goals for Fiscal Year 2012

Each year, a substantial amount of the staff's time is spent maintaining the basic foundation of the collaborative work—educating, sustaining relationships, continuing practices that have been put into place. In FY12 these and the above efforts will continue, along with some new initiatives which include:

Crisis Planning- Insuring that all youth have a crisis plan that is easily utilized and that includes natural supports. York County JTP is gathering data on the effectiveness of the crisis protocol they developed in conjunction with local and state police.

Restorative Justice- At least two areas of the state have a Restorative Justice Program. Both York and Cumberland County JTP's are looking to expand this to their regions. The Restorative Justice Project of Midcoast serves juvenile offenders in Knox and Waldo Counties and in four additional counties (Washington, Sagadahoc, Lincoln and Hancock).
Parents who have youth in the system are interested in assisting with this project. In the current legal system youth are frequently not encouraged to take responsibility for their actions, any consequence for their action may be months away from the actual offense they committed. From a developmental perspective, this is not effective. The current legal system frequently minimizes the victim's experience and pushes the youth further away from their community and from the people they may have caused harm to. Restorative Justice is a model that better matches adolescent development and helps the youth become a productive citizen of their community.

Transition- With a good foundation of treatment both in the community and in the correctional facilities, the next step is to refine the transition process for those youth going from one setting to the other. CBHS staff will continue to work with youth and families to assist in individual transition plans and to better operationalize the transition process.

Summary of Direct Services Provided and Utilization of Individual Planning Funds

In addition to systemic work, CBHS mental health personnel provided direct service to youth and families involved in DOC Juvenile Services and authorized funding for services and items that were not able to be paid by existing funding sources.

Mental Health Consultation- Consultation by community and facility based staff was provided by Mental Health Coordinators for approximately 475 individual youth. These consultations ranged from brief contact with a parent or provider while other consultations required extensive involvement, such as when youth with high risk behaviors and complex mental health needs transitions to another part of the continuum (community to facility or facility to community) or transitions to adulthood.

Clinical Counseling at Long Creek- Both clinical social workers at Long Creek left for other employment and these positions have not been filled. The workload of individual clinical counseling, suicide assessments, initial assessments, team meetings and behavior stabilization are being covered by the Program Manager and other DOC staff.

Mental Health Coordinator and Psychiatric Social Work Services at Mt. View

80 mental health appraisals for detained youth
10 initial assessments for committed youth
11 youth were served with ongoing case management
29 youth were provided cognitive skills training
16 youth were provided Aggression Replacement Therapy

Individual Planning Funds - In FY11 $105,985 was spent on youth who had entered the DOC system. The highest percentage was spent on specialized assessments and on specialized treatment. Expenditures were as follows:

	Region 1	Region 2	Region 3	Mt. View	Long Creek
Case Management		766			
Clothing			281		
Clinical Treatment		11,762			1,200
Crisis Support		1,333			
Evaluation	51,920	20,149	3,480	900	3,800
Family Support	783	445	610		
Housing					
Medication/medical equipment			329		
Recreation	1,115	422	597		
Respite					
Safety Equipment		503			
Supported Employment					
Transportation		681	2,319		
Emergency Funds to Keep Youth in Their Home (fuel/utilities)		668	1,925		
Totals	53,818	36,726	9,541	900	5,000

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 & 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 Services

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

OSA provides support for 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. The Office of Substance Abuse Services is involved in Drug Treatment Court programs in Biddeford, Portland, West Bath, Augusta, Waterville, Bangor and Lewiston. This activity is supported by the Juvenile Accountability Incentive Block Grant, administered by the Department of Corrections until June 30, 2010.

In FY11, OSA provided the following substance abuse services to adolescents (under the age of 19 at admission) in Maine: Evaluations (53) Outpatient (650); Intensive Outpatient (47); Detoxification (9); Residential (80); Shelter (1); and Methadone (10). The unduplicated clients served totals 851.

Data available from a survey of selected public schools conducted last year by the Office of Substance Abuse suggest that Maine has made progress in decreasing alcohol, marijuana, and other drug use among its youth. Detailed reports can be found in the right hand navigation bar at the following link: http://www.maine.gov/dhhs/osa/data/cesn/index.htm . During state fiscal year 2009, among the 985 youth who needed substance abuse treatment, most (49%) entered treatment for marijuana abuse. Thirty percent entered treatment for alcohol abuse, 12.5 percent entered treatment for opiate abuse, and ten percent entered treatment to address issues with other substances. OSA will continue to work with treatment providers and others to determine what barriers exist for adolescents and families trying to access treatment services.

Department of Education/CBHS

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. Presently, this committee is active in assisting providers in the redesign of their residential programs from long-term residential to shorter-term, family focused treatment programs with the goal of lessening length of out-of-home placement and maintaining connections to a child's natural community and extended family.

The Department of Education is a frequent collaborator with the other child serving state agencies, either as a participant or advisor to new initiatives which involve multiple agencies. CBHS has been an active partner with DOE regarding specific behavioral health MaineCare services provided through DOE. CBHS staff have assisted in re-writing policy related to children in the educational system that included Day Treatment Services (Section 41) and Early Intervention Services (Section 27).

Child Development Services (DOE)/ Children's Behavioral Health Services

In FY12/13 Children's Behavioral Health Services will continue 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 CBHS. These connections can be identified through CBHS contracted case management agencies.

Other objectives include training initiatives that provide a consistent and comprehensive overview of the CDS and CBHS missions and operations for pre-school/ early intervention services and to identify the assessment tools used by CDS and CBHS.

The Department supports a strengthened and enhanced relationship with CDS at the community level that will improve the coordination of care and service delivery to this population through vehicles such as team meetings and individual plan development.

MADSEC/BDS Liaison Committee

In an effort to support and implement the Memorandum of Agreement with DOE, a liaison committee was established in November of 2002 with statewide representation of the Maine Administrators of Special Education Services (MADSEC) and the Department of Behavioral and Developmental Services, Children's Services (BDS). The liaison committee meets monthly and its primary focus is to enhance the communication and coordination among schools, BDS contracted community case management provider agencies, and departmental staff on the local, regional, and state levels. CBHS central office and regional staff are active members of this committee.

For the past several years, this committee provided several statewide trainings called "Building Mutual Respect for Working Relationships" for participants and audiences which include parents, youth, community case managers and school personnel, and state child-serving department staff. This initiative grew out of the need to improve working relationships between community case managers and educators. Its mission has been "to foster statewide cooperation, collaboration, commitment and utilization of resources, services and personnel to provide timely and appropriate services for children/youth with disabilities."

Areas reviewed and discussed include the departments/agencies/school's respective missions, legal mandates and statutes, and includes information on the type, range, and access of services available from each sector. The trainings have been a welcome and helpful avenue for stakeholders to learn about others' roles and responsibilities and to build effective working relationships so that everyone may better serve children and families. Trainings were provided by various members of MADSEC, DHHS, DOE, local school personnel, parents and youth. Evaluations of the training have universally been very positive. In January 2009 the committee completed its work, concluding that its mission had been accomplished.

School-Based Health Centers

Twenty-seven (27) 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 student's primary care providers.

Most schools value the importance of the integration of physical and mental health services. Counseling, mental health and substance abuse services can include:

- Individual and group counseling
- Referrals to community providers
- Preventive health guidance/education
- Nutritional education and counseling
- Support groups for eating disorders, chronic diseases, smoking cessation, grieving, substance abuse, etc.
- Sexual health counseling
- Pregnancy counseling
- Job counseling
- Family counseling

School-Based Health Centers are funded from a variety of sources that may include the Fund for Healthy Maine, State general funds, federal funds, local school funds, and cash or in-kind services from schools, service providers and other community entities. Most SBHCs receive reimbursement for eligible services from public and private insurers.

Day Treatment/Local Education

Day treatment services are available to participating schools through Maine Care Day Treatment Services, Section 65. DHHS Maine Care 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 Maine Care staff to provide training and certification for Behavioral Health Professionals who will provide direct services to students in day treatment programs.

Day treatment services are designed to improve a child's functioning in daily living and community living. Programs commonly include a mixture of individual, group and activities therapy, and may also include therapeutic treatment oriented toward developing a child's emotional and physical capability in areas of daily living, community integration and interpersonal functioning. Services will be provided as prescribed in the Individual Education Plan and Individual Service Plan.

Transitional Services for Adolescents and Young Adults

In October 2002 an interdepartmental protocol for the coordination and transition of children served by the former DHS and BDS was completed. This protocol covers youth with identified diagnoses of mental illness, youth with intellectual disability and youth who are in need of adult

protective services who will transition from youth services to adult services. This protocol also covers youth served by both Child Welfare and Children's Behavioral Health services systems.

Currently, both the Office of Elder Services (OES) and Office of Adults with Cognitive and Physical Disabilities (OACPD) within DHHS are committed to providing a close collaborative working environment in order to plan and work together and share common expertise to support youth and young adults who are consumers of State services. Elder Services provides adult protective services to youth who transition and OACPD provides services for adults with intellectual disability. In setting forth this Protocol, the DHHS reaffirms its commitment to providing the best services and supports possible by building on the strengths of their mutual work. An interactive training module around guardianship was produced through the Muskie Institute in collaboration with Elder Services and OACPD at: http://www.maine.gov/dhhs/guardianship/guide.shtml.

The purpose of this Protocol is to set forth expectations and agreements that form a pathway to guide this work together, acknowledging and building upon excellent regional collaboration. In helping youth transition to adult services, collaboration, consumer-focus, information sharing and planning are recognized as the most crucial components.

MOU between CBHS and OAMHS Regarding Transition Age Individuals

An important product of the *Moving Forward* Initiative (discussed later in this Criterion) has been the concurrent development of an updated Memorandum of Understanding between the Division of Children's Behavioral Health Services and the Office of Adult Mental Health Services (OAMHS). 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.

OAMHS and CBHS are committed to collaborative systems approaches to ensure timely access to needed services and continuity of care to ensure a seamless transition to adulthood. The mental health system of care will be family-driven, youth guided, culturally competent, strengths based, trauma informed and apply the principles of effective interventions for transition age individuals.

The MOU details the responsibilities of both parties and contracted provider agencies regarding joint tracking of individuals from the age of 16 who are expected to require mental health services and supports into adulthood and to engage consumers, families, providers and advocates in the development of state regulations to ensure that services are available and consistent across child and adult services and barriers to accessibility are eliminated. Staff from both state agencies will be cross-trained in the Transition to Independence (TIP) curriculum, as will community providers.

Provider contract obligations will ensure that relevant information for transition planning is exchanged with individuals, other treatment providers, family members and others involved in the planning process. Both offices agree to monitor provider outcomes in a coordinated fashion

at the regional level, and coordinate on any corrective action plans with providers, and jointly monitor progress on plans.

CBHS and OAMHS will develop and implement training and support for case managers and clinicians in implementing effective transition planning, using TIP as the foundational approach to transition planning. Both parties agree to maximize existing and available resources to support individual needs, and to identify available funding and possible methods for integrating or enhancing funds related to individuals transitioning within the public mental health systems.

The policies and procedures developed under the MOU will be reviewed on a semi-annual basis by central office staff responsible for policy development and implementation, including the Directors of each Office. This review covers policies and procedures that in any way impact the system of care for transition age individuals. Data collected by each Office will be used to jointly evaluate the utility and benefit of the agreement by establishing performance measures to monitor the progress towards attainment of goals and to measure the level of progress.

Youth Transitioning from Foster Care

Children's Behavioral Health Services is one of several collaborators actively involved with Child Welfare Services to improve outcomes for youth leaving foster care, and to enhance opportunities to help these youth make a successful transition to adulthood.

Child Welfare Services has worked in collaboration with the University of Southern Maine, through the Jim Casey Youth Opportunities Initiative (JCYOI), and public and private partners on improving outcomes of youth transitioning from publicly funded foster care for the past 5 years.

This Collaborative, known as the Maine Youth Transition Collaborative (MYTC), with the help of JCYOI and The Finance Project, are identifying potential funding streams that could be used to assist youth in foster care to transition to adult life. This information will be used to prioritize youth transition services within the context of the following key goals: 1) Establishing permanent connections to family and other lifelong resources; 2) Ensuring economic stability-including education, employment, and housing; 3) Ensuring health and well-being.

With the knowledge and expertise of the working group, a broad range of resources are being categorized that will assist youth in accessing services and making informed choices as they prepare to leave the foster care system and improve their outcomes as adults. The entities helping to map out the options in a path to adulthood include staff from the Departments of Health and Human Services, Corrections, Labor, and Education. They are joined by other committed parties such as the Maine Youth Transition Collaborative, Common Sense Ventures, and Jobs for Maine Graduates.

As this initiative progresses the next steps will be to find local people, organizations or foundations that are "door openers" for these youth to find opportunities for independent living in Maine communities.

Additionally, as part of the Maine Youth Transition Collaborative, this public/private partnership, is also working on community engagement in York County. Implementing the network strategies of the Interactive Institute for Social Change, and in following the model of youth and adult partnership, Maine is focused on improving outcomes for youth transitioning from foster care in the areas of permanency, housing, education, and employment. Maine is looking this year to assist in similar network and community engagement efforts in Penobscot County as well.

Children's Behavioral Health Services and Child Welfare Services are also working in collaboration with the Office of Adult with Cognitive and Physical Disabilities (OACPD) to develop a protocol to assist in the smooth transition of young adults from the children's behavioral health system to the system serving adults with intellectual and cognitive disabilities. Under this newly developed protocol, Child Welfare Services will continue to provide placement and other funding for youth on a Voluntary Extended Care Agreement, while they receive all case management services from OACPD.

Notably, Child Welfare Services and Children's Behavioral Health Services worked in collaboration with youth in care and formerly in care to revise the Child Welfare Youth Transition Assessment as well as the Child Welfare Youth Transition Policy, which includes an enhanced Voluntary Extended Support Agreement that will more fully address on-going transition planning with youth.

Intellectual Disability Services Transition

Strategies that were initiated prior to the merger of the two Departments included work with Children's Services and the former Adult Intellectual disability Services. 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. 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/OACPDS/DS/CommCaseManagement/CM_Manual/Eligibility.html

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. Regional staff is meeting regularly to discuss planning efforts and ongoing collaboration. Finally, protocols for information sharing and resource development have been developed and agreed upon.

Wraparound Maine

Wraparound Maine is an initiative jointly funded through Child Welfare Services and Children's Behavioral Health Services that is operational in nine (9) sites in Maine. This state initiative focuses on school aged children and youth with severe emotional disturbance who are involved with multiple child-serving agencies and are in residential treatment or at risk for residential

placement. Sites are overseen by a statewide governing council and local collaborative boards consisting of child-serving agency representatives including personnel from the Office of Child & Family Services, Child Welfare Services, Children's Behavioral Health Services, the Department of Corrections, Juvenile Services, and Department of Education as well as local school systems and service providers. Parents and youth who have experience with the wraparound process are valuable members of the governing council and they share equal status with the other membership.

These sites are funded through a $4 million annual appropriation which is the equivalent in savings generated from a reduction in Child Welfare Services costs of residential foster care services over recent years. Wraparound or flexible funds are employed to address individual needs of families and youth when there is no other dedicated or categorical funding available to meet the individual's identified needs. CBHS pays the MaineCare seed costs for Targeted Case Management services for individuals served through Wraparound Maine. This initiative currently serves an average of 200 youth at any point in time.

The Children's Cabinet

The Children's Cabinet was established in 1995 to oversee and coordinate the delivery of services to children in Maine. The Children's Cabinet is composed of the Departments directly related to children and families: Corrections, Education, Health and Human Services, Public Safety, and Labor. The vision of the Children's Cabinet is that children's needs are best met within the context of relationships in the family and community.

The mission of the Children's Cabinet is to actively collaborate to create and promote coordinated policies and service delivery systems that support children, families and communities. The Children's Cabinet was previously chaired by the First Lady Baldacci. In 2007 the Children's Cabinet selected 3 priorities that were: Early Childhood Initiative; Adverse Children's Experiences (ACES) and Transition of children to other systems. In 2008 these priorities were expanded with greater definition and they work towards systems change. Initiatives include Early Childhood Systems and Supports, to sustain and enhance accomplishments in the juvenile justice system, to sustain and enhance permanency in Child Welfare, focus on children living in poverty or who are hungry, and a systemic approach to "Creating Safe, Fair, Healthy and Responsive Schools" training and supports.

The Children's Cabinet's approach includes a Shared Youth Vision Council for 18-24 year olds providing ongoing, cross-systems and stakeholder issues relating to youth in transition with a plan to replicate Trauma-Informed Systems of Care as an approach to Adverse Childhood Experiences.

In addition, the Children's Cabinet's Task Force on Early Childhood, now a legislated standing committee called the Children's Growth Council, inspired and informed the 2007 Governor's Summit on Economic Investment in Early Childhood from which the Educare Center project emerged. Educare Central Maine will open in August 2010 and be the demonstration program for the highest quality systems change to include public/private investments, childcare and

developmental supports, child and family/parent mental and physical health needs, home visiting and prenatal care, economic security, data-collection and tracking in Maine and New England.

The enthusiasm surrounding Educare's emergence in Maine spans across private and public sectors, early childhood provider groups, K-12 and higher education leaders and staff, and across state agencies serving families with young children. The recent focus on the need for quality early childhood expansion is grounded in a very tangible goal, as the national, state and local planning teams responsible for the first Educare Center in New England look at the short and long-term implications for policy and its related early childhood systems change.

Like all Educare centers across America, Educare Central Maine will provide center-based, birth to five early care and education focused on narrowing the student achievement gap between young children growing up in low-income families and their more advantaged peers. Educare center programs are a public-private partnership model that set high expectations for both quality and results for the infants, toddlers, pre-school-aged children, and their families.

Regional Cabinets, Communities for Children and Youth Coordinating Councils

In 1996, the administration created Regional Children's Cabinets, mirroring the composition of membership at the state level. Regional Children's Cabinets are the vehicle through which the initiatives from the Children's Cabinet flow, and are managed and overseen at the local level. The Communities for Children and Youth (C4CY) is a statewide prevention and positive youth development initiative of the Governor's Children's Cabinet connecting 65 local communities throughout the State. This network also has strong ties with several local initiatives.

For example, the C4CY office is managing two federal grants from the Department of Justice (Office of Juvenile Justice and Delinquency Prevention) that serve its constituency. The "Diversion to Assets" project is a pilot in five local communities that diverts youth who have their first encounter with law enforcement to strength building opportunities in the community. The local coordinator in Lewiston is from Thrive, the trauma-informed system of care initiative. The C4CY College Community Mentoring project is a primary prevention program funded by OJJDP which pairs college students in 7 community colleges in Maine with elementary or middle school students identified by their guidance counselors and teachers as in need of extra social and academic support. Both of these projects support the mental health needs of many Maine children.

Local Case Resolution Committees (LCRC) originated through a CMHS Infrastructure Project, "Family Partnerships", beginning in 1993. These committees are comprised of local parents, service providers, professionals and other community based caregivers. The purpose of the LCRC is to review and, where possible, resolve issues of treatment, services and community supports that impact on complex cases that are interdepartmental in nature. The "review" function changed to "resolution" after each committee was given access to pooled, flexible funds. The function of the Children's Regional Cabinet as it relates the LCRC is to coordinate, support and monitor the work of LCRC's, and to allocate flexible state funds to fill small service gaps when that is the only barrier to case resolution.

In FY10, Local Case Review Committees in Regions 1 and 3 sustained their collaborative efforts and helped to form the newly legislated eight District Youth Coordinating Councils. These councils are under the Children's Cabinet's Shared Youth Vision Council, which also emerged in FY09 and FY10, as the statewide stakeholder group to implement the Dropout Prevention and Juvenile Justice Task Force recommendations that seek to identify barriers and recommendations for systems change, in support of Maine's highest-need children and youth in transition. For the first time in Maine, there will be a comprehensive, statewide strategic plan emerging for specific school dropout plans as well as plans to reduce detention and incarceration of Maine youth.

Healthy Transitions Initiative: *Moving Forward*

Early in 2007 Children's Behavioral Health Services, the Thrive Trauma-Informed System of Care Initiative, Tri-County Mental Health Services and many other community agencies joined with the Maine Children's Cabinet to seize an opportunity to "marry" the Cabinet's Transition Priority with the Shared Youth Vision Council's interests in Trauma-Informed Services by writing a federal grant that would focus on the common goals of all parties involved in this collaboration.

In May, 2009 Children's Behavioral Health Services responded to the federal Center for Mental Health Services Request for Applications, Cooperative Agreements for State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions and Their Families (short title: Healthy Transition Initiative). State applicants are expected to select a locality in which to implement a comprehensive service delivery program that includes a strategic plan for promoting the successful transition to adulthood for youth and young adults with serious mental health conditions. In September, 2009 CBHS was notified by SAMHSA that it was one of only seven national applicants to be awarded a Healthy Transitions Initiative grant.

Maine is well positioned to address the purpose of this Initiative through its response titled **"*Moving Forward*: Achieving Independence for Transition-Aged Youth"**. The Maine Department of Health and Human Services, representing both children's and adult mental health, has joined with Tri-County Mental Health Services, the Thrive system of care Initiative which through its experience has developed solid relationships with local youth and has established credibility and trust with them, and with many other providers to implement the Transition to Independence (TIP) model in one of the neediest counties in the state, Androscoggin County.

Transition to Independence is an evidence-based practice which emphasizes youth-directed planning and development of practical skills which lead to independence. Maine intends to enhance TIP in two key ways. One is to train Peer Youth Specialists to support youth through the process of setting their goals and achieving their dreams. Among these will be members of Youth M.O.V.E.Maine, a local and national advocacy organization for youth, and the Somali Bantu Youth Association. The second is to assemble three community mental health agencies who will implement TIP, Tri-County Mental Health, Common Ties and New Beginnings, into a Learning Collaborative. The Learning Collaborative serves to support the case managers who implement TIP and reinforce the initial training provided by the TIP developers.

In addition, through the program's links to the Maine Children's Cabinet and Shared Youth Vision Council, *Moving Forward* will address identified systemic issues bridging the children and adult mental health systems including the different policies, structures and eligibility criteria that exist in each system**.**

Moving Forward aims to increase high school graduation or GED attainment, and increase access to higher education for these youth who complete high school. Other targets include reduction of involvement with juvenile justice, and increases in employment, satisfactory living arrangements, use of the community and informal supports, and increasing the perception of personal well-being by young people whose functioning has been impaired by substance abuse or mental illness.

Maine's Healthy Transitions Initiative is known as *Moving Forward*: Achieving Independence for Transition-Aged Youth. Moving Forward is in its second year with progress on numerous levels.

First, training in the Transition to Independence (TIP) model of case management was completed for staff at three local agencies collaborating with CBHS. The mission of the initiative is to provide youth and young adults with a seamless transition from the child serving system to adulthood and opportunities for meaningful participation in a system of care that empowers through leadership and advocacy. This is being accomplished by working diligently with Youth Move Maine, TriCounty Mental Health, New Beginnings and Common Ties which are all agencies located in the Initiative's targeted geographic area.

A second round of training in TIP is scheduled for August and invitations will be sent numerous to mental health professionals in an effort to perpetrate the use of the model across a multitude of venues and agencies. This model is evidence-based and youth driven and has been proven successful within the targeted population of the Initiative. As part of this round of training, Maine is well on the way to having a nationally certified TIP trainer based in Lewiston. This certification will allow Maine to continue to train others and is in line with our goal of sustainability.

A state advisory council has been established with the goal of crafting policy aimed at improving the seamless delivery of transition services in Androscoggin County and, eventually across Maine. Evaluation is ongoing with Hornby Zeller Associates conducting interviews with youth, gathering program information and participating in a nationwide evaluation among the states originally awarded the Healthy Transitions grants.

Staffs at three service delivery agencies identified as partners in Moving Forward continue to serve youth in Androscoggin County. Monthly case-based review meetings are on-going and provide support and education to case managers.

The evaluation component of Moving Forward is ongoing. Hornby Zeller Associates continues to work on a database for information sharing and federal reporting. Cross site evaluation between the seven states receiving the Healthy Transitions Initiative funding is in progress and Maine is actively involved in that process. SAMSHA is promulgating national evaluation

standards and Maine is working with that group to include information about Moving Forward is that study.

Moving Forward will continue to serve 30 to 50 youth per year experiencing serious mental health conditions that are disconnected from their homes and risk homelessness. Many will have experienced trauma from domestic violence, child welfare and juvenile justice involvement, and homelessness and some will have been displaced from their native countries such as Somalia.

Moving Forward continues to seek ways to involve state agencies providing services to adults in the application of the model. The common goal remains the transition of youth to successful adulthood in any of its myriad manifestations.

Keeping Maine's Children Connected

Keeping Maine's Children Connected (KMCC) is a program sponsored by the Maine Children's Cabinet in response to the rising incidence of school disruption. School disruption has reached alarming proportions not only in the State of Maine but also nationally, and is one of the major predictors of academic failure and school withdrawal. This program is an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement in-patient psychiatric care, and/or high mobility or combinations of the above.

The intent of the Keeping Maine's Children Connected is to simplify the process of transition to-and-from educational programs so that these students can stay connected or can re-connect to their education programs as soon as possible. Liaisons have been assigned statewide in regional state agency offices, juvenile corrections facilities, in-patient psychiatric facilities, residential treatment facility agencies and school districts. Children's Behavioral Health Services has been an active supporter of several "pilot" programs and members of a community training team with those programs. A very successful example is the Hospital to School Initiative model that has proven its value to children with serious emotional or behavioral needs and their families, and thus has since "graduated" from pilot status to become replicated in other areas of the state today.

KMCC received a planning grant from US Dept of Education to increase community capacity and coordination between school districts and mental health services. KMCC worked closely with CBHS on the implementation of the grant activities. For the first time in Maine, mobile crisis programs and the psychiatric hospital in Southern Maine are now tracking contacts with school districts. The initial data from the crisis programs showed a documented increase in the number of times crisis workers spoke with parents/guardians about coordinating with schools, and a marked increase in the number of contacts with schools. In regards to contact between schools and hospitals, data showed that hospital staff initially contacted schools 68% of the time, and data now shows that the number of contacts has risen to 81.5% of the time. As a result of the success of the pilot initiative, the tracking program will be expanded to mental health crisis programs statewide so school staff can more effectively support the mental health needs of their students.

Geographic Areas within Children's Integrated System of Care

The Department of Health & Human Services, Office of Child & Family Services (OCFS), is organized and administered through 8 District Offices. The District office structure is defined geographically by counties and the boundaries of each District are coterminous for the Divisions of Child Welfare Services, Children's Behavioral Health Services and Early Childhood Services. A visual map of the Districts appears in Section I of this Plan.

The Department of Corrections, Division of Juvenile Services is organized according to 4 Districts, in addition to Mountain View Youth Development Center 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. The main offices are located in South Portland for Region 1; Lewiston for Region 2; Augusta for Region 3; and Bangor for Region 4. The long standing boundaries for each region are also defined by county lines and do not conform to those of OCFS. CBHS 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.

Last year Maine had 164 school administrative units comprised of 490 municipalities. These school administrative units were served by 132 Superintendents of schools in 143 administrative offices. Over the course of FY11, the Department of Education continued to create new districts that conform to legislatively mandated guidelines that are intended to create cost savings through greater efficiencies of size, administration and operations. In July, 2011 this consolidation process had successfully reduced the number of districts approved by the Department to 249. Presently 56 school administrative units do not fully conform to the mandated guidelines.

Likewise, Child Development Services has undergone a reorganization of their system as a means to achieve parity in the size of sites and as a cost savings measure of 3 million dollars for FY 2011 beginning July 2010. These savings are to be achieved through efficiencies that include elimination of administrative positions. The original 16 sites have been consolidated and reduced to 9, and reconfigured to coordinate with School Administrative Units (SAU's) rather than county lines that cross SAU lines.

With the consolidation of sites the hope is to achieve more intra-state consistency while conforming to expanding national requirements and still maintaining the highest level of family/child commitment. In FY11 considerable work was done to organize and plan any resulting staff relocation, case management catchment area changes, program continuation for families and children, and site assignment changes for direct service providers. The focus of the

work has been to lessen the impact of the change on all involved with the system and to ensure that families and children are served with minimal interruption.

CRITERION 4: TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

Outreach to Homeless Youth

The federally funded Projects for Assistance in Transition from Homelessness (PATH) have historically been the primary source of services to homeless youth in Maine. The PATH allocation for Maine is $300,000 and is shared equally by Children's Behavioral Health Services and the Office of Adult Mental Health which contract these services to community service providers.

Youth who are served through PATH funds include adolescents with serious emotional disturbance who are at risk for being homeless as well as individuals who are "truly homeless" because they are living on the streets, in shelters or places not designed for, or ordinarily used as sleeping accommodations.

Services supported through PATH funds focus heavily on outreach services that are intended to identify youth and engage them in the service system to address individual needs that are dictated by their unique circumstances. These services frequently include counseling, crisis counseling and referral for necessary hospital, primary health, substance abuse, mental health and diagnostic services. Outreach workers perform case management services, including advocacy, and linking functions as necessary, such as family reunification and connecting with crisis services. PATH outreach workers also work with providers of Shelter services. A small portion of funds is dedicated to service provider education and training. This population faces unique challenges in preparing for the transition from youth services to adult status at 18 years of age

PATH GRANTS SUPPORTING HOMELESS YOUTH FY10

Region	Area Served	Agency	#Served	Funding
Region I	York County	Sweetser Children's Services * 30 day agreement	2	$3,042
Region II	Waldo/Knox Counties Lewiston/Auburn Areas	Home Counselors New Beginnings	1,96 35	$73,958 $36,500
Region III	Bangor area	Shaw House/Streetlight	394	$ 36,500
PATH Homeless Youth Totals				**$150,000**

State Funded Services to Homeless Youth: An expansion of funding for homeless services in 1998 allowed Maine to move from a single agency, outreach/case management model (PATH) to more creative, collaborative approaches to serve homeless youth. The addition of this new funding also meant that agencies were able to support more than a single staff person.

PROGRAMS SERVING HOMELESS YOUTH FY10			
Agency	**Service Area Focus**	**Number of Youth Served**	**FY10 Funding**
Day One	Cumberland County	55	$134,500
Preble Street Resource Center *	Cumberland County	1302	$310,000
Total Region I		**1357**	**$444,500**
Children's Center	All 8 Counties in Region 2	278	$25,000
Home Counselors includes: New Beginnings: Youth & Family Services :Rumford Group Home:	Knox, Waldo and Lincoln County Androscoggin and Franklin County Somerset and Kennebec County Oxford County	196 total youth Consortium	$335,875
New Beginnings	Androscoggin and Franklin County	35	$36,500
Total Region II		**509**	**$397,375**
Acadia	Bangor area	176	$6,500
Shaw House*	Bangor area	394	$223,000
Penquis Community Action Program	Penobscot, Piscataquis, Hancock and Washington County	70	$47,000
Total Region III		**640**	**$276,500**
*Includes Child Welfare Svcs. Funds			
STATEWIDE TOTALS, HOMELESS YOUTH SERVICES		**2,506**	**$1,118,375**

The table above illustrates the second significant benefit of program expansion for youth who are homeless in Maine. The table shows geographic areas where homeless services are now available for youth, especially those who do not live in one of the three major population centers of the state (Portland, Lewiston-Auburn and Bangor). Nearly all of the expanded services focus on smaller rural communities and previously underserved rural areas of the state. It is hoped that the availability of these services will result in earlier identification of youth at risk while they are still in or near their home communities, and that the prospects for family reunification will also be enhanced.

Expansion of Services in FY01-FY03 : The Maine legislature supported the Departments of Human Services and Behavioral and Developmental Services in a joint collaboration for the development of new services for homeless youth. The departmental contributions totaled $300,000 each year. Development occurred in southern Maine through the Preble Street Resource Center located in Portland, and in northern Maine through the Shaw House in Bangor.

Using these new appropriations for homeless services, the Preble Street Resource Center expanded its operations to include additional evening and weekend hours, as well as vocational services offered in the collaborative. The Homeless Youth Employment Project provides and promotes employment and education services. The Learn to Earn program provides formalized job placement and training services for homeless youth. The Teen Center offers a drop-in option for homeless and street-involved youth. The Teen Center operates 7 days/week, 365 days/year. In FY10 Preble Street programs served 1,302 youth.

Day One of Portland provides mental health community support services through case management and supportive counseling. Day One staff work closely with the Preble Street Teen Center staff to do outreach to youth who come into the Center to access food and safety. In FY10 Day One served 55 youth in Cumberland County.

A consortium of 4 agencies in central Maine provide outreach services throughout the region. These services are similar to the PATH model. In order to increase the prospects for family unification the model also focuses on early identification of youth who have left home. Outreach workers provide comprehensive community support services to youth consisting of some combination of community support, prevocational/ vocational and supported employment services for homeless youth with serious emotional or behavioral problems. The consortium which includes Home Counselors, New Beginnings, Rumford Group Homes and Youth & Family Services served 196 youth in FY10. Flexible funds to meet the needs of homeless youth throughout Region II in central Maine were provided to 278 youth through The Children's Center in Augusta.

The Shaw House Streetlight Outreach Program in Greater Bangor works to identify and assist homeless and at-risk youth through street outreach efforts. Shaw House funding also supports a Rapid Response approach in redesigning service delivery to homeless youth. The program focuses on youth, ages 10-17, who find themselves homeless for the first time. The objective is to identify this population and to deliver intensive outreach and case management services, outside of typical shelter services, which may result in reunification with the parent, family or relative. Rapid response relies on finding and delivering supports and services in the youth's community of origin.In this model, natural supports are an important ingredient for success. Shaw House participates in a HUD project with Acadia Hospital, which provides evaluation and diagnostic services by a substance abuse counselor for homeless youth identified through the Shaw House outreach services. In FY10 Shaw House programs served 394 homeless youth and Acadia served 176 youth.

The Penquis Community Action Program provides outreach activities to teens to work with them on life skills. Staff provides resources and referrals for teens and parents seeking assistance. Penquis CAP serves youth ages 12-18 in Penobscot, Piscataquis, Hancock and Washington County who are at risk of leaving home or who are homeless, due to conflict and works toward reunification with the family when youth are homeless. The agency provided services to 70 youth and their families in FY10.

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.

Considering that data, and taking into account Maine's overall population density patterns, it is also clear that mental health services that are delivered to rural populations are the norm, rather than the exception, in the State of Maine.

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, CBHS 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. There are, however, barriers to using this technology for direct services, including service providers apprehension about using the telemedicine in Emergency Departments and crisis programs due to concerns about confidentiality on the part of individuals in crisis using tele-medicine.

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 has been directed through a working group co-convened by the Governor's Office of Health Care Policy and the Maine Health Access Foundation (MeHaf), which is currently surveying stakeholders regarding barriers to implementation of this process.

The 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. The purpose of this program is to make available: 1) immediate phone consultation to primary care physicians regarding behavioral problems in children; and if necessary 1-4 hours of face to face evaluation and consultation to the primary care physicians. In addition the psychiatrist involved provides a monthly seminar on the basics of child and adolescent psychiatric assessment and provides supports to enhance the skills of the primary care physicians. The goal of this approach is to enhance the behavioral health skills of primary care physicians and their staff, providing knowledge and personal support. The program is extremely well received and appreciated by primary care physicians. In addition to providing a direct service, the program is collecting data to document changes in behavioral health care.

Increasing Services Statewide

One way to relieve transportation and service access problems is to increase the provider base and bring services closer to families. Over the last decade, and especially within the past six years, Children's Behavioral Health Services has successfully encouraged the expansion of providers who deliver case management services and in-home behavioral treatment services and community based rehabilitative services and supports. Both of these services are delivered in the home and the local community where children and families live.

In 2011, fifty-four (54) case management agencies were serving children and families, compared with six (6) community agencies and five (5) Children's Services regional offices providing those services in 1998. Many previously un-served areas in Maine, particularly smaller rural population centers, now have accessible case management services, due to service expansion and the location of case management personnel in rural areas

In-home behavioral support services were nearly nonexistent in 1998, and were provided primarily by individuals chosen by the family to do "one-to-one" supports for a limited number of hours, paid for through limited flexible funds. In 2011, forty four (44) agencies were providing Children's Home and Community Based Treatment services from 68 community based locations, delivering these services in the family's home and communities. Additional children are served under a separate in-home support program, Rehabilitative Community Support Services (RCS). In FY11 fifty-one (51) agencies were providing RCS in the family's home from 68 community based locations. In FY10 these programs combined served 4,323 children. Clinically based treatment and in-home supports represent the essence of addressing the rural challenge, since the service comes to the child and family, in their own home and own community.

Over the last 5 years new, clinically focused MaineCare Children's Home and Community Based Treatment (HCT) services became available to serve many children who transitioned from several previously available MaineCare services that were discontinued in FY08. Children's Home and Community Based Treatment services are treatment based intervention services provided by a clinician and a community based services professional. In 2010 the former Habilitation Services were replaced by Rehabilitative and Community Support Services (RCS) with much improved qualitative elements for persons with cognitive and physical disabilities.

Regional Programs and Resources

Children's Behavioral Health Services does not provide direct behavioral health services to children with serious emotional disturbances, intellectual disability or autism. However, CBHS does provide 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 non-profit agencies and a small number of for-profit organizations. There are no for-profit agencies that provide community services paid under CBHS contract that receive federal Children's Mental Health Block Grant funds.

Maine's Block Grant Application contains descriptive and statistical information about services that are available to children and families in several other sections of this plan. The table below illustrates the availability of core behavioral health services and supports within the three service regions of the DHHS. This section contains a Maine map illustrating where the 3 Regions are located. Region I forms the two southernmost counties and includes the city of Portland; Region II consists of nine counties stretching across central Maine and includes the cities of Augusta, Lewiston and Auburn; Region III is the northernmost section encompassing five counties including the cities of Bangor and Presque Isle.

The table below focuses on the geographic distribution of services available within each CBHS region in the State of Maine. The count of services available within each region is based on the number of provider agencies that deliver each type of direct service in that region. A number of these agencies offer services in more than one region; therefore there is duplication of providers reflected in the regional and statewide Total columns. The data that is the basis for this table is obtained from CBHS Resource Development field staff and from the DHHS Division of Purchased Services which works directly with the contracted agencies that are funded by Children's Behavioral Health Services. This data covers all contracted agencies that provided children's services in Fiscal Year 2011.

NUMBER of PROVIDERS LOCATED IN REGION (FY11)

SERVICE PROVIDED (and Unduplicated # Providers)	Region I	Region II	Region III	Total
Targeted Case Management (62)	28	47	24	99
Outpatient Services (62)	27	28	25	80
Medication Management (20)	5	12	8	25
Rehabilitative and Community Support Services (RCS) (51)	22	30	23	75
Children's Home and Community-Based Treatment (HCT) (44)	17	24	27	68
Crisis Services (9)	2	6	2	10
Respite Care Services (3)	1	1	1	3
Peer/Family Support (8)	6	5	5	16
Early Intervention Services (12)	5	5	3	12
Homeless Outreach (8)	3	3	3	8
Assertive Community Treatment (3)	2	1	0	3
Number of Provider Locations Regional and Statewide (138)	**118**	**162**	**121**	**399**

CRITERION 5 MANAGEMENT SYSTEMS

Fiscal Resources to Implement CBHS Goals, Targets and Action Plans

The FY12/13 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, PATH/Homeless, and SAMHSA System of Care funds for Thrive and the 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 & Human Services Office of Child & Family Services FY12 Children's Behavioral Health Services Funding - Community Services					
Services	General Fund 013607	MaineCare Seed*FY11 073117	MH Block Grant 015 Federal	Other 013 Federal/ HTI Thrive/PATH	Total
ACT		337,111			337,111
Crisis	1,859,693	1,306,307			3,166,000
Case Management		1,033,678			1,033,678
Rehabilitative Community Services and Supports (RCS)		2,848,526			2,848,526
Deaf Support (TCM)	120,000				120,000
Family/ Youth support – self help	102,448		641,378		743,826
Home and Community Based Treatment Services (HCT)		3,202,626			3,202,626
Outpatient Services		4,326,264			4,326,264
Medication Management		1,081,566			1,081,566
Homeless/ PATH	628,500			150,000	778,500
Early Intervention	883,789				883,789
Mediation	5,000				5,000
Flexible Funds	1,119,535				1,119,535
Respite	2,278,000				2,278,000
Information & Referral			110,500		110,500
Residential Treatment		1,966,483			1,966,483
Room & Board	4,282,932				4,282,932
Child Steps Initiative	277,994				277,994
Thrive Initiative	369,226			139,875	789,101**
Healthy Transition Initiative				480,000	480,000
Other /Place Holder	69,773		209,321		279,094
Total	11,996,890	16,102,561	961,199	769,875	30,110,525

* Estimates based on a proportion of FY11MaineCare expenditures **Total includes non-federal in-kind match

Note - The budget for the Division of Children's Behavioral Health Services was established in the FY12 state budget law enacted by the 125th Maine Legislature. Allocation of MaineCare seed by program type was estimated based on available expenditure information and trends from FY11.

In addition to these resources, the FY12 budget includes $4,990,660 in state funds for Personal Services which support 57.5 CBHS central office and regional staff who perform administrative, oversight, quality improvement and other functions that contribute directly to the achievement of the Priorities outlined in this Application and the Goals, Targets and Action Plans that appear in this Plan.

Training for Providers of Behavioral Health Services

Children's Behavioral Health Services is actively engaged in training for contract providers of children's services. This training is conducted by Children's Behavioral Health Services staff with the assistance of the Office of Quality Improvement (Assessment Training), and by consultants where there is an identified need (Wraparound Training for Case Managers, Training for Children's Home and Community Based Treatment Services and Services for Children with Intellectual disability or Autism Spectrum Disorders). Service providers also offer training for their staff that is supported by CBHS as a cost in determining their service rate. Specific examples of training that has been initiated over the past 6 years and continues on a regular basis include:

Ongoing training and staff certification for direct service providers of Children's Home and Community Based Treatment Services (HCT).

Training is developed through the Behavioral Health Sciences Institute and delivered to community agency personnel in a train the trainer model. A non-licensed individual who works under the supervision of a licensed clinician, and works one on one with the child in the home and community is required under MaineCare rule to complete 55 hours of training in addition to First Aid, CPR and blood borne pathogen training. Successful completion of this training and demonstrated competency of the individual trainee results in certification as a Behavioral Health Professional. Over the past eight years 1,822 individuals have successfully completed this training. In FY11 there were 883 Behavioral Health Professionals trained, with an additional 487 BHP's receiving certification in the previous 3 years.

MaineCare enacted several policy changes during 2010 that impacted the provider training system including the creation of Rehabilitative and Community Support Services for Children with Cognitive Impairments and Physical Limitations (RCS), and expanding Home and Community Based Treatment Services (HCT) to qualified children in a classroom setting. Both policies require the direct service provider achieve certification as a Behavioral Health Professional (BHP). CBHS has responded to the policy changes by adapting the BHP curriculum to reflect the policy changes, increasing the tracking capability of the certification process and diversifying the training method.

An on-line curriculum is now available which provide an additional training option. A demonstration of knowledge and skills is required before certification is complete. The on-line curriculum provides direct service staff flexibility in choosing the time and place to acquire the foundation for delivering children's behavioral health services.

Training for Providers who use the CAFAS

The Child and Adolescent Functional Assessment Scale (CAFAS) is used by several MaineCare services to assist in determining the appropriateness of treatment. The CAFAS is legislatively mandated to be administered to each child requesting or receiving Targeted Case Management. The CAFAS is also used to determine the appropriate level of care for children receiving Treatment Foster Care, and it continues to be used in Home and Community Based Treatment Services while providers transition to the Youth Outcome Questionnaire (Y-OQ).

CBHS worked with the company that produces the CAFAS, Functional Assessment Systems (FAS), to develop a cadre of certified CAFAS trainers and to bring the electronic version of the CAFAS to providers. FAS delivered a three day training to 21 staff at the master's or higher level from CBHS and provider agencies to create a pool of certified trainers. Sustaining a high quality training program that assures tool fidelity is achieved through regular communication via an electronic list serve and a monthly conference call meeting, training notification and registration using an on-line calendar and providing training in teams.

Functional Assessment Systems has developed an electronic version of the CAFAS that enables the agency to track and analyze the CAFAS results and to produce reports for personnel who administer the tool, the supervisor and the family. In addition to the increased capabilities of the CAFAS, the electronic version is "green", greatly reducing the provider's dependency on paper.

Other trainings available to CBHS service provides include:

- Training in Children's Services Grievance Procedures, for all providers of service.

- Use of the Children's Habilitation Assessment Tool (CHAT) for school age children and youth, delivered to all case management providers. Children with intellectual disability or autism spectrum diagnoses are assessed by the CHAT.

- Regular regional provider meetings that provide information on new developments, such as changes in MaineCare policy, jointly presented with other state agencies.

- Training for Department of Corrections, Juvenile Services staff on mental health and related issues for youth who are involved with the juvenile justice system in the community and for youth who are detained in the Youth Development Centers. Specific examples of these current issues and on-going dialogue and training delivered by mental health that are co-located in the juvenile services system and correctional staff are discussed in Criterion 3, Children's Services.

- Training on Evidence-Based Practices through the University of Southern Maine, Muskie School of Public Service with members of the CBHS Evidence Based Practice Committee and CBS staff.

- Training on a single case management system with Child Welfare Services and the University of Southern Maine, Muskie School of Public Service.

- Training children's case management service providers regarding transition to adult intellectual disability services.

- Training state central office and regional staff in the Enterprise Information System.

- Training children's case management service providers in family strengths and the wraparound process.

Training for Clinicians on Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood (DC: 03R)

This tool is available to clinicians who work with very young children (age's birth through 5 years). The Self-Study Guide assists the clinician in making observations, drawing conclusions and applying the DC-03R to make appropriate diagnoses. The Maine 0-3 Committee developed a DVD that is case-based. The DVD is promoted through the Maine Infant Mental Health Association and is now used as a centerpiece in the Association's menu of trainings.

Specific Training of Providers of Emergency Mental Health Services

Emergency mental health services for children and youth with emotional or behavioral needs are provided primarily through contracts with a statewide system of crisis services providers. Crisis services programs offer integrated services for both adult and child populations. Crisis response personnel must be certified as a Mental Health Rehabilitation Technician/ Crisis Services Provider (MHRT/CSP) prior to providing services.

The requirements for certification as MHRT/CSP were revised in February 2007 and became applicable for all existing crisis staff as of April, 2008. These requirements include:

- A minimum of an Associates Degree
- Successful completion of the Crisis Training Curriculum
- Non-didactic training such as job shadowing, skill practice, role-play and case discussions

All crisis services staff are required to demonstrate competency in crisis practice by successfully completing the Crisis Training Curriculum module tests. The curriculum was developed by The Maine Crisis Network, a collaboration of Maine crisis providers and professionals with extensive experience in the field. The following modules are included in the Crisis Training Curriculum:

- Values and Attitude – Crisis professionals are obligated professionally to react and intervene objectively and on purely clinical grounds; close and careful examination of personal attitudes, strengths and vulnerabilities can assist in providing services consistent with professional obligations.

- Theories of Human Development – The focus of this training is to present selected development theories that will aid crisis workers in developing and implementing intervention and stabilization plans with clients and client's systems.

- Psychosocial Rehabilitation – Understanding effective psychosocial rehabilitation models and interventions that include the importance of recovery orientation, goal setting, skill assessment and training, and linkage with community supports.

- Crisis Theory and Principles of Crisis Management - The framework presented in this module will support a thorough understanding of current best practice in the crisis field.

- Safety – The mobile, community-based, 24 hour design of crisis services provides unique safety concerns for crisis workers, consumers and administrators. This module provides an overview and understanding of various risk factors, how to recognize risky situations and how to manage them.

- Crisis Assessment – This module provides crisis workers with an investigation of the skills and knowledge needed to conduct a comprehensive accurate evaluation of clients in a behavioral crisis.

- Crisis and Trauma – Traumatic events shape the people that experience them. Having a basic understanding of the ways that these experiences may affect a person's emotional, behavioral and relational reality is key to providing effective crisis services.

- Crisis & Co-occurring Disorders – This module provides an overview of the principles of crisis management within the context of co-occurring disorders. The training highlights the need and importance of assessing accurately for the presence of co-morbid substance abuse, and how substance abuse can, at times, mimic the symptoms of a psychiatric disorder.

- Crisis Intervention – This module provides a general framework for implementation of a solid clinical intervention. This 6 step Crisis Intervention Model has been designed and researched by Gilliand and James, 2003, taking into consideration the complexity of crisis situations associated with mental health and substance abuse crisis intervention strategies and methods.

- Consultation and Collaboration – The crisis worker is frequently functioning alone in the field but is ultimately only a part of a consultative team. The nuances of how and why crisis work is structured in this way comprise the content of this module.

- Legal and Ethical Issues in Crisis Work – This module will assist the crisis worker with the development of a working knowledge of client rights, professional conduct as a crisis worker, confidentiality and its exceptions, protective custody and mandated reporting, plus the potential risks of ethical mistakes.

- Hospitalization – Admission to psychiatric inpatient hospitalization is a lengthy and detailed process. This module will familiarize crisis workers with the specifics of this process, offering instructional detail, procedural rationale and opportunity for review of other ethical and clinical considerations.

- Documentation – Accurate and appropriate documentation is almost as important as accurate and appropriate clinical work. This module offers crisis workers step-by-step guidance to the appropriate documentation of crisis assessment.

DHHS Disaster Response Plan

In FY07 the Department of Health & Human Services, through a newly created position of Program Director of Disaster Behavioral Health Services, funded through the Maine Center for Disease Control, produced an initial Pandemic Disaster Response Plan. In the event of a disaster within the state of Maine, the emergency management system would be activated and if the event is large enough, the governor may declare a state of emergency. DHHS resources would be allocated to respond to the disaster.

One possible resource available would be mental health and substance abuse providers to respond to the emotional needs of citizens. In order to provide these types of emergency services a training curriculum has been developed and is offered to personnel who may provide this type of service. The training curriculum was researched and chosen by a statewide Disaster Behavioral Health committee. The state of the art curriculum chosen was developed in New York following the September 11th 2001 disaster. It has been adapted to be specific to Maine and has recently been updated to reflect scenarios relevant to recent experiences, e.g., H1N1 response. The purpose of the curriculum is to provide behavioral health providers with the knowledge and skills to be able to respond to the needs of citizens in the event of a disaster. As a result of attending the training, participants will learn:

- Key phases of disaster preparedness, response and recovery and the role of emergency management personnel
- Range of psychological and psychosocial reactions that individuals experience in the aftermath of disasters
- Key interventions and activities utilized by behavioral health professionals in the aftermath of disasters
- Self-care tips for behavioral health professionals

This training is 16 hours in length and has been offered in 14 of 16 counties throughout the state of Maine. The trainings are conducted by the Director of Disaster Behavioral Health and other individuals specifically experienced in the area of disaster preparedness and response. The

Office of Public Health Emergency Preparedness within the Maine Center for Disease Control and Prevention oversees this program. Two additional areas of complimentary training are offered annually in conjunction with the curriculum. The national Incident Command System (IS-100) and the National Incident Management System (IS-700a), which is required for team membership, are offered as well as independent training in Psychological First Aid.

The Director of Children's Behavioral Health Services is an active member of the State's Emergency Operations Center located within the facility of Maine's Emergency Management Agency (MEMA).

The Emergency Operations Center members have been activated three times this past year, during a winter storm, flooding in the spring and Hurricane Irene. There is a much greater appreciation for the value of having the mental health / behavioral expertise at the table.

Disaster Behavioral Health: A Critical Response Maine's training curriculum for Behavioral Health, Spiritual Care and Substance Abuse Professionals and Natural Community Helpers has developed a skilled response team across the state

The volunteer teams of disaster behavioral health responders are available to provide mental health and substance abuse support in the event of a disaster or local emergency. The teams are managed at the state level by the Program Director of Disaster Behavioral Health Services through clinical team leaders at the local level. Each local team consists of those who have been trained in the curriculum, have completed the requisite FEMA courses (ICS, NIMS) and have undergone a background check. These teams are deployed through the state emergency management system. Teams are trained to respond to the emotional needs of disaster victims, responders, or community members in local, state, or nationally declared disasters as well as other traumatic incidents requiring a behavioral health response.

The training program is two full days in length. Team members must attend the full two-day training to become registered as a Disaster Behavioral Health volunteer.

Day One: Participants will learn about the behavioral health impact of disasters on individuals and communities. They will also learn about normal and adverse stress reactions. They will also be given information about how the state and national disaster preparedness and response systems work. Day Two: Participants will learn disaster behavioral health interventions used to identify and address these reactions (such as psychological first aid). They will go through an exercise to learn how to set up a family assistance center and respond to the needs of the victims and families. Finally, they will have the opportunity to learn about and join the formal state team in Maine tasked with responding to the behavioral health needs of the community after a disaster.

This training is intended for mental health and substance abuse providers, psychiatrists, nurses, psychologists, social workers, spiritual care providers, first responders, and other individuals who wish to learn more about the behavioral health response to disasters or are interested in joining the Maine Disaster Behavioral Health Response Team.

The Director of Disaster Behavioral Health Services (DBH) coordinates responses from the state Emergency Operations Center through team leaders at the county level. A quarterly newsletter and annual drills keep volunteers in touch and updates skills.

Disaster Behavioral Health provided three trainings last year, participated in a full scale county drill, offered two Psychological First Aid courses and an IS-100 & IS-700a qualifying course. Three trainings were completed last year in Franklin, Somerset and York Counties. In the coming year, trainings are planned for Sagadahoc, Hancock and a return to Penobscot counties.

Intended Use of CMHS Block Grant Fund

In accordance with the scope and requirements of PL 102-321 and Maine's Block Grant Children's Mental Health Services Comprehensive Plan, 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 through the Director of Children's Behavioral Health Services, in consultation with the Statewide QIC Children's Committee. The Department contracts for services which are funded entirely or in part through the Block Grant. The Children's Behavioral Health Services Program issues contracts with specifications for all services, including conformance with all PHS Act requirements and applicable service conditions of the CMHS Block Grant. DHHS Purchased Services Administrators monitor contracts through quarterly and year end fiscal and narrative reports from service providers. Regionally based CBHS Team Leaders and Resource Coordinators monitor services by regularly scheduled meetings with providers. The Children's Committee also will receive these reports in FY11.

Maintenance of State Effort (MOE)

As a condition of receiving federal CMHS Mental Health Block Grant funds, the State of Maine must demonstrate maintenance of effort by documenting that the State has maintained expenditures for community behavioral health services at a level that is not less than the average level of such expenditures maintained by the State for the 2 year period preceding the fiscal year in which the State is applying for the grant. Support shall be documented by the actual dollar expenditures committed for services, which in this instance means state general funds expended by the Division of Children's Behavioral Health Services within the DHHS Office of Child & Family Services and those expended by the DHHS Office of Adult Mental Health Services. Actual expenditures are compiled by the Department's Financial Service Center through the Advantage ME financial information system.

Maintenance of Effort
State General Fund Expenditures Children's Behavioral Health
State Fiscal Years 2009-2011

	SFY09	SFY10	Ave SFY09+10	SFY11
Children's Services	$54,540,651	$47,990,876	$51,265,764	$43,741,734

The average of state fund expenditures for Children's Behavioral Health Services in FY09+10 was $51,265,764. Expenditures for FY11 are $ 43,741,734 which is less than the two year average by (-$7,524,030). Children's Behavioral Health Services expenditures therefore do not meet the CMHS federal Block Grant program Maintenance of Effort criterion for State Fiscal Year 2012.

Maine dedicates more than three quarters (75%) of its Center for Mental Health Services Block Grant funds to address the needs of children who have serious emotional disturbance and their families. The allocation of FY11 Children's Behavioral Health Services Block Grant funds, including unallocated funds follows:

CHILDREN'S MENTAL HEALTH BLOCK GRANT FY12
Distribution by Region/Service Type

Agency	Service Funded	Amount	Estimated # Total Served
REGION I			
Community Counseling Center	Peer Support for Youth	33,000	75
S. Maine Parent Awareness	Family Support/I&R	44,000	500
Region I Total		**$77,000**	**575**
REGION II			
Community Concepts	Family Support	11,000	20
Region II Total		**$11,000**	**80**
REGION III			
Helping Hands	Family Support/I&R	50,000	500
Region III Total		**$50,000**	**500**
STATEWIDE			
Crisis & Counseling – GEAR	Family Support	212,000	962
Crisis & Counseling - GEAR	**Parent Advocacy FACES**	**60,000**	**750**
Maine Parent Federation	Information & Referral	32,000	NA*
Maine Parent Federation	**Starting POINTS Media**	**60,000**	**3,500**

Maine Parent Federation	QIC Support	5,000	N/A*
NAMI Maine	Information & Referral	18,500	**230**
NAMI Maine	**Primary Care**	**60,000**	
TCMHS – Youth MOVE	**Youth Transformation**	106,378	80
	Youth Transformation	**60,000**	**60**
Statewide Total		**613,878**	
Total Allocated 7/1/11		**751,878**	**7,850**
BG FY11Award Available	To expend by 9/30/11	136,678	
BG FY12 Award Available	To expend by 9/30/12	824,521	
Total Available		**961,199**	
Unallocated to Expend FY11		**209,321**	

* Information & Referral data contain substantial duplication and therefore are not added to the regional subtotals or the state total for number served. **BOLD = Transformation Activities funded by the Block Grant in FY12.**

Block Grant 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 mental health block grant 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

Distribution of FY12 CMHS Mental Health Block Grant funds is consistent with the Block Grant Agreement, Section 1916 (a) in that the State of Maine agrees that it will not expend the grant to provide inpatient services, make cash payments to recipients of health services, purchase land, facilities or major medical equipment or assist any entity other than a public or nonprofit public entity.

Maine law M.R.S.A. Title 34-B offers further 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 State 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 and children's transition services to adult services as priority services, using block grant carry over funds. 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.

In recent years, Maine was experiencing a budget shortfall common to many other states in the nation. In order to offset deficits caused by decreasing revenues, the Department was required to reduce general fund expenditures through a selective DE appropriation of grant dollars. The Department utilized unobligated block grant funds to restore level funding for all family support programs affected by these reductions. For the last six years the Department has continued its support of family organizations and family support services through federal funds in order to preserve these services, which are highly valued but vulnerable to state general fund budget reductions.

QIC Children's Committee Commitment to Transformation

In June, 2007 the Director, Children's Behavioral Health Services, and members of the Children's Committee of the Quality Improvement Council discussed possible investments in focused activities using Block Grant funds in the FY08 fiscal year. There was a mutual interest in doing significant work with family organizations in 2007, in addition to the family support work of various types and focus that these organizations have typically done in the course of carrying out their unique missions. Accordingly, each organization was asked to submit a proposal to the Director that would capture the spirit, intent and focus of transformation that would benefit and support families with children and youth with serious emotional disturbance. These proposals, each in the amount of $60,000, were reviewed by Children's Behavioral Health Services and subsequently recommended for consideration by the Children's Committee of the QIC for one year funding.

Children's Committee Recommendations for 2012/2013 Plan

This year the Children's Committee worked on standardizing the content of the Transformation Award proposals.

The Children's Committee discussed in detail recommendations for the award of block grant funds for new initiatives and for continuing support of funding for programs. The committee expressed a strong commitment to transformation in considering funding with block grant dollars, accountability for programs that have received block grant funds, and certainty that funding would be used for children with high emotional/ behavioral needs. The committee discussed some examples of transformational priorities such as new and innovative approaches to reaching these children and youth, family driven care, youth development and evidence-based practices.

On several occasion in July 2011 the Children's Committee met to review the four transformation initiatives seeking continuation of support or for a new initiative using FY12 Block Grant funding. As in the previous year, each applicant presented its accomplishments, progress and goals and measurable objectives for the coming year. The Children's Committee reviewed and voted to approve or disapprove the proposal. If a proposal was disapproved and opportunity was given to the applicant to meet with the committee and discuss the reasons why the proposal was rejected. An opportunity to revise and resubmit the proposal was given. Two proposals were rejected and revised to meet the requirements that the services be transformational in nature.

After committee discussion with each presenter, and specific suggestions for change, emphasis or addition, all three proposals were recommended for funding.

The committee approved the proposals outlined below:

Allocation of Children's FY12 Block Grant Funds for Transformation Activities

Provider	Transformation Initiative	NFC Goal	Block Grant $
Maine Parent Federation (MPF)	*Starting POINTS for Maine Families* delivers online access to information, support and networking that will make knowledge of children's mental health more available to families statewide. Web page connects families to a variety of short presentations and allow for easy, personal feedback that will be used to tailor topics of interest as the initiative is implemented over time. Focus this year will be on building the content, usability, evaluation and outreach for Starting POINTS, Facebook and Twitter. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Military Families, Recovery and Resiliency and Public Awareness and Support.	2	60,000

NAMI Maine	Transform access to mental health and substance abuse services for youth across the state of Maine by helping schools to identify and refer students in need and who have challenging behaviors. NAMI Maine will work with designated schools to assure they are implementing practices that build resilience in students and engaging students in activities that build resilience, and (2) transform the delivery of primary care health services to children and youth by assisting Primary Care Physicians and pediatricians to better identify and treat their patients with behavioral health issues. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Primary Prevention, Public Awareness, Strategic Partnerships	3 1	60,000
GEAR Parent Network	Development of 5 community Family Advisory Councils in areas where there are trained parents and alumni of the Family Empowerment Institute who are available to serve in an advisory capacity to local and state decision-makers. Involve other family organizations in the outreach to identify council members and broader family membership. FY12 will focus on training/ education/ awareness of trauma on families and caregivers, and advocacy for trauma-informed services for children and youth in the Council's geographic areas. Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Supports; Trauma and Justice	2 5	60,000
Youth MOVE Maine	Continued investment in support for developing a visible and active youth voice of the State in FY12. Maine's Youth MOVE Chapter will guide the implementation of an infrastructure of three staffed regional offices each having a strategic plan developed for achieving organizational and Youth and Family program goals. Each plan will include target audiences, a youth committee regional goals, a list of local resource partners, a continuous quality improvement plan and social marketing and outreach plan. Outcomes include community based trainings, peer-to-peer partnerships, anti-stigma campaign and youth training and provider technical assistance Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Support, Trauma and Justice	2 5	60,000
	FY12 Mental Health Block Grant Transformation Funding		**$240,000**

Management Systems
Children's Mental Health Transformation Efforts and Activities in Maine

Note to Readers: Each activity identified as Transformational is associated with one or more of the six Goals outlined in the New Freedom Commission on Mental Health (NFC), Achieving the Promise: Transforming Mental Health Care in America, DHHS Publication, Rockville MD, 2003.

NFC Goal 1. Americans Understand that Mental Health is Essential to Overall Health

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

- The Mental Health Recognition Day in 2011 featured expanded geographical visibility and fresh ideas to promote the positive aspects of mental health treatment, resiliency and recovery for children and youth and reduce the stigma associated with mental health issues for children and their families. This sixth annual celebration "Building resilience in young children dealing with trauma" gave us the opportunity to hear Maine youth and family members share stories of resiliency and the natural supports and skills so important in their lives. We heard how they have built and nurtured resiliency and gained empowerment through empathy and understanding, knowledge sharing, skills and love. We heard how resiliency and self-advocacy can be intergenerational with lessons learned passed from one generation to the next. The most visible setting to deliver this year's message was at the State House, Hall of Flags, where many service providers, youth and families were in attendance to hear the Governor's official Proclamation of Children's Mental Health Day and to speak out that it's okay to ask for help. Other local activities included a welcome breakfast cookout for OCFS staff, and, at a variety of local venues across the State, youth shared their experiences before public audiences in person and through "Digital Stories" visual media.

- The Maine Youth Suicide Prevention Program has been a long standing program in Maine and it receives support through the Director of Children's Behavioral Health Services and the CBHS' Medical Director's active participation in the MYSSP Clinical and Professional Committee. CBHS partners with MYSSP to promote effective clinical and professional practices and to improve access to mental health, substance abuse and crisis services.

NFC Goal 1.2: Address mental health with the same urgency as physical health

- Integrating Mental Health with Physical Health has been an ongoing effort for several years with CBHS playing an active role with other interested state agencies and public and private health care organizations. This effort has focused on collaborating with primary care physicians about signs of mental illnesses during early childhood, decreasing stigma for children and youth

receiving mental health services, and improving access to mental health services. Families strongly prefer that early childhood diagnosis, evaluation and referral to treatment lodged at the primary care professional practice level and not in a hospital or a community mental health outpatient clinic.

Child Psychiatry Access Program (CPAP): The Maine Medical Center (Portland) applied for and received a grant from Maine Health Access Foundation to pilot the Massachusetts Child Access Program, in another effort to provide psychiatric expertise in areas lacking these services. These services are delivered through consultation to pediatricians in the Mid Coast Region of Maine. The purpose of this program is to: 1) inform primary care practice about available community resources; 2) provide immediate (within 45 minutes) phone consultation to the primary care physician regarding behavioral health challenges; 3) quarterly office based educational sessions on common child psychiatric disorders; and 4) when indicated 1-4 hours of face to face psychiatric assessment. The goal of this approach is to enhance the behavioral health skills of primary care physicians and their staff, providing knowledge and personal support.

Criterion 3: Integration of Children's Services
NFC Goal 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

- Thrive's family representatives (now transitioned for sustainability to G.E.A.R. Parent Network's Family Advisory Councils for Empowerment Statewide-F.A.C.E.S.) received the silver award in the Professional Outreach category for Together we can build a bridge ("Bridge") July 21 at the 2011 Excellence in Community Communications and Outreach recognition ceremony sponsored by the Substance and Mental Health Services Administration's Caring for Every Child's Mental Health Campaign. As of August 1, 2011, Bridge has been viewed 1000 times on You Tube, and been broadcast by 40 Community Access TV stations to over 3.5 million homes in 70 Maine communities; 13 other states, South Africa and New Zealand. It has been presented by members of F.A.C.E.S. to hundreds of providers and service agencies at the state and local level throughout Maine.

NFC Goal 1.2: Address mental health with the same urgency as physical health

- Project LAUNCH is 6-year project that represents a strong partnership between Maine's public health and mental health domains that jointly commit to promote the overall wellness of young children.

Criterion 5: Management Systems
NFC Goal 1.2: Address mental health with the same urgency as physical health

- Work with Primary Care Physicians to educate on the importance of identifying and treating young children and school age children for signs of early mental health issues, and

with schools to educate professionals around the mental health and substance abuse resources in the local community to improve access to these services. – NAMI Maine

NFC Goal 2. Mental Health Care is Consumer and Family Driven

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- Family Organizations continue to respond to and support the Department's invitations to participate in critical areas of policy development by adding their voices to the discussions and in the process inform and educate others about what is important to families and their children. Representatives from these organizations have a long history in Maine of meaningful involvement, advocacy on behalf of families, contributing their values and perspectives to the system of care, informing parents on issues of the day through family friendly literature and information, and supporting and training their family members to more confidently navigate the system of care.

- In Youth MOVE Maine's second year they have been able to build off of the foundational work of 2009 to develop a strong, sound program through leadership of the Advisory Council, partnership with community members and supportive organizations, energy and inspiration of a broader network of youth members, and dedication of staff who identify as peers and interact with youth and young adults with reverence for the unique expertise they offer through the life experiences they have had.

  Youth MOVE Maine has developed as an organization to have a majority youth and young adult board, by-laws, standardized staff training, policies, procedures, a logic model and strategic plan and quality assurance measures, to ensure the program is youth-led, trauma-informed and achieving specified objectives.

NFC Goal 2.4: Create a comprehensive State Mental Health Plan

- **Criterion 1** addresses the development of a comprehensive, community based mental health system. CBHS notes that over the past decade, children's mental health services have expanded significantly. A retrospective look at service data 1998 to 2008 shows this transformation in the context of the original Children's Services 10 year plan.

- Restructuring of crisis programs. Integrating child and adult crisis services at the district level with assurance, those children's crisis personnel are appropriately trained to deal with issues presented by youth and their families. Restructuring achieves greater efficiency throughout the statewide system and established fiscal allocation criteria to enhance resource equity among crisis providers.

- Reduction in Out of State Placements. Criterion 1 presents data that clearly shows the transformation from Maine's previous practice of sending children out of state for treatment. Over the past 12 years the population out of state for treatment decreased from 260 in 1998 to 20 in 2011, certain evidence that a transformation has occurred.

However, this transformation was made possible by service expansion in Maine that was tailored to and met the needs of these children and youth, by increased public financing of the children's mental health system, and through the extraordinary diligence over the past few years by CBHS Utilization Review Specialists and Child Welfare Services to determine real need for placement and finding and developing the right services to bring children back home and keep them home.

- Improve coordination of care among multiple systems through collaboration with Child Welfare Services and Early Childhood Services in order to avoid parallel and duplicative behavioral service systems and transform them into a single behavioral health system of care.

Criterion 3: Integration of Children's Services
NFC Goal 2.1: Develop an individualized plan of care for every adult with serious mental illness and child with a serious emotional disturbance.

- The Office of Child & Family Services awarded four competitive grants to community providers in 2007 to receive training in the High Fidelity Wraparound process by national expert John VanDenBerg. The centerpiece of the wraparound process is the development of quality Individual Service Plans that emphasize the use of existing community resources, families, extended families, friends and other natural supports. Funding would be employed not as the first step in the process, but only to augment the people and systems that are committed to child and family's interests, and therefore are likely to be sustainable over time. These projects total $4 million in state general funds and became available through cost savings achieved from reduced expenditures in residential treatment services funded by Child Welfare Services.

- CBHS Child Psychiatrist provided training for CWS supervisors and caseworkers to ensure that the children they served received effective psychotherapy services. Training included development of a Fact Sheet used to guide the worker's interaction with the therapist, specifically regarding questions to ask when therapy is being considered as a treatment option.

NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- In the past year, the Thrive System of Care Initiative has established the value of youth participation in all aspects of Thrive is planning, organizing, and governing council business. Youth are especially visible in the community and their actions demonstrate a singular commitment to informing the public about the essential elements of trauma informed services. The youth voice is expanding to other areas of the state using a statewide youth conference as the initial vehicle to promote increased involvement at the local level.
- Youth and young adults have had numerous opportunities to address policy, including

- Co-chairing the Continuous Quality Improvement Workgroup for CBHS, where youth and families have co-led the development of Six Key Quality Areas to define quality services for children, youth and families, which will guide all CQI efforts.
- Development of a Youth And Family Workgroup advising CBHS from a collaborative youth and family perspective on key issues such as residential standards, implementation of the Youth Outcomes Questionnaire, CQI efforts, and more
- State and regional participation on the Shared Youth Vision Council, dedicated to reducing recidivism in Juvenile Justice and increasing successful school completion
- Developing a guide with another youth empowerment program, YLAT, to informed consent to Anti-psychotic medication for youth, which is being used as a foundation for similar national work with the FDA and SAMHSA
- Advising on peer support with the Moving Forward Healthy Transitions Initiative and Wraparound Maine

NFC Goal 2.4: Create a comprehensive State Mental Health Plan

- Criterion 3 of the Application discusses a number of formal Memoranda of Agreement or Understanding and describes collaboration between CBHS and other state child serving Departments that are both historical and recent. These agreements and working relationships continue to the present, and they are evidence that integrating children's services is a transformational process that takes time, effort and hard work. Each new component to inter-agency relationships is valuable no matter how small. Many examples of these steps are noted above. All of these steps add to the transformation from "silos" to collaborative working partners that are building a single system of children's behavioral health care.

- The 2009 Memorandum of Understanding between CBHS and Office of Adult Mental Health Services on transition of youth from the children's service system to adult mental health services goes beyond the traditional "public service system to another public service system," and instead it focuses on independent living, youth choice and needed skills to survive in an adult world. This MOU is framed in the larger picture of life and is more realistic as to the roles CBHS and OAMHS can play in preparing youth for adult living.

- Preparation for more independent living is also enhanced by the Jim Casey Youth Opportunities Initiative which has been an evolving project that now has focused on the Finance Project as a means to identify resources available for youth in foster care to transition out of the Child Welfare Services system. This work clearly involves the right partners in planning and is not limited to state child-serving agencies alone, but has reached down to the local and community level where the reality of independent living is.

- Of all the examples and successes described under Criterion 3 – Integration of Children's Services, perhaps the most exemplary example of transformation and sustainability at the state agency level has been the extraordinary working relationship between Children's Behavioral Health staff assigned to work within the Juvenile Justice system and Department of Corrections field and facilities personnel.

Criterion 5: Management Systems
NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- Web-based electronic information resources for parents, including interactive mode for users of the *Starting POINTS* system that also offers connections to other mental health information sites in a user –friendly design – **Maine Parent Federation FY12 Block grant activity**

- New Behavioral Health Informational Materials and Training Collaboration – **Maine Parent Federation FY12 Block grant activity**

- Parent Advisory Councils and Advocacy (F.A.C.E.S) with a FY12 focus on trauma – informed services - **GEAR Parent Network FY12 Block grant activity**

- Youth MOVE Maine provides an infrastructure for youth with emotional and behavioral challenges and those who have overcome them to participate fully in their communities and give their voice in advocacy and decision making while showing their strengths and abilities as a means to reduce metal health stigma by personal example – **Youth MOVE Maine FY12 Block grant activity**

NFC Goal 3 Disparities in Mental Health Services are Eliminated

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 3.1. Improve access to quality care that is culturally competent

- Project LAUNCH is a 6-year project is a partnership between Maine public health and mental health domains that jointly commit to promote the wellness of young children by selecting Washington County as the project site, an area that is severely economically deprived, has a diverse cultural background and heritage and will serve both addicted mothers and their infants.

- CBHS has established a collaborative partnership with APS Healthcare, which is providing valuable services to CBHS and the Office of Adult Mental Health Services as the Administrative Service Organization (ASO). This next step in the process of developing managed care system comes at an opportune time. CBHS now has additional utilization review capacity to monitor behavioral health treatment services for many children and youth in the system of care. The ASO represents another step forward toward in the transformation process that will ensure quality, effectiveness and appropriate duration of service that will benefit the child and family.

- Maine's first Multi-Cultural Conference was sponsored by Thrive, the Department of Health & Human Services and CBHS in 2007. The conference focused on youth with behavioral health needs and the importance of outreach and service delivery tailored to the needs of cultural and diverse societies within cities and towns in Maine. The most recent Multi-Cultural Conference, held in Kennebunk, Maine October 2008 was a stunning success on several fronts. The theme for "Healing Invisible Wounds" centered on a multi-generational perspective of trauma as told from an ethnic viewpoint that included recent refugees, immigrant adults and children as well as Native Americans living in Maine. This conference attracted a wide audience including attendees coming from many of the northeast States. As well received as this conference was locally, it also received national recognition by winning the SAMHSA System of Care Golden ECCO Award – first place for national Excellence in Community Communication and Outreach presentations at the Annual System of Care Conference in Anaheim, California in July 2009.

NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- Maintain full compliance with Revised Risinger Settlement Agreement which has been an 8 year effort to transform access to Maine's core case management and in-home behavioral supports from lengthy waiting periods for children in need of treatment to a responsive community based system of providers, available in all geographic areas of the state.

- Integration of all home-based treatment services in a single MaineCare section, Children's Home and Community Based Treatment, that has clinical and treatment integrity, provided by a team directly in the home and community, with the full participation of the family and an active utilization review component that assesses client progress measured by treatment outcomes. This is a transformational process that has taken 3 years of collaboration and dialogue with providers and families to achieve.

Criterion 2: Mental Health System Data Epidemiology
NFC Goal 3.1. Improve access to quality care that is culturally competent
NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- **The National Outcome Measure (NOM) Increased Access to Services (Number),** URS Basic Table 2, applies to Criterion 2 and is reported under the Goals, Targets and Action Plans (Performance Indicators) section of this Application.

- CBHS monitors program activity (total numbers served, State General Fund and MaineCare) expenditures to date) during a fiscal year when this information is needed by the Director, CBHS, the Office of Child & Family Services, the Department of Health and Human Services, the Executive Department, and Legislative Committees of

Jurisdiction. Yearend totals, such as contained in the Criterion *2 Children Receiving Publicly Funded Services*, provide a common foundation against which yearly changes in service activity and finances are analyzed and reported. One such reporting venue is SAMHSA, Division of Grants Management, Block Grant Office, which requires that comparative total fiscal data be compiled for purposes of determining the State of Maine's Maintenance of Effort (MOE) and Children's Set-Aside expenditures.

Criterion 3: Integration of Children's Services
NFC Goal 3.1. Improve access to quality care that is culturally competent

- CBHS Quality Improvement staff is trained to provide focused consultation services to assist contracted service providers. This training expands their ability to engage in a broader array of quality improvement functions, including consultation with families and providers as well as developing specialty roles for QIS staff as program consultant and auditor.

Criterion 4: Targeted services to homeless and rural areas.
NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- Expansion of service providers in all areas of the State of Maine, especially in Regions II and III that are heavily rural in composition (compared with Region I in Southern Maine). Provider availability allows for family choice, as well as increased timely access within rural communities.

Criterion 5: Management Systems
NFC Goal 3.1. Improve access to quality care that is culturally competent

- Work with Primary Care Physicians to educate on the importance of identifying and treating young children and school age children for signs of early mental health issues, and with schools to educate professionals around the mental health and substance abuse resources in the local community to improve access to these services. – NAMI Maine

NFC Goal 4 Early Mental Health Screening, Assessment and Referral to Services are Common Practice

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 4.1: Promote the mental health of young children

- CBHS District Staff continue to work on quality improvement and service expansion for the early intervention services providers. Significant revision occurred to multiple agreements. One long term provider agreement was revised to provide a new evidence-based early intervention services. In another district, staff assisted in the merging of two agencies into one organization in order for them to better manage resulting in cost savings; while also providing seamless services to these children and families. Technical assistance was provided to another agency which guided them in streamlining their budget, while also reflecting a program with specific goals aimed at establishing better

performance measures. One of the highlight form a northern district was assisting a provider in the redesign their early intervention supports to enhance and expand the services they were providing to a greater geographic area and support a larger number of children.

- The District Staff regularly monitors all of these agencies regarding their delivery of early intervention services. As unexpected adjustments are revealed due to unforeseen situations by any agency, the district staff is prepared to negotiate in order to offer a proper conclusion and reach a decision in accordance to the contract requirements that is extended to the provider on an annual basis.

NFC Goal 4.3 – Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies.

- Project LAUNCH is 6 year project is a partnership between Maine public health and mental health domains that jointly commit to promote the wellness of young children. By selecting Washington County as the project site, an area that is severely economically deprived, has a diverse cultural background and heritage and will serve both addicted mothers and their infants. LAUNCH is also improving access to quality care that is culturally competent.

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 4.1: Promote the mental health of young children

- A 2009 Quality Improvement initiative utilized CBHS regional Quality Improvement Specialists and other staff in statewide review of all Early Intervention contracts to assure consistency with and adherence to the program model and adjusting contract service strategy or content when necessary. This effort demonstrated the capacity of CBHS field personnel to successfully perform contract management, monitoring and quality improvement functions and integrate those responsibilities within OCFS operations at the District level.
- Children's Behavioral Health Services has engaged with Child Welfare Services on several trainings to improve assessment and screening of children with behavioral health issues, to improve knowledge of certain types of medications and improve caseworker interaction with behavioral therapists.

- Screening all children coming into CWS care for mental health needs. After study and consultation with CBHS, the Pediatric Screening Checklist was chosen based on its extensive reliability and validity data, and is being used for screening children ages 5-18 in primary care settings.

- CBHS is actively collaborating with the Office of MaineCare Services to identify infants and younger children with Developmental Disabilities in the child's home. This work is part of the ABCD Academy (Assure Better Child Health and Development). The screening would be done during well child screening visits.

NFC Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 5.2: Advance evidence –based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation

- CBHS is moving ahead with proven evidence based practices and conducting inquiry, research, and consideration of other promising practices on the horizon. CBHS, Juvenile Justice and Child Welfare Services are all engaged in supporting the 3 required Children's EBP'S for the FY12 Plan (Therapeutic Foster Care, Multi Systemic Therapy and Functional Family Therapy). Other practices are under consideration by the DHHS Evidence-Based Practice Committee. Other practices have already been implemented such as Children's Assertive Treatment Teams. In 2008 the System of Care site (Thrive) chose Trauma-Focused Cognitive Behavioral Treatment and Child and Family Psychotherapy in a process that included youth and parents. One year later extensive training opportunities have been realized by agency clinicians and independently licensed professionals through supervision and professional growth in a learning collaborative setting through Thrive.

NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- Infusing Trauma Informed Care within CBHS Systems and Practice. All contracted provider agencies will implement Quality Improvement Plans addressing needs identified in system of care self-assessment for federal system of care principles. The principles are family driven, youth guided, culturally and linguistically competent and Maine has added trauma informed. Thrive and CBHS will continue work to develop training and technical assistance for agencies in the form of webinars, written training materials, learning collaborative and agency trainings.

- Developing Co-Occurring Competency within CBHS Systems and Practice. All contracted provider agencies will implement Quality Improvement Plans addressing needs identified in Co-Occurring self-assessments. Trainings and technical assistance are available through the Maine Co-Occurring Collaborative Serving Maine and CBHS.

Criterion 3: Integration of Children's Services

NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- The Thrive Initiative can be credited for many successes during its first 4 years of operation. Among its many areas of strength is the planning work done with child-serving state agencies in local and district offices. This year continues an expansion of direct trauma informed services to the regional juvenile justice community based service

system, following the lead of involvement in the child welfare system last year. Thrive stands alone as the only Children's System of Care site that is committed to public and private inter-agency collaboration that recognizes and focuses on childhood trauma, and improving the quality of behavioral health services by implementing a trauma informed approach to services through education and training through local partnerships.

- Training on psychotropic medication prepared by a CBHS Child Psychiatrist centered on Fact Sheets developed for Child Welfare staff on the major classes of types of medication such as: stimulants, non-stimulant ADHD medications, antidepressants, atypical antipsychotics and typical mood stabilizers.

- A screening tool designed to identify and treat children in the Child Welfare system who have experienced trauma or may have other mental health disorders is being studied by the CBHS Director of Clinical Policies and Practices. Final selection of this instrument will greatly aid child welfare staff, and will be applied to cases where there is a substantiated finding of child abuse or neglect, which is highly suggestive of trauma.

Criterion 5: Management Systems
NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- Parent Advisory Councils and Advocacy (F.A.C.E.S) with a FY12 focus on trauma – informed services - **GEAR Parent Network FY12 Block grant activity.**

- Youth MOVE Maine FY12 provides an infrastructure for youth with emotional and behavioral challenges and those who have overcome them to participate fully in their communities and give their voice in advocacy and decision making while showing their strengths and abilities as a means to reduce metal health stigma by personal example –

NFC Goal 6 Technology is Used to Access Mental Health Care and Information

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC 6.2: Develop and implement electronic health records and personal health information systems

- Networks of Care became fully operational in 2009. This is an internationally recognized web-based system for personal health record portability and resource access. Families and youth can place their personal health records with this secure site and grant access to others they choose so that they do not have to repeat their history multiple times, and feel safe about the privacy of their information.

Criterion 4:
- Initiation of tele-medicine as a psychiatric consultation option, with planning to implement a statewide tele-medicine pilot to determine feasibility for use at the primary care level of medical care delivery.

[i] Mary Takach, Reinventing Medicaid: State Innovations to Qualify And Pay For Patient-Centered Medical Homes Show Promising Results, *Health Affairs*, 30, no.7 (2011):1325-1334

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

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, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must 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 serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, 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.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Office of Adult Mental Health Services
Step 2: Identify the unmet service needs and critical gaps within the current system

The OAMHS service infrastructure has been designed to identify and respond to unmet service needs before they can develop into "critical service gaps." The Office of Quality Improvement and the OAMHS data collection system provide a continuous source of information upon which sound policy and program decisions are based and implemented. Each of these components of the OAMHS service infrastructure comprises an important part of the whole of what has developed into an increasingly sophisticated data collection system.

OAMHS 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. Recently, we have reached out to each of Maine's Indian Tribes and are building relationships, which include an invitation to join the QIC. We have also incorporated into the home page of our website the opportunity for anyone to review and comment on Maine's Block Grant.

Input from multiple and diverse sources provide a critical benchmark against which the validity of our data is assessed and refined. 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 may differ from those in the other, more rural regions of the state.

Unmet needs data is compiled by county then tabulated statewide. The most recent data indicates the following statewide unmet need areas in the third quarter of state FY 2011. Specific data is from the OAMHS statewide Resource Data Summary, and represents 2,537 distinct clients with unmet resource needs from a data pool of 7,566 consumers. This data was collected for all individuals enrolled in community integration services.

Sources for the following 2 tables: DHHS/OAMHS Statewide Report of Unmet Resource Needs for Fiscal Year 2011 Quarter 3
http://www.maine.gov/dhhs/mh/consent_decree/august-2011/cd-7.pdf

Total number of unmet resource needs reported.

Reported Unmet Resource Needs	2010 Q4	2011 Q1	2011 Q2	2011 Q3
7a. Mental Health Services	1,238	1,153	1,085	1,255
7b. Mental Health Crisis Planning	205	181	173	200
7c Peer, Recovery, and Support	291	224	254	307
7d. Substance Abuse Services	151	125	131	117
7e. Housing	1,164	1,073	1,031	1,115
7f. Health Care	1,136	973	996	1,161
7g. Legal	175	155	138	129
7h. Financial Security	548	503	532	587
7i. Education	389	329	327	330
7j. Vocational / Employment	454	398	378	420
7k Living Skills	369	300	267	286
7l. Transportation	796	661	676	739
7m. Personal Growth/Community	564	429	408	453
Other Resources	154	53	43	32
Total Statewide Unmet Needs	7,634	6,557	6,439	7,131

OAMHS is beginning to develop longitudinal data on the following services. Below is a table detailing these services and utilization from FY09 to FY10. This and other information will be utilized in helping us to determine unmet needs.

DHHS Office of Adult Mental Health Services			
Community Resources and Treatment Services			
MaineCare Data FY 2009 and FY2010			
Mental Health Treatment Services Received	**MaineCare Code**	**FY09 Total Number**	**FY10 Total Number**
Assertive Community Treatment	CBB10	1,178	1,141
Community Integration	H2015	9,834	10,856
Crisis Services	H2011	5,121	5,411
Crisis Residential (CSU)	H0018	1,405	1,518
Day Treatment	H2012	661	773
Medication Management	H2010	12,184	13,173
Outpatient (Comp Assess & Therapy)*	H2000 OR H0004	26,516	31,918
Residential	RMI, RMI2	839	1,511
Skills Development	H2025 OR H2014	69	105
Daily Living Supports	H2017	581	883
Total Unduplicated Count		**58,388**	

*Numbers were revised on 11/17/2010 and included H2000 OR H0004. Numbers reported in 2009 used H2010 OR H0004.			

OAMHS 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 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 information technology solutions and implementation.

Children's Behavioral Health Service

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

Summary Statement on Strengths and Needs

It has been the practice of CBHS to identify system needs each year and to include the most pressing and significant of those needs in the annual Priorities section of the Block Grant Application/ Plan. Progress and outcomes for these areas and topics are accounted for in the subsequent annual plan. In this fashion CBHS keeps pace with new challenges that appear each year, and over time, has been successful in turning many of these needs into system strengths.

Sources of Data and Information in this Application

Because the FY12/13 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 plan, it is useful to state the specific data sources that Maine employs for these purposes in the current application.

Year End Contract Reports Children's Behavioral Health Services (CBHS) 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 (yearend) reports are a major source of data used by the Department, and are referenced in this Application. Yearend reports are not always available in August of the previous full fiscal year; which is the case for State Fiscal Year 2010. Because Year End Contract Reports for FY09 are complete for all services covered, this is the base year available for inclusion in the current Plan. 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. This system came on-line in September, 2009. 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) this is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children's Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children's Home and Community Based Treatment and Children's Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08. An updated version of this system became operational on July 1, 2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. 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 FY10 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health & Human Services for children, through the Division of Children's Behavioral Health Services and for adults, through the Office of Adult 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 in Part B, Section 3. of the Mental Health Block Grant Application and Plan.

Service Gaps and Unmet Needs

The Department's information systems provide data upon which service gaps, unmet needs and individuals waiting for services are determined. Currently the Enterprise Information System (EIS) generates data to track children who have requested and are waiting for Case Management Services, Behavioral Health Treatment Services and Rehabilitative Community Services and supports under the Risinger Settlement Agreement. Other data resources utilized are from the Office of Quality Improvement and APS.

Other sources of identifying needed services are from regional 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 mental retardation or autism.

CBHS regional Resource Coordinators are well positioned to detect service gaps and needs, as are CBHS community based Family Information Specialists, who because they have experienced the service system as parents raising children with behavioral or emotional needs, have special sensitivity to what is missing for families in their service area. Their insight into the needs of families resulted in the development of an intensive community treatment service (Assertive Community Treatment) or Children's ACT team in the mid-coast area.

Children's Behavioral Health Services central office staff and field management personnel routinely meet on a bi-monthly schedule to discuss current policy and operational issues as well as larger systems concerns. . As a new fiscal year begins, CBHS staff discuss possible systems

needs and service gaps that are not already addressed as action targets under the current Block Grant 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 Adult Mental Health Services.

• 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.

• Lack of publicly funded treatment and rehabilitative services for children with traumatic brain injury. The Maine Legislature has expanded the former Adult Mental Retardation Services to include a wider population in the new DHHS Office of Adults with Cognitive and Physical Disabilities that include persons with brain injury, but did not change the service population under Children's Behavioral Health Services.

Other needs, such respite care and therapeutic child care will be partially addressed through services under a new Children's Home and Community Based 1915(c) Waiver which received in approval this past February. In July the proposed Maine Care (Medicaid) rule as adopted and the implementation plan finalized. Currently CBHS staff is working with families and providers to begin provision of these valuable services.

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 over the past four years, and wait times for these services will continue to be monitored in FY12/13.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Adults with Severe and Persistant Mental Illness	Take advantage of the expertise of consumers in developing peer driven, recovery oriented, systems of care
2	Adults with Serious and Persistent Mental Illness	Linking Mental Health system with other Behavioral Health and Physical Health care systems.
3	Adults with Severe and Persistent Mental Illness	Enhance Olmstead related activities; particularly focusing on those persons being discharged from institutions such as psychiatric hospitals, jails, prisons, and congregate care environments.
4	Adults with Servere and Persistent Mental Illness	Support outreach and engagement to underserved populations such as tribes, racial and ethnic minorities, LGBTQ individuals, and the homeless.
5	Adult with Severe and Persistent Mental Illness	Support a stable, safe and healhty place to live that reduces stigma.
6	Adults with Severe and Persistent Mental Ilnness	Understand and inform core elements of Maines implementation of the A.C.A
		Children's Behavioral Health Services (CBHS) will continue in its role in ensuring quality of services delivered by contracted providers and will be enhancing this work with a standardized process across program areas, including residential, outpatient, case management and home and community based services. CBHS staff will take part in advanced training provided by the Department of Health and Human Services Office of Quality Improvement and the Muskie School of Public Service of the University of Southern Maine. The trainings will address components of quality assurance and quality improvement from the perspective of a state oversight entity and serve to prepare staff to

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7	Quality Improvement	perform this work in greater detail with respect to the anticipated start of a Managed Care Organization in next year. Work will also focus on the use and further development of systems for the recording, reporting and analysis of data, including the state Enterprise Information System (EIS) and the new Maine Integrated Health Management Solution (MIHMS). Staff will be expected to analyze data collected in these systems and also review client charts, agency procedures and quality improvement plans. CBHS staff will also be overseeing the implementation and use of quality improvement outcome measures including the Child and Adolescent Functional Assessment Scale (CAFAS) and the Youth Outcome Questionnaire (Y-OQ). CBHS staff will work to ensure that the tools are utilized in a consistent manner and that providers use the data in their own quality efforts. Staff may be engaged to train providers on the use of the tool and quality reporting aspects.
8	Transition from Youth to Adult Life	Transition has long been recognized as a crucial and, for many, a challenging time in a young person's growth and development. The Maine Children's Cabinet acknowledged this dilemma and identified transition as one of its three priorities under the current Administration. In Maine, the primary focus has been on a young adult's transition from one environment to another, such as from foster care to permanency, or from inpatient psychiatric care back to home and community or from homelessness to safe and supportive housing. While these initiatives are important to assure health and wellness, the work has been more focused on the young person's transition to different systems rather than to successful independent adulthood. Historically, transition age has been considered to be 18, the age a minor becomes legally an adult. Research is showing that transition age is really a phase of emerging adulthood beginning around the ages of 15 or 16 up through age 25. During this phase, the young person explores and experiments with finding pathways to the rights, responsibilities, and expectations of adulthood. The needs of this group are unique, but all the more so if they are homeless, exiting the foster care system or correctional facilities, or trying to manage emotional illness.
9	Youth Leadership	This priority builds on the experience gained from seeing young people participate as peers in Maine’s System of Care Initiative over the past 5 years, hearing them while they speak, recognizing their potential, and celebrating their successes at home and on the national stage. The FY12 priority will be to infuse youth in a leadership role statewide Leadership means moving from voice to active participation and involvement, and personal investment in the future for themselves and for their peers. There are presently three youth leadership components in place that will be further developed through opportunities to lead by experience through participation in opportunities that, with the exception of youth involved in the Thrive Initiative, did not exist in prior years. The first is the formal designation of a Youth MOVE chapter in Maine, originating during the formative years from Thrive, which in FY12 will expand and build on development of an infrastructure in Northern Maine. Youth MOVE (Motivating Others through Voices of Experience) is supported through Transformation Initiative resources from the Children’s Community Mental Health Block Grant . The second and third opportunities to further develop youth leadership lie in experiences gained through the training and peer support functions that youth will perform as supports to their peers in the Healthy Transitions Initiative, leading to greater choice and progress toward independence and successful adulthood living for many youth and young adults. The third opportunity is in the creativity young people will

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		bring to the reformation of Thrive as the organization adapts to a changing landscape and mission that will focus on sustaining the excellent work of the past 6 years through strategies that will demand critical thinking and choices that are in touch with the young people who have been such a large part of its success.
10	Trauma Informed System of Care	This Priority addresses the transition of Maine's Trauma Informed System of Care Initiative, Thrive, as it "turns the corner from superstar to sustainability." Trauma is pervasive among children, youth and families, especially those involved in public systems. These very same systems serve these trauma survivors often without treating them. Even more significant, systems are unaware of the traumas that these children, youth and families have experienced often because society does not look at behaviors through a trauma lens. It is this lack of awareness that can result in poor outcomes and the likelihood of retraumatizing families. Adverse Childhood Experiences and data collected in Maine by the Thrive Initiative demonstrate that trauma results in poor physical and mental health outcomes. Trauma matters because of the enormous societal cost and the preventability of these poor outcomes. Reconciling the balance between current research and knowledge about effective practices and the implementation of a trauma-informed framework requires a set of policies, practices and community education. Maine, along with other states, has undertaken this shift to become a trauma-informed system of care which focuses on cross system collaboration, training, education, accountability and meaningful family and youth involvement. In Maine the question is no longer, "What is wrong with you?" but instead, "What happened to you?". The last 6 years have focused on the creation of a Trauma informed Agency Assessment created by families, youth and providers in consultation with Thrive staff. This agency assessment is now a requirement as set forth in contract language for child serving agencies contracting with the Department of Health and Human Services' Office of Child and Family Services. The Thrive Initiative has created a crosswalk that matches local and national resources to trauma informed domains and establishes best practice guidelines. This crosswalk is administered along with regional and on site trainings on Trauma, Trauma Informed, Youth Guided, Family Driven and Cultural and Linguistic principles and practices. These trainings begin the technical and adaptive process of creating change in an organization. Thrive recognizes that ongoing support outside of an initial training is necessary to sustain change which is why phases of support would be offered that identify and train "trauma informed champions", creates agency specific strategic plans for becoming trauma informed and assesses change through continuous quality improvement and on site monitoring for those organizations who score with significant challenges. Thrive, in partnership with the Office of Child and Family Services, would track agency change against these system of care trauma informed principles through a re-administration of the Trauma Informed Agency Assessment. The efforts listed above would enhance an already existing system without creating additional services. Ultimately, families and youth would report increased satisfaction, safety, trust, empowerment and collaboration with their treatment providers resulting in improved treatment outcomes.
		In FY12/13 CBHS will continue to support current program and practices already in place that include Functional Family Therapy, Multi Systemic Treatment,Trauma Focused Cognitative Behavioral Treatment and Child and Family Psychotherapy.CBHS staff will also

11	Evidence based practices	oversee the further development and maintenance of quality of Evidence Based Practices throughout the state, including Multisystemic Therapy, Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy and Multidimensional Treatment Foster Care. Residential treatment facilities will be the ongoing subject of intensive quality reviews, focusing on facilities, staffing and in particular on clinical interventions and adherence to Evidence Based and Best Practice Parameters. Over the past several years the focused work of the CBHS Evidence Based Practice Advisory Committee, the Thrive Evaluation Committee, the CBHS Medical Director and Director of Clinical Policy and Practice has resulted in an increase of children's EBP's that have proven their effectiveness regarding treatment outcomes. Strategies include recognition of and reimbursement for EBP's and new promising practices through MaineCare policy. The objective is to stimulate a conversion from less effective service delivery and outcomes to new approaches to treatment for specific emotional and behavioral needs of children and youth
12	Statewide Family Organizations	In FY12 CBHS will support the statewide family organizations in thier newly formalized alliance, Maine Alliance of Family Organizations(MAFO). Family voice and choice are critical elements of the present system of care. Each partner provides crucial service with in the various geographical areas of the State.

Footnotes:

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II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Adults with Severe and Persistant Mental Illness	Increase the Percent of homeless persons with SMI receiving services	Targeted Services to Rural and Homeless Population: - Continue to develop strategies to accurately portray the numbers of homeless mentally ill who need services in Maine; - Continue to develop more reliable data that can be used as a baseline for comparison from year to year regarding the homeless population; - Maintain current level of funding for OAMHS support for programs that serve homeless mentally ill individuals.	Adult - Increased Stability in Housing (20%)	Standard data elements within Data Infrastructure Grant.
		Development of a Comprehensive Community-Based Adult Mental Health System. The implementation of a new transition initiative at Riverview Psychiatric Center should result in better community integration of discharged patients and lower 180 day readmission		

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Adults with Severe and Persistant Mental Illness	Reduced utilization of state psychiatric inpatient beds.	rates: - State will continue to promote recovery based planning for patients including strengthening connections with community providers; - 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 hosptials with psychiatric beds.	Reduced Utilization of Psychiatric Inpatient Beds - 180 days(21)	DIG Uniform Reporting System Basic Table 20A.
Adults with Severe and Persistent Mental Illness	Increase number of adults with SPMI receiving services	Mental Health System Data Epidemiology - Prepare current FY10 utilization data that represents most components of the adult mental health system. - Analyze and track specific service utilization through using performance based indicators. - Identify current trends in service utilization with reference to previous FY08 and FY09 data. - Commit OAMHS staff to fully participate in the CMHS DIG activities carried out through the DHHS-Office of Quality Improvement. - Prepare service utilization data related to financial expenditure data in order to inform: Department of Health and Human Services Administration; Executive Department Administration; Relevant legislative committees--Appropriations and Financial Affairs and Health and Human Services.	Increased Access to Services (12,000)	DHHS is working through the DIG initiative to develop standard data elements to collect prevalence data in a consistent way. DHHS uses the SAMHSA prevalence figures to establish estimated rates.

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Adults with Severe and Persistent Mental Illness	Promotion and support of evidence-based practices.	Development of a Comprehensive Community-Based Adult Mental Health System: - State will continue to promote and support evidence based practices by contracting for these services; - Continue to develop more reliable data regarding evidence based practices that can be used for comparison from year to year; - Continue to track data regarding utilization, age, gender and ethnicity. - OAMHS is currently working with Maine Medical Center's Division of Vocational Rehabilation to provide employment specialists working in conjunction with the Community Service Network system and benefits specialists.	Evidence Based - Adults with SMI Receiving Supported Employment (550)	Contract Performance Reports
Adults with Severe and Persistent Mental Illness	Promotion and support of evidence-based practices.	Development of a Comprehensive Community-Based Adult Mental Health System: - State will continue to promote and support evidence based practices by contracting for these services; - Continue to develop more reliable data regarding evidence based practices that can be used for comparison from year to year.	Evidence Based - Adults with SMI Receiving Supported Housing (100%)	Contract Performance Reports.
	Increase in	Continue to fund increased numbers of employment specialists statewide as well as training in employment practices for community		

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Adults with Servere and Persistent Mental Illness	community support clients employed full time in competitive jobs.	support workers. Develop consistent data collection strategy that captures employment data across all with recipients. Support and promote best practices regarding the Club House Model which supports and encourage employment.	Adult - Increase/Retained Employment (90%)	Contract performance measures
Quality Improvement	Increase access for children and youth served by CBHS who receive services that address their behavioral, emotional and mental health issues	Continue to support access to needed services through cost efficient services , excellent management of services necessity and duration , and elimination of geographic barriers to access .	Total number served according to measure discussed below	Data includes children whose behavioral health services are identified by Medicaid/ MaineCare procedure codes that represent services appropriate to address the treatment needs of these individual children and youth . The number is reported in URS Basic Table 2A .
Quality Improvement	Increase/ maintain Stability of Housing Situation for Children and Youth with social ,emotional or mental health needs	Continue Stability in Housing questions in the OQI annual Survey and track results to see where there are trends over time	Stability is determined as the percentage of all respondants who have remained in the same place or has moved to a single other place over the year	Sources of Information : Reported on URS Table 15 fromthe 2011 Maine Youth &Family Meantal Health & Well-being Survey Measure : Stability is determined as the percentage of all respondants who have remained in the same place or has moved to a single other place over the past year
Quality Improvement	Maintain/Improve the percentage of postitive client (Children's) outcomes reported in an annual OQI Youth /Family Mental Health & Well Being Survey	Analysis of information in Maine OQI survey which is based on information reported in the YSS/Family survey .	Percentage of Children/Families reporting Postitive Outcomes in OQI Survey	Source of Information: DIG Uniform Reporting System , Table 11, specific to Questions 1-6 on the OQI Measure : Denominator: Number of Chidlren/families responding to OQI survey; Numerator: Number of children/families who report positively to the Positive Outcomes of Services (questions 1-6)

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Quality Improvement	Reduce recidivism for youth who are incarcerated in one year and who are at risk of re-incaration in the next year	Data will be reported and analysed on a continuing basis	Percentage of Youth who do not experience recidivism	Source of Information: IRS Table 19A. Incarceration data for youth obtained from the Maine Department of Corrections;data analyzed and reported by the Bristol Observatory (Vermont) under contract with the Maine DOC
Evidence based practices	Decrease percentage of children and youth receiving Therapeutic Foster Care each year	Continue successful efforts to place children and youth from therapeutic foster care setting to more permanent, family like environments while still meeting their behavioral health needs through available community based treatment services. Two proven avenues to accomplisth this objective are the Maine Caring Families program(placement with relatives or extended family members) and DHHS adoptive programs where permanency is achieved.	Actual unduplicated number of children in Therapeutic Foster Care placements during the Fiscal Year served by Child Welfare Services	Source of information: DHHS Office of Child & Family Services, Child Welfare Services. Numbers are tracked by the OCFS Residential Services Program Manager and are provided by 10 Maine community agencies under contract with DHHS/OCFS offering this service. Measure: Measured by the number of children in TFC from Fiscal Year to Fiscal Year divided by the estimated number of children with SED (DIG/URS Table 16)
Evidence based practices	Maintain /increase percentage of chidlren and youth receiving Multi-Systemic Therapy	Continue to support the development , implementation and sustainability of MST EBP's for Maine children. This EBP is funded by MaineCare Children's Home and Community Based Treatment (Section 65)	Unduplicated Numbers served under MST by community providers	Source of Information : Numbers in service are obtained from Tri-County Mental Health Services and Kennebec Behavioral Health Services, estimate of SED estimate provided by Maine Data Infrastructure Program for current fiscal year (Table 16) Measure: number served under MST divided by the estimated number of children with SED
Evidence based practices	Maintain or Increase number of Evidence Based Practices (EBP) in the State	Maintain current provider of EBP and increase the number of locations in which EBP is available to children and youth , within the parameters of legislative appropriation and Medicaid/Maine Care rules allowing for higher rate of reimbursement for providers delivering EBP with	Number is from 0 to 3	Source of Information : Community agencies contracting for these services. Measure: Count 1 each for : Theraputic Foster Care; MultiSystemic Therapy ;Functional Family Therapy

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		fidelity.		
Evidence based practices	Maintain the number and percentage of children and youth recieving Functional Family Therapy at current levels	Continue to support the development ,implementation and sustainability of FFT EBP's for Maine children. This EBP is funded by MaineCare Children's Home & Community Based Treatment (Section 65)	Unduplicated number served under FFT by community providers	Source of information: Numbers inservices is obtained from Catholic Charities and the Spurwink School; estimate of SED is provided by Maine Data Infrastructure Program for current fiscal year (DIG/URS Table 16) Measure: Number served under FFT divdided by the estimated number of children with SED

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	Services Contracted include: Peer, Community Support, Crisis, Outpatient, Residential, Transportation ,Family Support, Information & Referral,Youth Self Help. Both the Office of Adult Mental Health and Children's Services utilizes the Department of Health and Human Services' contract management staff and procedures to ensure uniformity in the management and administration of grants and contracts. Each division also employs dedicated program and fiscal staff to help manage contracts unique to the population group being served. DHHS also has a Quality Management division, the lead on the Data Infrastructure Grant, which provides much assistance and information in tracking outcomes and other performance measures.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	10-25% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	<10% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	10-25% 6
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	10-25% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	26-50% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	10-25% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	<10% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	10-25% 6
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	26-50% 6
System improvement activities		10-25% 6
Other		<10% 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year:

End Year:

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$
11. Total	$	$	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$		$			$
2. Quality Assurance	$		$			$
3. Training (Post-Employment)	$		$			$
4. Education (Pre-Employment)	$		$			$
5. Program Development	$		$			$
6. Research and Evaluation	$		$			$
7. Information Systems	$		$			$
8. Total	$	$	$	$	$	$

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

D. Activities that Support Individuals in Directing the Services

CBHS has been actively involved in developing Youth and Family Guided services for an extended period. Below are descriptions of current initiatives.

Case Management services: Case management services for children entail an individualized planning process with a Child and Family Team that includes all behavioral services and natural supports involved in a child's life. Representatives from child serving systems would be included, such as state Juvenile Community Corrections Officers, Child Welfare Protective Workers, school teachers and administrators, and physical health care providers. These individuals are involved from Assessment through discharge and in meetings and communications necessary to carry out the goals established in the plan. 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. An individual service plan is built on the results of assessment, taking into account child and family strengths, needs, and preferences. Plans reflect services to be secured, with measurable goals and time frames, natural supports and service providers. An individual plan is developed through a child and family centered wraparound planning process, with a Child and Family Team. Case management involves brokering services, advocacy, insuring that a quality treatment plan is developed and implemented, and reviewing the child's progress. Case management involves aggressive outreach on behalf of the child and family and working with a wide range of community agencies and resources.

Children's Behavioral Health Services case management services are provided through contracts with local service providers. Mental health case management services for children have recently undergone a major redesign that recognizes the need for uniform screening and assessment tools that are used to help determine the level of care or intensity of service that the child needs. 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 in 12 months and at completion of services.

Youth Voice and Leadership: Youth MOVE Maine is a youth-led organization dedicated to modeling, teaching and supporting the youth-guided philosophy in Maine's systems of mental health, juvenile justice, child welfare and alternative or special education. "Youth Guided" is the philosophy adopted by Systems of Care which asserts the rights of all young people to access authentic opportunities for empowerment, education and decision-making in their own lives, and in the policies and practices in youth-focused systems.
Through the Thrive System of Care grant, young people ages 14-25 with lived experience in the mental health, juvenile justice, child welfare or special education systems have been coming together as the Thrive Youth Group since 2005. Coordinating this Youth Group was a young adult with personal experience in the system of care. Members of this group were able to access peer support, training, experiential learning activities and authentic opportunities to influence state and local policies and services in Maine. In

2008, two staff with personal experience in the system of care were hired to help implement this program.

In 2009, this new regional program became Maine's chapter of the national youth movement Youth MOVE, which stands for Youth Motivating Others through Voices of Experience. New staff was hired, all with diverse personal experiences in the systems of care, in keeping with the peer relationship model that makes Youth MOVE Maine unique. A statewide advisory council of over 60% young people under the age of 26 was developed as the governing body of Youth MOVE Maine. In this first year as Youth MOVE Maine, program leadership, members, staff and the Advisory Council worked to develop policies, governance by-laws, mission, vision and identity as Maine's youth-led program dedicated to youth voice in the system of care. Outreach efforts to youth and stakeholders in the community, as well as training and development of products and strategies to support a more youth-guided system made that foundational year a success.

In Youth MOVE Maine's second year they have been able to build off of the foundational work of 2009 to develop a strong, sound program through leadership of the Advisory Council, partnership with community members and supportive organizations, energy and inspiration of a broader network of youth members, and dedication of staff who identify as peers and interact with youth and young adults with reverence for the unique expertise they offer through the life experiences they have had.

Key Successes to Date:

- Development of a network of four regional Youth MOVE groups in Augusta, Lewiston, Portland and Damariscotta. Each group, made up of about 12 youth ages 14-25 is dedicated to peer support and community action to develop the ability of young people to achieve fulfillment and success in their lives as they grow toward adulthood.
- Trainings for youth are offered in each region focused on the issues that matter most according to youth and young adults in the region. Trainings have included cooking classes, personal artistic expression; resume writing, meditation, among others. In May, the annual What Families and Youth Want Conference was co-hosted by Youth MOVE Maine and offered a youth-developed track developed by and for young people including trainings by young people on team planning and anti-bullying.
- Youth and young adults have had numerous opportunities to address policy, including:
    - Co-chairing the Continuous Quality Improvement Workgroup for CBHS, where youth and families have co-led the development of Six Key Quality Areas to define quality services for children, youth and families which will guide all CQI efforts.
    - Development of a Youth And Family Workgroup advising CBHS from a collaborative youth and family perspective on key issues such as residential standards, implementation of the Youth Outcomes Questionnaire, CQI efforts, and more

    - State and regional participation on the Shared Youth Vision Council, dedicated to reducing recidivism in Juvenile Justice and increasing successful school completion
    - Developing a guide with another youth empowerment program, YLAT, to informed consent to Anti-psychotic medication for youth, which is being used as a foundation for similar national work with the FDA and SAMHSA
    - Advising on peer support with the Moving Forward Healthy Transitions Initiative and Wraparound Maine
- Youth MOVE has developed as an organization to have a majority youth and young adult board, by-laws, standardized staff training, policies, procedures, a logic model and strategic plan and quality assurance measures, to ensure the program is youth-led, trauma-informed and achieving specified objectives.
- Developed strong reciprocal partnerships with other youth organizations, family organizations, state and local agencies and community collaborative/initiatives bringing youth voice into these programs and strategically working together to improve services.
- Social marketing "Shift Your Mind, Drive Your Dream" campaign, dedicated to raising awareness through info cards, kicked off with 'resiliency cards.' Facebook and website updated with resources and information on our program.
- Training and technical assistance offered including:
    - Webinar created with Thrive on Trauma-Informed From a Youth Perspective
    - Training co-created with other youth organizations on the Shared Youth Vision Council on best practices for involving youth on boards and collaboratives
    - Training for youth and providers at the YLAT conference on youth voice in mental and physical health care
    - Training child welfare workers on best practices in youth informed consent to anti-psychotic medication
    - Ongoing youth consultations on various boards and initiatives

Healthy Transitions Initiative: *Moving Forward:* Early in 2007 Children's Behavioral Health Services, the Thrive Trauma-Informed System of Care Initiative, Tri-County Mental Health Services and many other community agencies joined with the Maine Children's Cabinet to seize an opportunity to "marry" the Cabinet's Transition Priority with the Shared Youth Vision Council's interests in Trauma-Informed Services by writing a federal grant that would focus on the common goals of all parties involved in this collaboration.

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In September, 2009 CBHS was notified by SAMHSA that it was one of only seven national applicants to be awarded a Healthy Transitions Initiative grant, and since then has "moved forward" during 2010, in the first year of this 5 year federal Cooperative Agreement.

Maine was well positioned to address the purpose of this Initiative through its response titled **"*Moving Forward*: Achieving Independence for Transition-Aged Youth"**. The Maine Department of Health and Human Services, representing both children's and adult mental health, has joined with Tri-County Mental Health Services, the Thrive system of care Initiative which through its experience has developed solid relationships with local youth and has established credibility and trust with them, and with many other providers to implement the Transition to Independence (TIP) model in one of the neediest counties in the state, Androscoggin County.

Transition to Independence is an evidence-based practice which emphasizes youth-directed planning and development of practical skills which lead to independence. Maine intends to enhance TIP in two key ways. One is to train Peer Youth Specialists to support youth through the process of setting their goals and achieving their dreams. Among these will be members of Youth M.O.V.E.Maine, a local and national advocacy organization for youth, and the Somali Bantu Youth Association. The second is to assemble three community mental health agencies who will implement TIP, Tri-County Mental Health, Common Ties and New Beginnings, into a Learning Collaborative. The Learning Collaborative will serve to support the case managers who implement TIP and reinforce the initial training provided by the TIP developers.

In addition, through the program's links to the Maine Children's Cabinet and Shared Youth Vision Council, *Moving Forward* will address identified systemic issues bridging the children and adult mental health systems including the different policies, structures and eligibility criteria that exist in each system**.**

Moving Forward aims to increase high school graduation or GED attainment, and increase access to higher education for these youth who complete high school. Other targets include reduction of involvement with juvenile justice, and increases in employment, satisfactory living arrangements, use of the community and informal supports, and increasing the perception of personal well-being by young people whose functioning has been impaired by substance abuse or mental illness.

Moving forward is in its second year with progress on numerous levels.

First, training in the Transition to Independence (TIP) model of case management was completed for staff at three local agencies collaborating with CBHS. The mission of the initiative is to provide youth and young adults with a seamless transition from the child serving system to adulthood and opportunities for meaningful participation in a system of care that empowers through leadership and advocacy. This is being accomplished by working diligently with Youth Move Maine, TriCounty Mental Health, New Beginnings and Common Ties which are all agencies located in the Initiative's targeted geographic area.

A second round of training in TIP is scheduled for August and invitations will be sent numerous to mental health professionals in an effort to perpetrate the use of the model across a multitude of venues and agencies. This model is evidence-based and youth driven and has been proven successful within the targeted population of the Initiative. As part of this round of training, Maine will have the first nationally certified TIP trainer based in Lewiston. This certification will allow Maine to continue to train others and is in line with our goal of sustainability.

A state advisory council has been established with the goal of crafting policy aimed at improving the seamless delivery of transition services in Androscoggin County and, eventually across Maine. Evaluation is ongoing with Hornby Zeller Associates conducting interviews with youth, gathering program information and participating in a nationwide evaluation among the states originally awarded the Healthy Transitions grants.

Staff at three service delivery agencies identified as partners in Moving Forward continue to serve youth in Androscoggin County. Monthly case-based review meetings are on-going and provide support and education to case managers.

The evaluation component of Moving Forward is ongoing. Hornby Zeller Associates continues to work on a database for information sharing and federal reporting. Cross site evaluation between the seven states receiving the Healthy Transitions Initiative funding is in progress and Maine is actively involved in that process. SAMSHA is promulgating national evaluation standards and Maine is working with that group to include information about Moving Forward in that study.

Moving Forward continues to seek ways to involve state agencies providing services to adults in the application of the model. The common goal remains the transition of youth to successful adulthood in any of its myriad manifestations.

Thrive – System of Care:

For the past six years Children's Behavioral Health Services (CBHS) in partnership with the THRIVE initiative, community providers, youth and families have been transforming community mental health services in some critical ways, consistent with the System of Care principles developed at the federal level. These include giving youth who are affected by serious emotional and behavioral challenges and their families a greater voice in their treatment and to make the treatment experience "trauma-informed," family driven, youth guided and culturally and linguistically competent. This means educating agencies who deliver these services to understand System of Care principles and the trauma that many seeking help have experienced and to avoid contributing to that trauma through the treatment process itself. Maine's evaluation has demonstrated reductions in trauma symptoms in children, as well as reductions in use of the most expensive residential services and therefore lower treatment costs overall.

One of the main deliverables and successes of Maine's trauma-informed system of care has been the creation of a Trauma informed Agency Assessment created by families, youth and providers in consultation with Thrive staff. This agency assessment is now a requirement as set forth in contract language for child serving agencies contracting with the Department of Health and Human Services' Office of Child and Family Services. Results of the first administered assessment were rolled out to provider organizations in the summer of 2010 with a requirement that providers seek out training and technical assistance on trauma, trauma informed principles and system of care principles. Agencies also created Continuous Quality Improvement (CQI) plans based on the results and submitted these plans to Children's Behavioral Health Services for review and comment. The second re-administration of the TIAA occurred in July of 2012. Results will be disseminated in late summer with subsequent CQI plans to be created and submitted.

Development of the TIAA coincided with the creation of the THRIVE Guide to Trauma-Informed System of Care Organizational Development, a guide for agencies with steps to implement Trauma-Informed System of Care Practices. In addition to best practice literature, the guide includes information about CQI planning steps. Dissemination of this information is followed by a 90-minute webinar prepared by youth, family, THRIVE, and CBHS. Agency staff was required to participate and take a quiz at the end. These trainings are archived and available for agencies to use in team meetings, orientation for new employees and continuing education.

Next steps in assessment include expansion to other child serving systems. The Division of Juvenile Services met with THRIVE and CBHS in April 2010 to discuss adaptation of the TIAA for Juvenile Services staff in the community and at Youth Development Centers as well as with contracted providers. Through the expansion Maine also intends to adapt the assessment for military families.

In addition to the above trainings THRIVE offers regional and on site trainings on Trauma, Trauma Informed, Youth Guided, Family Driven and Cultural and Linguistic principles and practices. These trainings begin the technical and adaptive process of creating change in an organization. Thrive recognizes that ongoing support outside of an initial training is necessary to sustain change which is why phases of support would be offered that identify and train "trauma informed champions", creates agency specific strategic plans for becoming trauma informed and assesses change through continuous quality improvement and on site monitoring for those organizations who score with significant challenges.

Thrive, in partnership with the Office of Child and Family Services, will continue to track agency change against these system of care trauma informed principles through a re-administration of the Trauma Informed Agency Assessment on an every other year basis. The efforts listed above would enhance an already existing system without creating additional services. Ultimately, families and youth would report increased satisfaction, safety, trust, empowerment and collaboration with their treatment providers resulting in improved treatment outcomes.

New System of Care Expansion Planning Grant: Submission 6/2/11

Given the successes of the TIAA and the ongoing training needs, THRIVE and CBHS have applied for an expansion grant to further embed and sustain system of care and trauma-informed principles and practices in state and local agencies. This expansion grant application, entitled "Expand ME", will support the expansion of the trauma-informed System of Care practices developed by THRIVE[1] System of Care from three western Maine counties to the entire state, involving not just the 130 agencies who deliver mental health services but other systems as well. Thus, the geographic area is statewide, encompassing 16 Maine counties. In terms of service system expansion, the immediate focus will be juvenile justice whose leadership has participated in training and now want full integration with trauma-informed System of Care practices as well as military families where CBHS is already engaged in the Military Adjustment Program.

In order to expand the system of care CBHS will undertake an assessment to occur at two levels, one focusing on state infrastructure to sustain System of Care and the second at the agency level to assure all providers follows trauma-informed System of Care principles. The state effort will be led by the multi-stakeholder Statewide Expansion Team, including representatives from Child Welfare, Juvenile Justice, and Education. It will update the Logic Model and Strategic Plan to expand and sustain a System of Care approach across child serving entities. It will review policies, administrative and regulatory standards and make recommendations to support service improvements and coordinate funding streams. It will inform and improve the Social Marketing Communication and Education Campaign ensuring cultural and linguistic competency and family and youth voice. A statewide focus will be to modify the TIAA for juvenile justice and agencies serving military families. At the agency level the tool will be critical to help agencies assess their own practices and make improvements consistent with System of Care principles. The assessment includes components for agency staff, family and youth to complete, with the evaluator developing sample sizes depending on the number served by each agency. Agencies need ongoing education on the importance of assessment and planning on System of Care Principles through trainings and webinars.

Statewide Family Organization:

This year work to form an alliance of the seven family organizations was completed. The Maine Alliance of Family Organizations (MAFO) is a statewide alliance that formed to better serve families of children with disabilities and special health care needs and to strengthen family voice. As indicated in their brochure "Family concerns, needs and voice are foundational to what we do. We believe families are the primary decision-

[1] While initially developed under the auspices of Tri-County Mental Health, THRIVE has been incorporated as a non-profit organization to continue training, technical assistance and system development both in Maine and nationally.

makers regarding care of their children, and we promote the family role in influencing policies and procedures governing care for all children". The seven family organizations are adoptive and Foster Families of Maine (AFFME); Autism Society of Maine (ASOM); GEAR Parent Network; Learning Disability Association of Maine; Maine Parent Federation (MPF); National Alliance for the Mentally Ill (NAMI) and Southern Maine Parent Awareness (SMPA). Each of the partner organizations offer trainings, support, referral, advocacy and specialized information to help families cope with the special needs of their children and obtain the services and support they need. Each of the partner organizations website contains partner web connections to facilitate family access to all available resources. Early in the alliance MAFO produced a two part web based video of personal family stories of the life- changing importance of family organization membership. The videos, Family Organizations: Working Together, Growing Stronger Part 1 and Part 2 can be accessed from all seven organizations websites. A copy of the MAFO brochure is in the attachment section of this application.

Office of Adult Mental Health Services

Independent housing vouchers with supports as directed by the consumer, empowers individuals with *choice, independence, and control* over where they live and what services they receive—if any. OAMHS administers and funds a broad variety of mental health community-living support services which assist individuals with SPMI to live in a community that meets his or her needs and desires.

Each consumer is encouraged to develop an Individual Service Plan (ISP) with the assistance of a community integration worker. Service planning may include professionals and personal supporters of the consumer's choosing. The ISP process is flexible and responsive to each consumer's needs and desires and is as simple or as complex as those needs and desires dictate. Community Integration Services are provided through contracts with community agencies.

Every support service to consumers is self-directed including all those reimbursable by Medicaid and the Mental Health Block Grant with the exception of involuntary hospitalization, Progressive Treatment Program and legal guardianship. These self-directed support services include but are certainly not necessarily limited to:

- Supportive Housing and Employment
- Daily Living Support Services
- Social and leisure activities
- Social support activities
- Community integration, skills
- Personal growth activities
- Education
- Referrals and assistance obtaining other services

Intensive Case Management (ICM) services are provided to a high risk population. This group is comprised of individuals with SPMI who are in jails and prisons or on probation. It also includes people who are chronically homeless or at risk of becoming homeless. ICMs work in jails and prisons, are involved in discharge/release planning and work to ensure success for consumers who have historically had difficulty establishing and maintaining community supports and services. ICMs also perform a crucial outreach role to consumers in homeless shelters who need, but have been unsuccessful in obtaining and maintaining supports and services. These individuals are often among the most vulnerable of the individuals served by OAMHS.

The Office of Adult Mental Health Services in collaboration with the Office of Quality Improvement Services (OQIS) is designing and implementing a system for measuring mental health outcomes for individuals who are receiving community integration services. Over the past 36 months, the two offices have worked with representatives of Office of Child and Family Services, Office of Substance Abuse, and the Office of Information Technology. The Outcome Monitoring System will involve the use of several consumer self-assessment tools including: the Outcome

Questionnaire (OQ) Measures, the Recovery Assessment Scale and the Data Infrastructure Grant (DIG) Mental Health & Well-Being Survey. Other tools utilized by clinician include the LOCUS and ANSA. These systems will enable both aggregate and individual outcomes to be measured.

The Statewide Quality Improvement Council (QIC) has dedicated funding toward the support of the OQ Measure component of this project and is providing the Pilot Advisory Group with representation from both the Adult and Child Subcommittees. SAMHSA, through NASMHPD, is also supporting this work through a technology transfer initiative grant.

Wraparound Maine is a statewide, multi-site initiative that supports an integrated planning approach for youth with complex needs. The Wraparound Maine Initiative supports the application of High Fidelity Wraparound Services. Each Wraparound Maine site serves multi-agency involved children and youth, ages 5-18, with serious emotional or behavioral disturbance who are either in intensive temporary residential treatment, a juvenile correctional facility or at imminent risk of such placement. High Fidelity Wraparound is a family centered, community oriented, strengths based, highly individualized planning process that relies on a balance of formal and informal or natural supports to help children and families achieve important outcomes while they remain, whenever possible in their homes and communities. Service planning is accomplished through “wrapping” individual services and natural supports around the child and family, based on their unique strengths and needs.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Children's Behavioral Health Services (CBHS)

E. Data and Information Technology

* Maine has the capability to report specifics on individuals and service components from data received from our providers who are contractually required to submit such data reports quarterly;

* Reports are submitted to our Purchased Services Division which monitors contracts;

* Data is utilized by CBHS and the Office of Quality Improvement to monitor fiscal and performance information;

* CBHS uses data gotten from individual and aggregate reports based on scores on the Child & Family Assessment Scale (CAFAS) for all children/youth in our Targeted Case Management and Home Based Treatment services. The CAFAS is a nationally recognized tool used to determine level of functioning in home, school and community.

*Functional Assessment Systems, the developer of the CAFAS, has developed a web based system that enhances the provider's ability to identify problem behaviors and functional ability informing the development of a strengths- based outcome-driven treatment plan incorporating the child's status ,as well as the caregiver's ability to meet the child's needs. The web based system includes reporting functions, management options and caregiver involvement.

*Children's Behavioral Health Services, with the Office of Continuous Quality Improvement, has provided the necessary supports for implementation of this system, including purchasing of the license, and administrative oversight and training, for providers of TCM and TFC to complete the transition from paper to the web based CAFAS tool.

*Fidelity to the CAFAS was increased by the development of a cadre of certified trainers. The trainers will train the raters who rate each CAFAS subscale with a behavioral descriptor that describes the child resulting in a score. Each trainer will be re-certified annually and each rater re-certified every two years.

*All data collected is reviewed by CBHS staff with providers to address problem areas and develop remediation plans.

Data systems utilized:

Maine Integrated Health Management Solution (MIHMS)

This is the current MaineCare claims management system that replaced the MECMS system. This system came on-line in September, 2009. 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) this is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children's Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children's Home and Community Based Treatment and Children's Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08. An updated version of this system became operational on July 1, 2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. 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 FY11 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health & Human Services for children, through the Division of Children's Behavioral Health Services and for adults, through the Office of Adult 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

Office of Adult Mental Health Services

The Office of Adult Mental Health has several Information Technology systems. Our Enterprise Information System (EIS) has been built from the ground up with capacity to track information at the client level. More recently, our Division of Purchases in conjunction with OAMHS has created a Service Encounter database. This system collects client identifiable data, demographic data, unit and rate utilization and provider information. It does not however get to the granular level of identifying the funding source, such as the difference between State grant dollars and Federal Block Grant funding. We anticipate utilizing a percentage of Block Grant funds to supplement and enhance the functionality of this system to allow for more granular reporting by funding source.

Providers NPI's are tracked through Office of MaineCare Services . The Office of Adult Mental Health Services assigns unique Vendor Codes to providers through the contracting process. This allows us to aggregate data by provider.

The system does have unique client identifiable data allowing for de-duplication. Client level data is in the form of Service Encounters. It does not fully comply with ICD-10 or CPT/HCPCS codes. Upgrades will be phased in over an approximate two-year period culminating with the transition to ICD-10 on October 1, 2013.

The electronic systems allow for linkages with Medicaid, Social Security, Food Stamps, TANF, and other mainstream resources.

Monthly reports are produced using Service Encounter data.

The state's IT division, the OAMHS, and the Medicaid Office meet regularly concerning system IT issues across divisions.

The Department of Health and Human Services has created an Office of Health Information Technology in compliance with the federal Recovery Act.

The Medicaid Office is continually improving its IT systems to better meet changing federal and state regulations and priorities. OAMHS is consulted regularly (monthly) by the Office of Information Technology which helps to coordinate efforts and provide a feedback loop to ensure initiatives are carried out according to plan.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

F. Quality Improvement Reporting:

Children's Behavioral Health Services (CBHS) Continuous Quality Improvement (CQI) efforts include the following:

- A stakeholder group comprised of youth, parents, providers and staff is developing a CQI process to be used across service areas. The group has established six Key Quality Areas: Accessible; Effective, Integrated and Related to the Whole Person; Participant Driven; Physically and Emotional Safe; and Strength-Focused. Work is continuing to review and improve performance measures and indicators. Prior to the work, CBHS staff worked with the youth and family members to gain a common understanding of Continuous Quality Improvement terms, including definitions of quality, performance measures, indicators, data sources, and methods, including Plan, Do, Study, Act; Lean Management; Rapid CQI; and Star-SI. The group is also looking at data sources and will work to develop indicators and performance measures that are meaningful and do not require any undue reporting or data collection burdens.
- Assessment tool efficiencies have been achieved and effectiveness increased by transitioning from paper to web based administrations and from face to face training to web-based training that is accessible any time. $50,000 from the FY 10 Block Grant assisted in achieving this outcome.
- Lean Management Principles are increasingly being used to develop new processes and to improve existing ones. For example, CBHS is implementing its first home and community based waiver. Over a two-month period, a trained Lean facilitator led a group of staff and managers in developing forms and procedures for implementing operating the waiver. The Lean process focuses on mapping out the operational steps and reducing any redundancy or waste.
- During 2010-11, CBHS contracted providers have been required to administer a Trauma Informed System of Care Agency Assessment and a Co-Occurring Substance Abuse and Mental Health self assessment. Contracts with over 130 providers required that they develop agency specific Continuous Quality Improvement Plans based upon the results of the assessments which were then reviewed by CBHS. Feedback was provided by CBHS and Thrive, Maine's Trauma Informed System of Care Initiative. There will be regular readministrations of the assessments and ongoing review of progress on plans.
- Data produced by APS Healthcare, the state's administrative services organization, is shared with agencies on a quarterly basis and is reviewed by CBHS staff. In addition, CBHS staff perform chart reviews at agencies and interview family and youth in services. This information is reviewed and there are annual or more frequent meetings with agencies regarding the results. Agencies are expected to engaged in corrective actions with measurable outcomes in areas where there are deficiencies. CBHS district staff monitor progress and provide regular feedback to the agencies.

Children's Behavioral Health Services (CBHS) has continued to expand its role in ensuring quality of services delivered by contracted providers. These QI activities include:

- The development and use of a quality improvement tool for assessing intensive temporary residential treatment facilities, when there are clinical concerns raised during routine licensing or contract site visits. Reports are discussed and shared with provider organizations along with recommendations and standards for improvements.

- Training Home and Community Treatment Providers in the use of the Youth Outcome Questionnaire. The Youth Outcome Questionnaire (Y-OQ) is the most well developed and tested rapid clinical feedback system available. Outcome Measures, Inc., the developer of the Y-OQ, used a rigorous development process to select the questions with the greatest sensitivity to clinical change possible. The Y-OQ has been shown, in studies described in peer reviewed articles, to be able to predict poor treatment outcome on the basis of the trajectory of Y-OQ scores. This "early warning system" allows the clinical team (youth, parent, clinician, and supervisor) to reassess and reorient to maximize the possibility of a positive outcome.

- CBHS staff will also oversee the further development and maintenance of quality of Evidence Based Practices throughout the state, including Multisystemic Therapy, Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy and Multidimensional Treatment Foster Care. Residential treatment facilities will be the ongoing subject of intensive quality reviews, focusing on facilities, staffing and in particular on clinical interventions and adherence to Evidence Based and Best Practice Parameters.

Included in all of these efforts is ongoing work to ensure that there is no duplication of effort with other quality oversight entities and that data is shared among these entities. CBHS will be collaborating with the DHHS Division of Licensing; Public Service Management; APS Healthcare (the current Administrative Service Organization in Maine); the Office of MaineCare Services and Molina (Administrator of the New Health Management Information System).

Office of Adult Mental Health Services

The Office of Adult Mental Health Services in collaboration with the Office of Quality Improvement Services (OQIS) is designing and implementing a system for Measuring mental health outcomes for individuals who are receiving community Integration services. Over the past 36 months, the two offices have worked with representatives of Office of Child and Family Services, Office of Substance Abuse, and the Office of Information Technology. The Outcome Monitoring System will involve the use of several consumer self-assessment tools including: the Outcome Questionnaire (OQ) Measures, the Recovery Assessment Scale and the Data Infrastructure Grant (DIG) Mental Health & Well-Being Survey. Additional data and information from the LOCUS and ANSA tools are also analyzed and help inform these systems.

OAMHS also obtains data from a quarterly reports drawn from the OAMHS Enterprise Information System (EIS). Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections. Provider documentation that unmet needs data and information is used in planning for resource development and preparing budget requests.

Unmet needs reports are posted on the OAMHS website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs.

The State of Maine has developed a Maine Department of Health and Human Services' Performance Metrics Dashboard. The Dashboard initiative promotes information sharing for DHHS managers, staff, stakeholders and customers. It provides information on the work DHHS performs for the people of the State as well as access to many different types of measurement – from community level health indicators that are tracked for public health improvement purposes, to measures of service provision and quality across all DHHS Offices. The tool is designed to assist in understanding the work of DHHS, monitoring performance, communicating results, identifying areas for increased focus, and supporting a culture of accountability and responsibility throughout the Department. This tool will continue to change overtime as measures are refined and improved, and as strategy changes based on program continuous improvement plans. Our dashboard can be found at https://gateway.maine.gov/dhhs-apps/dashboard/

The collection and reporting of the SAMHSA selected client-level Mental Health National Outcome Measures serve as the primary measures for gauging effectiveness of services and supports for Maine's publicly funded mental health services. Maine's DHHS Office of Continuous Quality Improvement Services is committed to developing and strengthening data collection and reporting structures and processes that are inclusive

to a wide range of stakeholder and enhance the transparency and timeliness of the NOM reporting. The State Mental Health Block Grant Planning Committee collaborates with state mental health agencies, community mental health agencies, consumers, families and policymakers to monitor activities for NOM reporting and promotes actionable activities based on data reports to improve the effectiveness of services.

OAMHS also reports on a quarterly basis to the Court Master and other parties compliance with 34 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.

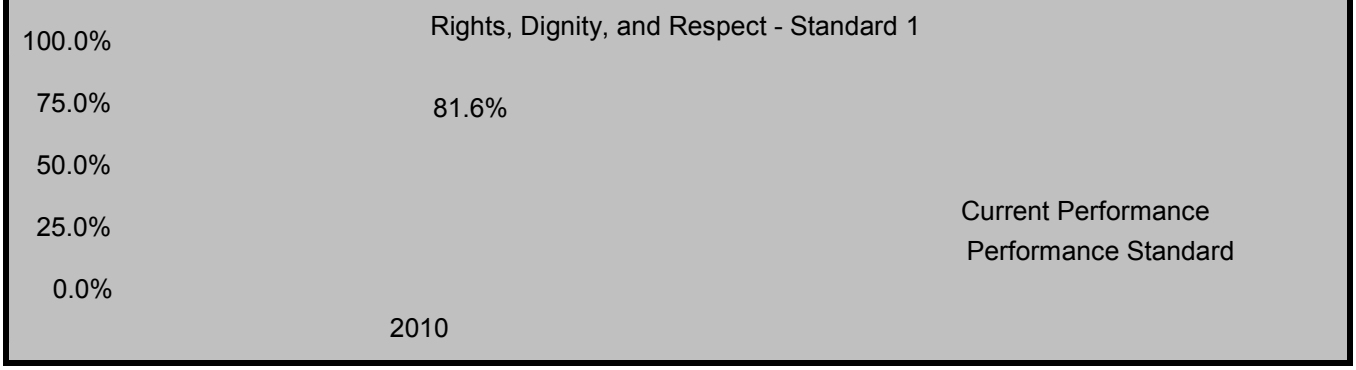
OAMHS has a well-developed and thoroughly vetted grievance process which encourages grievance to worked and resolved at the local level first. When this is not possible, there are clear steps a consumer and/or his representative may take to have their grievance addressed. This includes a formal hearing and commissioner review.

The Data Tracking System contains grievances and rights violations for consumers in Adult Mental Health Services. The Grievance Tracking Data includes the following:
Data Type/Method: Information pertaining to Level II and Level III Grievances.
Target Population: Consumers receiving any community based mental health service licensed, contracted or funded by DHHS and consumers who are patients at Riverview Psychiatric Center or Dorothea Dix Psychiatric Center.

Source of Attachments: DHHS /Office of Adult Mental Health Consent Decree Performance and Quality Improvement Standards: July 2011 / Compliance and Performance Standards April 2011-June 2011

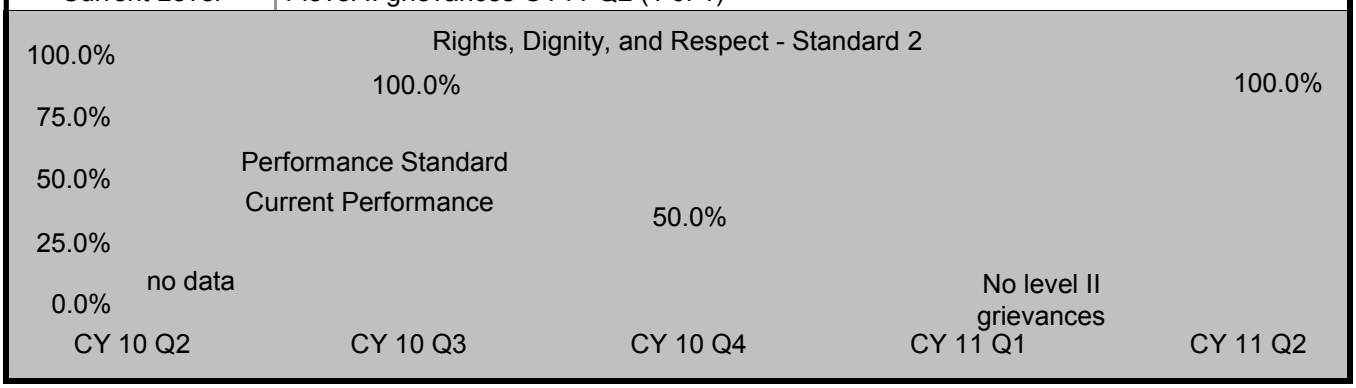
Standard I: Treated with respect for their individuality
Average of positive responses in the DIG Survey Quality and Appropriateness domain

Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
Data Source	DIG Survey
Current Level	81.6% (N=1379)



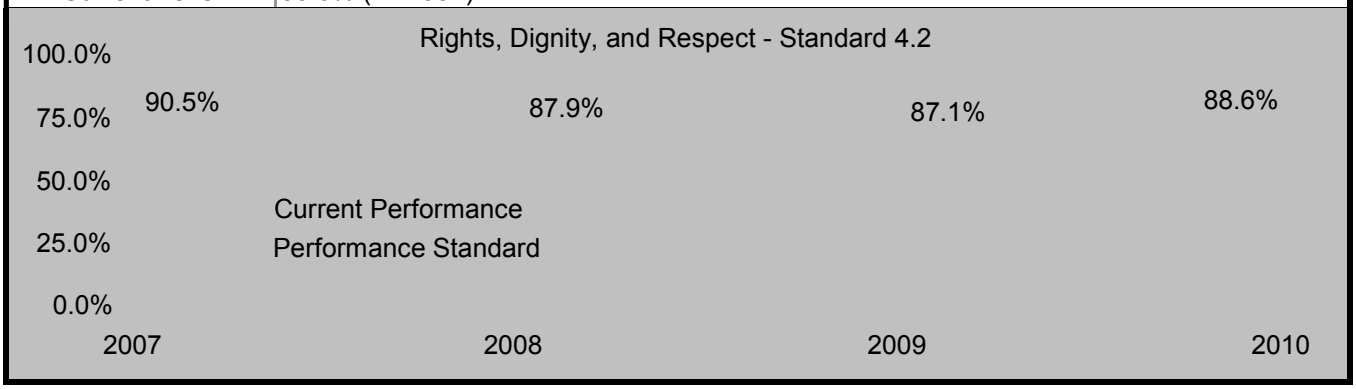
Standard 2: Grievances are addressed in a timely manner
Response to Level II Grievances within 5 days

Standard 2	
Measurement	Response to Level II Grievances within 5 days or agreed upon extension
Standard	Performance: 90% Within 5 days or during extension
Data Source	DHHS Grievance Tracking System
Current Level	1 level II grievances CY11 Q2 (1 0f 1)



Standard 4: Rights Dignity and Respect
2. Consumers given information about their rights

Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Data Infrastructure Grant Survey, Q22
Current Level	88.6% (N=1337)



The Quality Management Division will be focusing on the Services Quality Management Plan to review current applications to shape policy and service changes.

The DHHS/Office of Adult Mental Health Services developed a CQI Plan ,"Services Quality Management Plan" (see attached) which strives to on an ongoing basis:

- Improve overall quality and integrity of services provided to its customers
- Ensure programs and services are responsive to consumer needs
- Comply with the terms of the Bates v. DHHS Consent Decree

The purpose of the Office of Adult Mental Health Services Quality Management Plan is to describe its office-wide quality management initiatives that will support ongoing learning within the system, data-based decision making and rapid identification and resolution of quality problems; and ensure that:

- New processes are well designed
- Data is systematically collected, and
- Data is used for ongoing monitoring and improvement activities.

This plan presents the framework for the quality management processes for services that OAMHS provides to adults who are eligible for mental health services supported by the state in the following service areas:

- peer services;

- crisis services (including crisis stabilization units);
- community support services (currently includes community integration, assertive community treatment, daily living skills, skills development and day support services);
- outpatient services
- medication management services;
- vocational services;
- inpatient services (community based);
- residential treatment services; and
- housing.

Quality Management in these areas focuses on access to services, continuity of care, treatment planning processes, consumer rights and systems monitoring. Quality management includes both quality assurance and performance improvement activities. Quality assurance is a monitoring activity that reviews pertinent data against standards designed to promote quality care, with a frequency that assures sufficient confidence in the ongoing delivery of quality care. Performance improvement is the process that defines problems identified through the quality assurance process, analyzes data in greater depth, and evaluates and improves processes and systems of care to improve quality. To be effective, performance improvement activities need to include a process to assure that the performance improvement is maintained.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

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, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Office of Adult Mental Health Services

DHHS/Office of Adult Mental Health Services for the first time has posted the FY2012 SAMHSA Mental Health Block Grant on our State of Maine Web Site. The Web site also has a link that will allow the community to comment directly on the block grant and those comments come directly to the DHHS Office of Adult Mental Health via email to review. This feedback mechanism is located at http://www.maine.gov/dhhs/mh/

DHHS/Office of Adult Mental Health Services has reached out to all State of Maine tribal members. Currently there are no tribal members on the State of Maine QIC but the committee has been reaching out to tribal members for membership and representation. We will continue to work with the QIC by encouraging more tribal representation and membership. Future communications will make an effort to meet with the tribes at a location of their choosing. Below is a copy of the template sent to the tribal community:

July 8, 2011

John
Aroostook Band of Micmacs
7 Northern Road
Presque Isle, ME 04769

Dear Tribal Health Director:

The State of Maine , Department of Health and Human Services , Office of Adult Mental Health Services is applying for approximately $800,000.00 SAMHSA Mental Health Block Grant for FY 2012-2013. (MHBG) The Block Grants are grants given to States to allow them to address their unique behavioral health issues. States will use the MHBG program for prevention, treatment, recovery supports and other services that will supplement services not covered by Medicaid, Medicare and private insurance. Specifically the MHBG funds will be directed toward four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- Fund primary prevention – universal, selective and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.

The State of Maine is committed to an effective tribal consultation process and as representatives of the Office of Mental Health Services for Maine SAMHSA Block Grant we would like to reach out to you for your comments and feedback as well as ongoing consultation for this particular grant. At the tribes request, the Office of Adult Mental Health Services will designate a meeting time to further discuss the Block Grant and develop a work plan to insure ongoing consultation and feeback.

The SAMHSA Block Grant has been posted on the Office of Adult Mental Health (OAMHS) home page: http://www.maine.gov/dhhs/mh/ . This link connects you to the FY 2012-2013 SAMSHA Block Grant for review and opportunity to comment section.

If you have any questions or comments, please do not hesitate to contact Cynthia McPherson 207-592-2279 or email at Cynthia.McPherson@Maine.gov .

We look forward to working with you on this and future efforts.

Sincerely,

Sheldon W. Wheeler
Policy Development Manager

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

Office of Adult Mental Health Services

Service Management Strategies

Children's Services, Substance Abuse Services, and Adult Mental Health Services have jointly coordinated service management strategies by consolidating: utilization review, prior authorization, retrospective review, quality management and improvement functions, as well as appeals and grievances through a contract with APS Health Care.

APS submits monthly service data that we compare and contrast with our service encounter data. This process allows us to measure, manage, and adjust provider utilization of both Medicaid and grant funded services. We will employ the same process as last year, hopefully with additional resources from the block grant for more granular reporting regarding capacity to identify the specific grant source within the utilization reports.

OAMHS will be incorporating peer review of these utilization issues to include Block Grant provider monitoring as well as question and answer sessions.

Resources needed have been identified in Section E, which specifically include an allocation from the Block Grant to support enhanced reporting capacity within our IT System which includes our Service Encounter Data Base. With this enhancement, we will be able to positively identify the grant funding source and individuals served. With support of Block Grant funds we will have this functionality within 6 to 12 months.

H. Service Management Strategies

Community Mental Health Services Block Grant (CMHBG) fund received by Children's Behavioral Health Services (CBHS) are used to fund community services. Distribution of federal funds under the CMHS Block Grant is implemented through decisions made by the Department through the Director of Children's Behavioral Health Services, in consultation with the Statewide QIC Children's Committee.

Block Grant 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 mental health block grant funds for initiatives that are transformational in nature and directly benefit children with serious emotional and behavioral issues and their families.

The Department contracts for services which are funded entirely or in part through the Block Grant. The Children's Behavioral Health Services Program issues contracts with specifications for all services, including conformance with all PHS Act requirements and applicable service conditions of the CMHS Block Grant. DHHS Purchased Services Administrators monitor contracts through quarterly and year end fiscal and narrative reports from service providers. Regionally based CBHS Team Leaders and Resource Coordinators monitor services by regularly scheduled meetings with providers. The Children's Committee of the QIC also will receive these reports in FY12.

Maine dedicates more than three quarters (75%) of its Center for Mental Health Services Block Grant funds to address the needs of children who have serious emotional disturbance and their families. The allocation of FY11 Children's Behavioral Health Services Block Grant funds, including unallocated funds follows:

CHILDREN'S MENTAL HEALTH BLOCK GRANT FY12
Distribution by Region/Service Type

Agency	Service Funded	Amount	Estimated # Total Served
REGION I			
Community Counseling Center	Peer Support for Youth	33,000	75
S. Maine Parent Awareness	Family Support/I&R	44,000	500
Region I Total		**$77,000**	**575**
REGION II			
Community Concepts	Family Support	11,000	20
Region II Total		**$11,000**	**80**

REGION III			
Helping Hands	Family Support/I&R	50,000	500
Region III Total		**$50,000**	**500**
STATEWIDE			
Crisis & Counseling – GEAR	Family Support	212,000	962
Crisis & Counseling - GEAR	**Parent Advocacy FACES**	**60,000**	**750**
Maine Parent Federation	Information & Referral	32,000	NA*
Maine Parent Federation	**Starting POINTS Media**	**60,000**	**3,500**
Maine Parent Federation	QIC Support	5,000	N/A*
NAMI Maine	Information & Referral	18,500	**230**
NAMI Maine	**School based +Primary Care workshops**	**60,000**	
TCMHS – Youth MOVE	Youth Transformation	106,378	80
	Youth Transformation	**60,000**	**60**
Statewide Total		**613,878**	
Total Allocated 7/1/11		**751,878**	**7,850**
BG FY11Award Available	To expend by 9/30/11	136,678	
BG FY12 Award Available	To expend by 9/30/12	824,521	
Total Available		**961,199**	
Unallocated to Expend FY11		**209,321**	

* Information & Referral data contain substantial duplication and therefore are not added to the regional subtotals or the state total for number served. **BOLD = Transformation Activities funded by the Block Grant in FY12.**

QIC Children's Committee Commitment to Transformation

In June, 2007 the Director, Children's Behavioral Health Services, and members of the Children's Committee of the Quality Improvement Council discussed possible investments in focused activities using Block Grant funds in the FY08 fiscal year. There was a mutual interest in doing significant work with family organizations in 2007, in addition to the family support work of various types and focus that these organizations have typically done in the course of carrying out their unique missions. Accordingly, each organization was asked to submit a proposal to the Director that would capture the spirit, intent and focus of transformation that would benefit and support families with children and youth with serious emotional disturbance. These proposals, each in the amount of $60,000, were reviewed by Children's Behavioral Health Services and subsequently recommended for consideration by the Children's Committee of the QIC for one year funding.

Children's Committee Recommendations for 2012/2013 Plan

This year the Children's Committee worked on standardizing the content of the Transformation Award proposals.

The Children's Committee discussed in detail recommendations for the award of block grant funds for new initiatives and for continuing support of funding for programs. The committee expressed a strong commitment to transformation in considering funding with block grant dollars, accountability for programs that have received block grant funds, and certainty that funding would be used for children with high emotional/ behavioral needs. The committee discussed some examples of transformational priorities such as new and innovative approaches to reaching these children and youth, family driven care, youth development and evidence-based practices.

On several occasion in July 2011 the Children's Committee met to review the four transformation initiatives seeking continuation of support or for a new initiative using FY12 Block Grant funding. As in the previous year, each applicant presented its accomplishments, progress and goals and measurable objectives for the coming year. The Children's Committee reviewed and voted to approve or disapprove the proposal. If a proposal was disapproved and opportunity was given to the applicant to meet with the committee and discuss the reasons why the proposal was rejected. An opportunity to revise and resubmit the proposal was given. Two proposals were rejected and revised to meet the requirements that the services be transformational in nature.

After committee discussion with each presenter, and specific suggestions for change, emphasis or addition, all three proposals were recommended for funding.

The committee approved the proposals outlined below:

Allocation of Children's FY12 Block Grant Funds for Transformation Activities

Provider	Transformation Initiative	NFC Goal	Block Grant $
Maine Parent Federation (MPF)	*Starting POINTS for Maine Families* delivers online access to information, support and networking that will make knowledge of children's mental health more available to families statewide. Web page connects families to a variety of short presentations and allow for easy, personal feedback that will be used to tailor topics of interest as the initiative is implemented over time. Focus this year will be on building the content, usability, evaluation and outreach for Starting POINTS, Facebook and	2	60,000

	Twitter. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Military Families, Recovery and Resiliency and Public Awareness and Support.		
NAMI Maine	Transform access to mental health and substance abuse services for youth across the state of Maine by helping schools to identify and refer students in need and who have challenging behaviors. NAMI Maine will work with designated schools to assure they are implementing practices that build resilience in students and engaging students in activities that build resilience, and (2) transform the delivery of primary care health services to children and youth by assisting Primary Care Physicians and pediatricians to better identify and treat their patients with behavioral health issues. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Primary Prevention, Public Awareness, Strategic Partnerships	3 1	60,000
GEAR Parent Network	Development of 5 community Family Advisory Councils in areas where there are trained parents and alumni of the Family Empowerment Institute who are available to serve in an advisory capacity to local and state decision-makers. Involve other family organizations in the outreach to identify council members and broader family membership. FY12 will focus on training/ education/ awareness of trauma on families and caregivers, and advocacy for trauma-informed services for children and youth in the Council's geographic areas. Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Supports; Trauma and Justice	2 5	60,000
Youth MOVE Maine	Continued investment in support for developing a visible and active youth voice of the State in FY12. Maine's Youth MOVE Chapter will guide the expansion of the current infrastructure to include a fourth staffed regional office in Bangor. Each regional office will have a strategic plan developed for achieving organizational and Youth and Family program goals. Each plan will include target audiences, a youth committee regional goals, a list of local resource partners, a continuous quality improvement plan and social marketing and outreach plan. Outcomes include community based	2 5	60,000

	trainings, peer-to-peer partnerships, anti-stigma campaign and youth training and provide technical assistance Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Support, Trauma and Justice		
	FY12 Mental Health Block Grant Transformation Funding		**$240,000**

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2013

Priority	Performance Indicator	Selected
Adults with Severe and Persistant Mental Illness	Adult - Increased Stability in Housing (20%)	ó
Adults with Severe and Persistant Mental Illness	Reduced Utilization of Psychiatric Inpatient Beds - 180 days(21)	ô
Adults with Severe and Persistent Mental Illness	Evidence Based - Adults with SMI Receiving Supported Housing (100%)	ó
Adults with Severe and Persistent Mental Illness	Evidence Based - Adults with SMI Receiving Supported Employment (550)	ó
Adults with Severe and Persistent Mental Illness	Increased Access to Services (12,000)	ó
Adults with Servere and Persistent Mental Illness	Adult - Increase/Retained Employment (90%)	ó
Quality Improvement	Total number served according to measure discussed below	ó
Quality Improvement	Percentage of Children/Families reporting Postitive Outcomes in OQI Survey	ô
Quality Improvement	Percentage of Youth who do not experience recidivism	ó
Quality Improvement	Stability is determined as the percentage of all respondants who have remained in the same place or has moved to a single other place over the year	ó
Evidence based practices	Number is from 0 to 3	ó
Evidence based practices	Actual unduplicated number of children in Therapeutic Foster Care placements during the Fiscal Year served by Child Welfare Services	ó
Evidence based practices	Unduplicated Numbers served under MST by community providers	ó
Evidence based practices	Unduplicated number served under FFT by community providers	ó

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

J. Suicide Prevention

The Maine Youth Suicide Prevention Program has been a long standing program in Maine and it receives support through the Director of Children's Behavioral Health Services and the CBHS' Medical Director's active participation in the MYSSP Clinical and Professional Committee. CBHS partners with MYSSP to promote effective clinical and professional practices and to improve access to mental health, substance abuse and crisis services.

The Maine Youth Suicide Prevention Plan is comprised of 10 goals modeled on the National Strategy. It represents the thoughts and input of over 100 stakeholder and was released in September 2008. In the Attachment section of this application there is a copy of the current plan.

Office of Adult Mental Health Services

The Department of Health and Human Services, Maine Centers for Disease Control and Prevention Maine Injury Prevention Program, Plan for the Prevention of Suicide among Adults is currently in DRAFT phase and not yet ready for public comment. The anticipated date for the final plan is December 2011. Please refer to the attachment, "Plan for the Prevention of Suicide among Adults".

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Office of Adult Mental Health Services

A significant technical assistance need is consultation regarding the exploration of State Plan Amendments and/or Waiver options available through the Centers for Medicaid and Medicare Services. Currently we are taking an initial look at the Section 1915(i) State Plan Amendment for the Office of Adult Mental Health. Systems change of this magnitude will demand expertise and thorough communication by and between all interested parties (consumers, providers, families, state and federal government).Technical assistance, specifically around components of future plans, eligibility, services, and cost will be necessary as Maine looks at future options under the Affordable Care Act and Medicaid.

Another Technical Assistance need is support in further implementing the OQ Measures system. This TA may take the form of a financial commitment to support TA from this provider, or other financial support to help implement the system statewide. The OQ Tool is a nationally (and internationally) recognized instrument promoting consumer involvement and measurement in the Recovery Process.

The third TA need is assistance and/or financial support in developing an increased Information Technology capacity with the ability to identify client level information and discreet funding sources.

The fourth TA need is assistance and/or financial support in sustaining the SOAR Program in Maine. As SOAR recipients are typically uninsured homeless person. We believe SOAR is well aligned with the Block Grant.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Office of Adult Mental Health Services

The State of Maine, OAMHS through various mechanisms strengthens and provides recovery oriented organizations, family, peer advocacy self-help programs, support networks and recovery oriented services.

Through OAMHS contracting process, mental health community providers are required to give all new consumers

- information regarding services available through peer support organizations/groups.
- include among their services the referral of family members, with whom the providers have contact, to area family support groups.
  When referring a family member to a family support group the agency shall provide information regarding the group and shall additionally offer to call the support group to give the family member's name and means whereby the support group may contact him or her, required to give all new clients information regarding organized opportunities within the agency for consumer voice and input into policies, development and implementation of mental health services such as a consumer advisory group.
- to give all new clients and make available for existing clients, information about the Consumer Council System of Maine (CCSM) and opportunities for participation in local councils of the CCSM. Printed information will be made available through the CCSM.
- to support and participate in the Annual Mental Health Data Infrastructure Consumer and Family Satisfaction Survey Project in accordance with the protocols developed by the DHHS Office of Quality Improvement. The surveys are administered directly by the Department. Provider agencies will be required to assist in notifying clients about the survey prior to administration, encouraging client participation and addressing client questions regarding surveys. Three surveys are used for specific populations, including: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey (for ages 18 and older); the Youth Services Survey for Families (YSSF) (families of children below 12 and younger); and the Youth Services Survey (YSS) (for youth between the ages of 13 and 18).
- Through the CONSENT DECREE COMPLIANCE, the Provider agrees to provide services in a manner consistent with terms of this section and to work cooperatively with the Department in fulfilling its requirements under the "AMHI Consent Decree" in Bates vs. DHHS, Civil Action No. 89-88 (Me. Superior Ct., Kennebec County that supports recovery oriented services through 1) grievance policy and procedure in compliance with the Rights of Recipients of Mental Health Services 2) Provider shall notify all clients who apply for services of their rights under the Bates v. DHHS Consent Decree and under the Rights of Recipients of Mental Health Services. Furthermore, the Provider shall notify clients of their right to name a designated representative or representatives to assist them. The Provider shall also provide information to clients regarding available advocacy programs. 3) Providers of comprehensive mental health

services are required to have a consumer on their Board of Directors. This may be a current or former consumer who self discloses as a consumer and does not have to be a consumer of the provider's services. Other mental health providers are required to either have a consumer on their Board of Directors or to have a consumer advisory committee. 4) Providers of Community Support Services (defined herein as CI, ICI, and ACT) The Community Support Services Provider must:

- Ensure that community support workers (CI, ICI, and ACT) develop Individual Support Plans (ISPs) collaboratively and convene ISP meetings as directed by the consumer, and actively coordinate services that are part of the Individual Service Plans. Documented consent of the consumer shall be necessary for the ISP meeting to be held without the presence of the consumer;
- Ensure that community support workers (IC, ICI, ACT) develop and maintain up-to-date crisis plans and advance directives with each consumer, or document when and why this hasn't occurred. Additionally, it shall be the role of the community support worker to review with the consumer both the ISP and the crisis plan whenever there is a major psychiatric event;
- Ensure that community support workers (CI, ICI, and ACT) receive not only annual training on the importance of work to recovery, but also ongoing training to improve engagement skills regarding work and documenting work goals in each ISP;

The State of Maine, OAMHS supports consumer driven Social Clubs, Recovery and Drop in Centers through the contracting process with community mental health agencies throughout the state. This contract identifies service specifications and performance guidelines. This service includes social, recreational, leisure and related services provided from a fixed location, or peer-run services regardless of location. These services provide support and skill-building opportunities that facilitate movement towards community inclusion. These services shall be consumer-directed. Participation is directed toward enhancing and supporting the individual's independence within the community.
The programs will:
•provide recovery-focused groups, events, and activities that provide opportunities for individuals both at the center and in the community and that allow individuals to engage fully in the community.
•provide support, learning/educational opportunities, and recreation for mental health consumers.
•provide an accessible environment in which to develop social skills, wellness skills and community living skills
•provide opportunities to engage in peer support, wellness and leadership development
•promote personal empowerment, peer leadership and self-advocacy
•provide continued exposure to natural support opportunities that members can begin to do own their own and with other community members.

The Office of Adult Mental Health has launched an initiative to prioritize the development of a system of recovery-oriented care and support. Transforming mental health services to a recovery oriented system are words that many of us are using but few

can easily define. Recovery language is part of many documents and philosophies. In this collaborative process, we will look at what recovery-oriented care looks like and how that vision affects policy, contracts, program development and evaluation. We will develop processes to evaluate how services support recovery. Part of this recovery initiative is an outcomes project that utilizes a toolkit, which includes the OQ Measures and the RAS (Recovery Assessment Scale), to measure individual change and for program evaluation to assess aspects of recovery. Using gathered data and subsequent understanding and knowledge, we will work towards continuously improving our mental health system of care. Recovery-oriented care is a major focus for OAMHS.

OAMHS has begun a process of defining, measuring, and improving recovery outcomes. Outcomes are the way something, often a treatment or a program turns out, such as how it impacts the lives and well-being of people. Three agencies are already involved in piloting recovery outcome tools for Community Integration. This pilot is utilizing an electronically administered outcome toolkit which includes the OQ, the Recovery Assessment Scale (RAS), and the DIG Adult Mental Health and Well-Being Survey. We anticipate that consumers will be more active in accessing and directing their own treatment progress as a result of using these tools and this will support a more effective partnership between individuals receiving services and individuals providing services.

As OAMHS develops recovery core values and principles and establish a conceptual and policy framework, OAMHS will...

- align fiscal and administrative policies in support of recovery guidelines,
- implement recovery measurement tools,
- build competencies and skills,
- change programs and service structures as needed, and
- monitor, evaluate, and adjust.

Using webinars and discussion questions, OAMHS will gather feedback on each domain of recovery-oriented care.

Mental health service providers receive funding through a variety mechanisms, primarily state general funds and Medicaid. General funds are allocated through Maine's biennial budget process. The budget process is inclusive, in that OAMHS actively seeks provider, consumer, family and other public input in budget planning and development. The budget document presented to the Maine Legislature reflects the needs of consumers of mental health services based on the best data and information available. The legislative process is open and public comment is welcomed and listened to. OAMHS' budget is presented to the legislature within the context of the DHHS overall budget.

OAMHS provides, directly or through contract, training and technical assistance to

mental health service providers statewide. Training initiatives are coordinated by OAMHS' Training and Best Practices Coordinator. The University of Southern Maine, Muskie School of Public Service provides data, research and technical assistance through a cooperative agreement. Tuition support is available for direct service staff for certification.
Examples of training provided include:
• Competency based certification training for Mental Health Rehabilitation Technicians including crisis certification
• Competency based certification training for Intentional Peer Support Specialists
• Competency based certification training for Mental Health Support Specialists
• Specialized training in employment

Through independent housing vouchers with supports as directed by the consumer, we empower individuals with choice, independence, and control over where they live and what services they receive—if any.

Each consumer develops an Individual Service Plan (ISP) with the assistance of a community integration worker. Service planning may include professionals and personal supporters of the consumer's choosing. The ISP process is flexible and responsive to each consumer's needs and desires and is as simple or as complex as those needs and desires dictate. Community Integration Services are provided through contracts with community agencies.

Every support service to consumers is self-directed including all those reimbursable by Medicaid and the Mental Health Block Grant with the exception of involuntary hospitalization, Progressive Treatment Program and legal guardianship. These self-directed support services include but are certainly not necessarily limited to:

- Supportive Housing and Employment
- Daily Living Support Services
- Social and leisure activities
- Social support activities
- Community integration, skills
- Personal growth activities
- Education
- Referrals and assistance obtaining other services

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 System of Maine represents fellow consumers with an effective, organized voice in shaping public policy and mental health services. THE CCSM holds

as essential the participation of all consumers and look to collaborate with allies to find realistic solutions to local and statewide issues and to advance recovery-oriented, consumer-driven mental health care and peer-run recovery opportunities. The Consumer Council System of Maine is a well-established cornerstone of a recovery-oriented system of mental health care, directed by an informed, diverse grassroots consumer network.

L. Involvement of Individuals and Families

CBHS has been actively involved in developing Youth and Family Guided services for an extended period. Below are descriptions of current initiatives.

Case Management services: Case management services for children entail an individualized planning process with a Child and Family Team that includes all behavioral services and natural supports involved in a child's life. Representatives from child serving systems would be included, such as state Juvenile Community Corrections Officers, Child Welfare Protective Workers, school teachers and administrators, and physical health care providers. These individuals are involved from Assessment through discharge and in meetings and communications necessary to carry out the goals established in the plan. 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. An individual service plan is built on the results of assessment, taking into account child and family strengths, needs, and preferences. Plans reflect services to be secured, with measurable goals and periods, natural supports and service providers. An individual plan is developed through a child and family centered wraparound planning process, with a Child and Family Team. Case management involves brokering services, advocacy, insuring that a quality treatment plan is developed and implemented, and reviewing the child's progress. Case management involves aggressive outreach on behalf of the child and family and working with a wide range of community agencies and resources.

Children's Behavioral Health Services case management services are provided through contracts with local service providers. Mental health case management services for children have recently undergone a major redesign that recognizes the need for uniform screening and assessment tools that are used to help determine the level of care or intensity of service that the child needs. 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 in 12 months and at completion of services.

Youth Voice and Leadership: Youth MOVE Maine is a youth-led organization dedicated to modeling, teaching and supporting the youth-guided philosophy in Maine's systems of mental health, juvenile justice, child welfare and alternative or special education. "Youth Guided" is the philosophy adopted by Systems of Care which asserts the rights of all young people to access authentic opportunities for empowerment, education and decision-making in their own lives, and in the policies and practices in youth-focused systems.
Through the Thrive System of Care grant, young people ages 14-25 with lived experience in the mental health, juvenile justice, child welfare or special education systems have been coming together as the Thrive Youth Group since 2005. Coordinating this Youth Group was a young adult with personal experience in the system of care. Members of this group were able to access peer support, training, experiential learning activities and authentic opportunities to influence state and local policies and services in Maine. In

2008, two staff with personal experience in the system of care were hired to help implement this program.

In 2009, this new regional program became Maine's chapter of the national youth movement Youth MOVE, which stands for Youth Motivating Others through Voices of Experience. New staff was hired, all with diverse personal experiences in the systems of care, in keeping with the peer relationship model that makes Youth MOVE Maine unique. A statewide advisory council of over 60% young people under the age of 26 was developed as the governing body of Youth MOVE Maine. In this first year as Youth MOVE Maine, program leadership, members, staff and the Advisory Council worked to develop policies, governance by-laws, mission, vision and identity as Maine's youth-led program dedicated to youth voice in the system of care. Outreach efforts to youth and stakeholders in the community, as well as training and development of products and strategies to support a more youth-guided system made that foundational year a success.

In Youth MOVE Maine's second year they have been able to build off of the foundational work of 2009 to develop a strong, sound program through leadership of the Advisory Council, partnership with community members and supportive organizations, energy and inspiration of a broader network of youth members, and dedication of staff who identify as peers and interact with youth and young adults with reverence for the unique expertise they offer through the life experiences they have had.

Key Successes to Date:

- Development of a network of four regional Youth MOVE groups in Augusta, Lewiston, Portland and Damariscotta. Each group, made up of about 12 youth ages 14-25 is dedicated to peer support and community action to develop the ability of young people to achieve fulfillment and success in their lives as they grow toward adulthood.
- Trainings for youth are offered in each region focused on the issues that matter most according to youth and young adults in the region. Trainings have included cooking classes, personal artistic expression; resume writing, meditation, among others. In May, the annual What Families and Youth Want Conference was co-hosted by Youth MOVE Maine and offered a youth-developed track developed by and for young people including trainings by young people on team planning and anti-bullying.
- Youth and young adults have had numerous opportunities to address policy, including:
    - Co-chairing the Continuous Quality Improvement Workgroup for CBHS, where youth and families have co-led the development of Six Key Quality Areas to define quality services for children, youth and families, which will guide all CQI efforts.
    - Development of a Youth And Family Workgroup advising CBHS from a collaborative youth and family perspective on key issues such as residential standards, implementation of the Youth Outcomes Questionnaire, CQI efforts, and more

    - State and regional participation on the Shared Youth Vision Council, dedicated to reducing recidivism in Juvenile Justice and increasing successful school completion
    - Developing a guide with another youth empowerment program, YLAT, to informed consent to Anti-psychotic medication for youth, which is being used as a foundation for similar national work with the FDA and SAMHSA
    - Advising on peer support with the Moving Forward Healthy Transitions Initiative and Wraparound Maine
- Youth MOVE has developed as an organization to have a majority youth and young adult board, by-laws, standardized staff training, policies, procedures, a logic model and strategic plan and quality assurance measures, to ensure the program is youth-led, trauma-informed and achieving specified objectives.
- Developed strong reciprocal partnerships with other youth organizations, family organizations, state and local agencies and community collaborative/initiatives bringing youth voice into these programs and strategically working together to improve services.
- Social marketing "Shift Your Mind, Drive Your Dream" campaign, dedicated to raising awareness through info cards, kicked off with 'resiliency cards.' Facebook and website updated with resources and information on our program.
- Training and technical assistance offered including:
    - Webinar created with Thrive on Trauma-Informed From a Youth Perspective
    - Training co-created with other youth organizations on the Shared Youth Vision Council on best practices for involving youth on boards and collaboratives
    - Training for youth and providers at the YLAT conference on youth voice in mental and physical health care
    - Training child welfare workers on best practices in youth informed consent to anti-psychotic medication
    - Ongoing youth consultations on various boards and initiatives

Healthy Transitions Initiative: *Moving Forward:* Early in 2007 Children's Behavioral Health Services, the Thrive Trauma-Informed System of Care Initiative, Tri-County Mental Health Services and many other community agencies joined with the Maine Children's Cabinet to seize an opportunity to "marry" the Cabinet's Transition Priority with the Shared Youth Vision Council's interests in Trauma-Informed Services by writing a federal grant that would focus on the common goals of all parties involved in this collaboration. In September, 2009 CBHS was notified by SAMHSA that it was one of only seven national applicants to be awarded a Healthy Transitions Initiative grant.

Maine was well positioned to address the purpose of this Initiative through its response titled **"*Moving Forward*: Achieving Independence for Transition-Aged Youth"**. The Maine Department of Health and Human Services, representing both children's and adult mental health, has joined with Tri-County Mental Health Services, the Thrive system of care Initiative which through its experience has developed solid relationships with local youth and has established credibility and trust with them, and with many other providers to implement the Transition to Independence (TIP) model in one of the neediest counties in the state, Androscoggin County.

Transition to Independence is an evidence-based practice, which emphasizes youth-directed planning and development of practical skills, which lead to independence. Maine intends to enhance TIP in two key ways. One is to train Peer Youth Specialists to support youth through the process of setting their goals and achieving their dreams. Among these will be members of Youth M.O.V.E.Maine, a local and national advocacy organization for youth, and the Somali Bantu Youth Association. The second is to assemble three community mental health agencies who will implement TIP, Tri-County Mental Health, Common Ties and New Beginnings, into a Learning Collaborative. The Learning Collaborative will serve to support the case managers who implement TIP and reinforce the initial training provided by the TIP developers.

In addition, through the program's links to the Maine Children's Cabinet and Shared Youth Vision Council, *Moving Forward* will address identified systemic issues bridging the children and adult mental health systems including the different policies, structures and eligibility criteria that exist in each system**.**

Moving Forward aims to increase high school graduation or GED attainment, and increase access to higher education for these youth who complete high school. Other targets include reduction of involvement with juvenile justice, and increases in employment, satisfactory living arrangements, use of the community and informal supports, and increasing the perception of personal well-being by young people whose functioning has been impaired by substance abuse or mental illness.

Moving Forward is in its second year with progress on numerous levels. First, training in the Transition to Independence (TIP) model of case management was completed for staff at three local agencies collaborating with CBHS. The mission of the initiative is to provide youth and young adults with a seamless transition from the child serving system to adulthood and opportunities for meaningful participation in a system of care that empowers through leadership and advocacy. This is being accomplished by working diligently with Youth Move Maine, TriCounty Mental Health, New Beginnings and Common Ties, which are all agencies, located in the Initiative has targeted geographic area.

A second round of training in TIP is scheduled for August and invitations will be sent numerous to mental health professionals in an effort to perpetrate the use of the model across a multitude of venues and agencies. This model is evidence-based and youth driven and has been proven successful within the targeted population of the Initiative. As part of this round of training, Maine will have the first nationally certified TIP trainer

based in Lewiston. This certification will allow Maine to continue to train others and is in line with our goal of sustainability.

A state advisory council has been established with the goal of designing policy aimed at improving the seamless delivery of transition services in Androscoggin County and, eventually across Maine. Evaluation is ongoing with Hornby Zeller Associates conducting interviews with youth, gathering program information and participating in a nationwide evaluation among the states originally awarded the Healthy Transitions grants.

Staff at three service delivery agencies identified as partners in Moving Forward continues to serve youth in Androscoggin County. Monthly case-based review meetings are on going and provide support and education to case managers.

The evaluation component of Moving Forward is ongoing. Hornby Zeller Associates continues to work on a database for information sharing and federal reporting. Cross-site evaluation between the seven states receiving the Healthy Transitions Initiative funding is in progress and Maine is actively involved in that process. SAMSHA is promulgating national evaluation standards and Maine is working with that group to include information about Moving Forward in that study.

Moving Forward continues to seek ways to involve state agencies providing services to adults in the application of the model. The common goal remains the transition of youth to successful adulthood in any of its myriad manifestations.

Thrive – System of Care:

For the past six years Children's Behavioral Health Services (CBHS) in partnership with the THRIVE initiative, community providers, youth and families have been transforming community mental health services in some critical ways, consistent with the System of Care principles developed at the federal level. These include giving youth who are affected by serious emotional and behavioral challenges and their families a greater voice in their treatment and to make the treatment experience "trauma-informed," family driven, youth guided and culturally and linguistically competent. This means educating agencies who deliver these services to understand System of Care principles and the trauma that many seeking help have experienced and to avoid contributing to that trauma through the treatment process itself. Maine's evaluation has demonstrated reductions in trauma symptoms in children, as well as reductions in use of the most expensive residential services and therefore lower treatment costs overall.

One of the main deliverables and successes of Maine's trauma-informed system of care has been the creation of a Trauma informed Agency Assessment created by families, youth and providers in consultation with Thrive staff. This agency assessment is now a requirement as set forth in contract language for child serving agencies contracting with the Department of Health and Human Services' Office of Child and Family Services. Results of the first administered assessment were rolled out to provider

organizations in the summer of 2010 with a requirement that providers seek out training and technical assistance on trauma, trauma informed principles and system of care principles. Agencies also created Continuous Quality Improvement (CQI) plans based on the results and submitted these plans to Children's Behavioral Health Services for review and comment. The second re-administration of the TIAA occurred in July of 2012. Results will be disseminated in late summer with subsequent CQI plans to be created and submitted.

Development of the TIAA coincided with the creation of the THRIVE Guide to Trauma-Informed System of Care Organizational Development, a guide for agencies with steps to implement Trauma-Informed System of Care Practices. In addition to best practice literature, the guide includes information about CQI planning steps. Dissemination of this information is followed by a 90-minute webinar prepared by youth, family, THRIVE, and CBHS. Agency staff was required to participate and take a quiz at the end. These trainings are archived and available for agencies to use in team meetings, orientation for new employees and continuing education.

Next steps in assessment include expansion to other child serving systems. The Division of Juvenile Services met with THRIVE and CBHS in April 2010 to discuss adaptation of the TIAA for Juvenile Services staff in the community and at Youth Development Centers as well as with contracted providers. Through the expansion, Maine also intends to adapt the assessment for military families.

In addition to the above trainings THRIVE offers regional and on site trainings on Trauma, Trauma Informed, Youth Guided, Family Driven and Cultural and Linguistic principles and practices. These trainings begin the technical and adaptive process of creating change in an organization. Thrive recognizes that ongoing support outside of an initial training is necessary to sustain change which is why phases of support would be offered that identify and train "trauma informed champions", creates agency specific strategic plans for becoming trauma informed and assesses change through continuous quality improvement and on site monitoring for those organizations who score with significant challenges.

Thrive, in partnership with the Office of Child and Family Services, will continue to track agency change against these system of care trauma informed principles through a re-administration of the Trauma Informed Agency Assessment on an every other year basis. The efforts listed above would enhance an already existing system without creating additional services. Ultimately, families and youth would report increased satisfaction, safety, trust, empowerment and collaboration with their treatment providers resulting in improved treatment outcomes.

New System of Care Expansion Planning Grant: Submission 6/2/11

Given the successes of the TIAA and the ongoing training needs, THRIVE and CBHS have applied for an expansion grant to further embed and sustain system of care and trauma-informed principles and practices in state and local agencies. This expansion grant application, entitled "Expand ME", will support the expansion of the trauma-informed System of Care practices developed by THRIVE[1] System of Care from three western Maine counties to the entire state, involving not just the 130 agencies who deliver mental health services but other systems as well. Thus, the geographic area is statewide, encompassing 16 Maine counties. In terms of service system expansion, the immediate focus will be juvenile justice whose leadership has participated in training and now want full integration with trauma-informed System of Care practices as well as military families where CBHS is already engaged in the Military Adjustment Program.

In order to expand the system of care CBHS will undertake an assessment to occur at two levels, one focusing on state infrastructure to sustain System of Care and the second at the agency level to assure all providers follows trauma-informed System of Care principles. The multi-stakeholder Statewide Expansion Team, including representatives from Child Welfare, Juvenile Justice, and Education, will lead the state effort. It will update the Logic Model and Strategic Plan to expand and sustain a System of Care approach across child serving entities. It will review policies, administrative and regulatory standards and make recommendations to support service improvements and coordinate funding streams. It will inform and improve the Social Marketing Communication and Education Campaign ensuring cultural and linguistic competency and family and youth voice. A statewide focus will be to modify the TIAA for juvenile justice and agencies serving military families. At the agency level, the tool will be critical to help agencies assess their own practices and make improvements consistent with System of Care principles. The assessment includes components for agency staff, family and youth to complete, with the evaluator developing sample sizes depending on the number served by each agency. Agencies need ongoing education on the importance of assessment and planning on System of Care Principles through trainings and webinars.

Statewide Family Organization:

This year work to form an alliance of the seven family organizations was completed. The Maine Alliance of Family Organizations (MAFO) is a statewide alliance that formed to better serve families of children with disabilities and special health care needs and to strengthen family voice. As indicated in their brochure "Family concerns, needs and voice are foundational to what we do. We believe families are the primary decision-makers regarding care of their children, and we promote the family role in influencing policies and procedures governing care for all children". The seven family organizations are adoptive and Foster Families of Maine (AFFME); Autism Society of Maine (ASOM); GEAR Parent Network; Learning Disability Association of Maine; Maine Parent Federation (MPF); National Alliance for the Mentally Ill (NAMI) and Southern Maine Parent Awareness (SMPA). Each of the partner organizations offer trainings, support,

[1] While initially developed under the auspices of Tri-County Mental Health, THRIVE has been incorporated as a non-profit organization to continue training, technical assistance and system development both in Maine and nationally.

referral, advocacy and specialized information to help families cope with the special needs of their children and obtain the services and support they need. Each of the partner organizations website contains partner web connections to facilitate family access to all available resources. Early in the alliance, MAFO produced a two-part web based video of personal family stories of the life- changing importance of family organization membership. The videos, Family Organizations: Working Together, Growing Stronger Part 1 and Part 2 can be accessed from all seven organizations websites. A copy of the MAFO brochure is in the attachment section of this application.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology

Presently, Children's Behavioral Health Services (CBHS) is utilizing the follow Interactive Community Technology (ICT):

I. <u>Project #1 Youth Outcome Questionnaire (Y-OQ)</u>

The Youth Outcome Questionnaire (Y-OQ) is the most well developed and tested rapid clinical feedback system available. Outcome Measures, Inc, the developer of the Y-OQ, used a rigorous development process to select the questions with the greatest sensitivity to clinical change possible. The Y-OQ has been shown, in studies described in peer-reviewed articles, to be able to predict poor treatment outcome based on the trajectory of Y-OQ scores. This "early warning system" allows the clinical team (youth, parent, clinician, and supervisor) to reassess and reorient to maximize the possibility of a positive outcome.

The parent and the youth when s/he is over 11 years old complete the Y-OQ. The Y-OQ serves to amplify the youth and parent voice in Continuous Quality Improvement (CQI) efforts at all levels of the System of Care, which will become even more important as the Department moves toward full risk managed care.

Implementation of the Youth Outcome Questionnaire has been rolled out statewide in the Intensive Home and Community Treatment (HCT) program that provides services for @ 1,388 children (June 21/2011) and 4,050 children per year (July 10, 2011-June 21, 2011). The Y-OQ is being used in place of the Child and Adolescent Functional Assessment Scale (CAFAS). The move to the Y-OQ was made to access parent and youth feedback, (The CAFAS depends solely on input from the clinician). The purpose of this questionnaire is twofold:

a. To function as an outcome measure than can detect change in the a child's clinical functioning, and
b. To serve as a continuous quality improvement tool that gives the therapist "live feedback from the youth and parents on the effectiveness, or lack thereof, of therapeutic interventions. Thirty Provider organizations had 212 of clinicians trained and 954 of youth have been administered the tool August 1, 2011.

c. The tool can be administered to the consumer in the "field" or office on a portable computer, net book, or PDA. The tool is synched with OQ measures using a web based link, and essentially instantaneously the provider is fed back a report which highlights the child or youths functional abilities as well as any concerning critical items (such as suicide or psychosis). There also is a client report available and both reports can be discussed with the clinician, child, and family.

d. Regular Reports are provided to Children's Behavior Health Services:
    i. The number of children receiving each scale
    ii. The number of clinicians using each scale

iii. The frequency of admission of each scale
iv. Outcomes by agency
v. Proportion of families with both youth and parent completing tool

Future Plans for the use of this ICT:

Maine spent two years preparing for the implementation of the Y-OQ in our intensive Home and Community Based Treatment. The next step will be to pilot implementation of the Y-OQ in Maine's outpatient services. This is planned for the beginning of 2012.

Incentives to encourage the use of this ICT:

The initial training was done face to face in two sites. The challenges of collecting 212 clinicians from across the state were significant and the challenge of fitting a day of training into a busy workweek was substantial. Currently OQ Measures and CBHS are developing a comprehensive web based training module that can be attended anywhere there is a computer, and in segments when the clinician, supervisor, or manager has an open hour

Support systems to encourage the use of this ICT:

The best support is continuous feedback. The state plans to distribute a serious of reports that will allow reliable and valid feedback on consumer progress or lack thereof.

In addition, CBHS has contracted with OQ Measure to provide six consultation sessions with a child psychologist familiar with the Y-OQ and evidence based practices for children.

Barriers to the implementation of this ICT:

Barriers are the required training of clinicians, supervisors, and managers in use of technology and then overcoming inertia that is a challenge to all change in system functioning. There also is a need for ongoing monitoring and consultation, as a didactic training and a dime does not buy a cup of coffee. Systems change requires an ongoing sustainability effort.

How the State plans to work with organizations and other local service providers to identify ways ICTs can support the integration with primary care and emergency medicine:

CBHS has worked with a broad group of stakeholders (youth, parent representatives, providers, and DHHS staff) in implementation of the Y-OQ. We will continue this collaboration throughout the implementation and monitoring process (through the use regular meetings, phone interviews, and questionnaires)

Collecting data for program evaluation at both the client and provider levels for this ICT:

This will be one component of a continuous quality improvement effort by CBHS. Data will be shared with clinicians, supervisors, managers and CBHS staff, providing opportunities for monitoring and improvement at all levels.

The state is going to be tracking the percentage of children who are admitted to the Home and Community Treatment that receive one of the Y-OQ tools. The state also will follow changes in the child's functional assessment using the Y-OQ

In addition, CBHS will monitor the improvement in children's scores by provider, and sharing aggregate results

Measures and data collection for promoting and judging use and effectiveness of this ICT:

CBHS will determine what percentage of children/youth in HCT programs are being administered the Y-OQ, and how many clinicians/supervisors/managers are accessing the reports on these children/youth.

II. Future Plans for the use of ICT's

Project #1: CBHS Provider's of specified Maine Care services will be required to directly enter their service information into the Department's web based data system, The Enterprise Information System. This information will be used by CBHS to determine eligibility of service, to authorize amount and duration of treatment service, track wait time for service, calculate costs of service, track denial and appeal, and determine effectiveness of service. The EIS system will be used by both the provider and the CBHS staff for interactive communication for prior authorization, utilization review and outcome reporting for these identified services.

Incentives to encourage the use of this ICT:

Reduction in costs associated with mailing, copying, and faxing hardcopy required forms. The contracted provider's will be able to reduce personnel costs associated with the collection, collation and proof reading of hardcopy materials that are currently required to be mailed to the Regional offices. There will no longer be confusion on which forms to use or attempting to locate the most current, reducing returned forms. Deceased wait time for processing of material and for CBHS eligibility and treatment authorization decisions.

Support systems to encourage the use of this ICT:

Individual provider location trainings from regional CBHS staff, ongoing phone and contact support from the local CBHS Training Teams, an Instructional Manual available on the CBHS website with e-mail notifications of manual updates. Bi yearly refresher classes.

Barriers to the implementation of this ICT:

There are providers who may have to purchase additional computers. Personnel will require training on an additional data system.

How the State plans to work with organizations and other local service providers to identify ways ICTs can support the integration with primary care and emergency medicine:

Through the Hanely Behavioral Health IT Strategic Action Task Force. As a result of work with Maine behavioral health practitioners and stakeholders the task force will:

A. Significantly increase awareness of the value of electronic information sharing and the most significant barriers to be overcome
B. Plan and begin to implement activities to remove barriers and encourage acceleration of clinical information sharing
C. Develop a strong, knowledgeable, and effective constituency for continuing to accelerate clinical information sharing
D. Finalize a report with specific recommendations that will lay the groundwork for appropriately accelerating the sharing of information with primary care providers.

Office of Adult Mental Health Services

Maine believes that empowering consumer voice is necessary for system transformation. The Office of Adult Mental Health Services (OAMHS), a part of the Maine Department of Health and Human Services (DHHS), has a solid history of consumer involvement in designing, implementing, and evaluating mental health services as well as expanding peer services. Recovery language is part of many of our documents and our philosophy. The next step in system transformation is to bring recovery concepts truly to life.

OAMHS has completed an OQ pilot program, and is beginning statewide implementation of the OQ Measures Tool. Concurrently, OAMHS is in the planning stages of an OQ Measures Tool pilot program within the state psychiatric hospital system.

A component of this tool is the Recovery Assessment Scale (RAS) that will be used for a system assessment of recovery. Approximately 9,000 people are enrolled in community integration services, a case management and rehabilitation service, largely funded by Medicaid. Community integration was chosen as the focus because it is a core mental health service, is built on a common service model; the population meets the definition of persons with serious or severe and persistent mental illness, and represents a relatively long term service.

The Recovery Assessment Scale (RAS) was developed as an outcome measure for program evaluation to assess aspects of recovery and will be electronically self-administered annually. Consumers particularly like this tool because of its focus on hope and self-determination. OAMHS and the Office of Quality Improvement (another division of the DHHS) are working with the RAS developers to assure that the tool is valid at the statewide level.

The consumer uses a Web Based PDA, a netbook, or computer to answer questions at regular intervals. The OQ provides real time feedback on interpersonal relations, symptomatic distress, and functioning in daily activities. The scoring software applies algorithms to identify strengths and weakness with the consumer's recovery process. The software provides additional help for problem solving along with a decision tree and suggested interventions, thus providing the structure for the consumer to interact with the provider.

The funding for the implementation of the OQ and RAS tools, the training, and the technology is already a part of the OAMHS budget. Additional funding from the Block Grant will allow us to expand the community implementation statewide, and help to get the state psychiatric hospital pilot off the ground. Of course such an allocation would be based on our needs analysis in order to incorporate recovery training, materials, and strategies into an ongoing initiative.

Barriers to the statewide implementation of the OQ and RAS tools are principally technology and training based. Even with Air-Cards, there are locations in rural Maine where IT connectivity is not possible. Another technology related barrier is addressing

provider capacity and comfort level with sophisticated IT technologies. Full implementation of the OQ/RAS tools represents a recovery tool for consumers, a clinical tool for providers, as well as a quality management and outcome measurement tool for the state. The OQ Measures vendor has informed us that it is likely to take between 12-18 months for a reliable baseline to be built before we can fully take advantage of the analytic capabilities of this tool in making accurate assessments of various services and methodologies used by our provider network. The immediate benefit is to the consumer and clinician.

Another tool we have implemented in the last year targets persons living in Residential Treatment Facilities. In reviewing a number of well-known tools tested for their reliability and validity, a group consisting of providers, consumers, and OAMHS staff, have come to agreement that the Adult Needs and Strengths Assessment (ANSA) is an appropriate tool to use in supporting persons in residential settings moving towards more independent living situations in the community. The ANSA is a multi-purpose tool developed for adult 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. To date, every residential treatment provider has trained ANSA staff. OAMHS and our Office of Quality Improvement is currently collecting and analyzing data from this tool which is helping to inform us in the decision making process of moving persons to more independent settings in the community.

OAMHS will be examining the existing IT infrastructure with respect to our ability to meet current and future IT needs. . This IT review will not be limited to examination of existing systems, it will include a review of 3rd party IT vendors. Existing systems include Enterprise Information System (EIS), the Service Encounter Database, OQ Measures system, as well as SOAR, and ANSA data. Another database being used in Maine is the Homeless Management Information System (HMIS), using Bowman's Service Point Product. We will continue to work on interoperability by and between these and other state IT systems including: SSI, Medicaid, Food Stamps, etc.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into 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.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local 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 child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

N. Support of State Partners

Children's Behavioral Health Services (CBHS) Interdepartmental Collaboration

Chapter 790, beginning with Memoranda of Agreement linking Children's Services and each of the 3 child-serving state agencies, has promoted a high level of interdepartmental collaboration since that time. Because these partnerships began prior to the merger of the Department of Behavioral and Developmental Services (BDS) and the Department of Human Services (DHS), the original Departments are cited in the discussion below. These collaborative efforts are summarized as follows:

Children's Behavioral Health Services/ Office of MaineCare Services

Children's Behavioral Health Services and the Office of MaineCare Services, in accordance with their previous Memoranda of Agreement, jointly share responsibility for the development of policies for behavioral health care for children and adolescents. Once developed, these policies are formally promulgated by OMS, the state Medicaid authority. Public informational meetings with providers following the release of a MaineCare policy change also include representatives from the Department of Education and Department of Corrections. Providers have indicated they find these meetings to be very helpful, which is both indicative of and reflective of the excellent working relationships between the state agencies.

Significant changes have been made or are presently undergoing formal rulemaking that directly affect the children's system of care. Representative provider agencies participate in the process for proposed changes to MaineCare policies. One of the very important changes occurred over the last two years with the development of MaineCare rules establishing the Children's Home and Community Based Treatment Services, including evidence-based practices such as MultiSystemic Therapy and Functional Family Therapy.

Other Medicaid policy areas underwent revision and resulted in the consolidation of many individual treatment services that are now incorporated in a single section of policy under Children's Mental Health Services (MaineCare Section 65). Currently there is major policy changes focused on Residential Treatment services.

Interdepartmental MOU for Assisting Children At Risk

The goal of this protocol was to establish a clear framework and process for meeting the behavioral health needs of children effectively and efficiently. This approach is one of collaborative and joint problem solving. The primary focus is to include and support parents in their efforts to continue nurturing their child and participating in their child's treatment in and out of the child's home. Children's Behavioral Health Services and Child Welfare Services expected all providers to have active family involvement components in their treatment programs and to encourage families to continue to actively participate in all aspects of their child's care and treatment in order to expedite the child's successful transition to their home and community.

Interdepartmental MOU for Assisting Children At Risk -Post Adoption Addendum

Providing a home for children adopted from the child welfare system has a set of challenges and rewards that can differ from raising birth children. This addendum clearly identified the shared responsibility in supporting adopted children and their families when it is apparent that a possible out-of-home placement may be necessary.

This agreement provides for information sharing between DHHS/ Child Welfare Services Adoption Program and Children's Behavioral Health Services, regarding children receiving adoption assistance who also access CBHS grant funds for residential treatment. Both CWS and CBHS facilitate coordination of resources to maximize utilization of appropriate funding and prevent duplication.

Adoptive parents applying for residential services (Intensive Temporary Residential Treatment Services) are informed of CWS and CBHS coordination regarding children receiving Adoption Assistance through Child Welfare Services. Families receiving post-adoption assistance, who have children with special needs, are encouraged by CBHS and its contracted providers to access appropriate services available through the CWS Post-Adoption Support Program. A family receiving post-adoption assistance, who have children with special needs, will be encouraged by the CWS Post-Adoption Support program to access assistance available through Children's Behavioral Health Services and its contracted providers. Both CBHS and CWS recognize there is a shared responsibility to provide adoptive families the most appropriate services that are supportive of their children's needs in a continuum of community-based services. This amendment was finalized in June 2004.

CBHS Partnership with Maine Center for Disease Control

Project LAUNCH: Linking Actions for Unmet Needs in Children's Health is the most recent illustration of close and successful intra-departmental relationships that CBHS has established with its peers in Maine's Department of Health & Human Services. The Maine Center for Disease Control, Division of Maternal and Child Health, in collaboration with the Office of Child and Family Services, including CBHS, was awarded one of six SAMHSA grants funded for five years at $916,000 per year to promote wellness for children birth to 8 years of age. Project LAUNCH is grounded in the public health approach, working towards coordinated programs that take a comprehensive view of health, addressing the physical, emotional, social and behavioral aspects of wellness

The Community Caring Collaborative (CCC) in Washington County will implement Project LAUNCH. CBHS has had a continuing relationship with this collaborative prior to this current initiative, providing Children's Mental Health Block Grant support for an infant mental health specialist position to develop a curriculum for working with new parents with substance abuse issues. The CCC is comprised of community members, child-serving agencies and tribal entities. The CCC has developed three groups to advance its collaborative efforts. A work group of front-line workers and family

members define areas of concern and needs. The Executive Council includes heads of agencies or tribal organizations and family members develop policies and procedures for the collaborative. The State Agency Advisory group explores policy and program issues that require state action and inclusion. The children to be served under Project LAUNCH include those born affected with substances or are at risk due to a variety of other issues and their families and older siblings through age eight.

CBHS Collaboration with Early Childhood Care and Education

The National Early Childhood Technical Assistance Center (NECTAC) in collaboration with the Office of Special Education Programs (OSEP) is supporting 11 states that are establishing a statewide framework to strengthen families and support a continuum of inclusive community-based early care and education opportunities. Children's Behavioral Health Services is a member of the expanded cross-systems team known as Maine's Expanding Inclusive Opportunities Initiative that is ensuring that children birth through 5 and their families have increased access to high quality community based inclusive early care and education. The team works collaboratively and transparently across sectors and systems both locally and statewide to promote interagency understanding and support of this inclusive initiative.

Assistance to CMS Long Term Services and Supports

Maine is participating in a two-year grant sponsored by the Center for Medicare & Medicaid Services (CMS). Phase I requires the development of a state profile tool that identifies the current long term services and supports system, describes the administration of these services and supports and includes demographic and utilization data. In Phase 2 Maine will work with a National Balancing Indicator Consultant (NBIC) to develop common measures across states for measuring the balance between home and community based services and institutional services. The Office of Child and Family Services is contributing to this project by providing vital information on children with long term service and supports needs. Central office personnel supporting this work include the CBHS Quality Assurance and Training Manager and the CBHS Information Systems Manager.

Department of Corrections - Juvenile Services/Children's Behavioral Health

The following narrative summarizes the work of Children's Behavioral Health Services staff assigned to support the Department of Corrections (DOC), Juvenile Services, in all 4 DOC regional offices and in the 2 Youth Development Centers in Fiscal Year 2011.

The collaborative integration of behavioral health services within the juvenile justice system is managed by a CBHS Social Services Manager who oversees the behavioral health services provided within juvenile facilities and by CBHS Team Leaders who supervise Mental Health Program Coordinators attached to the community-based system in DOC regional offices.

The original Memorandum of Agreement beginning this collaboration and the placement of children's mental health staff in Juvenile Youth Development Centers and co-location DOC field offices was signed in 2002 between CBHS and Juvenile Services and was updated in 2007. Current work of staff involved with this program fall into two broad categories:

Individual Consultation, Assessment, Treatment, Advocacy

- **Initial Mental Health Assessment**- Long Creek and Mountain View Youth Development Centers have worked hard to implement a system to assure that each youth entering the facility has a mental health assessment. Both facilities administer the Massachusetts Youth Screening Inventory-2 (MAYSI-2) to each youth upon admission. The results are given to nursing personnel who further assesses the youth. If a youth scores in the critical area of suicide they are immediately put on a "watch" and further assessed by the Suicide Prevention Protocol. Results of the MAYSI are then given to the CBHS clinical social worker who then completes an additional mental health assessment. These results inform staff about the level of support that youth may need while in the facility, and help inform their teams on mental health symptoms that may need to be treated once they leave the facility. Prior to this system, CBHS clinicians relied on client's self-referring, staff observation or on reports from outside providers to signal that, a youth may need mental health support. The MAYSI assessment tool and process now provides an objective and systematic way to screen for mental health needs and has been especially helpful in detecting youth with internalizing behaviors.

- **Aggression Replacement Therapy "ART"** This is a multimodal therapy designed to help reduce aggressive behavior in chronically aggressive youth. CBHS staff at Mt. View have co-lead this group therapy with DOC staff.

- **Trauma Affect Regulation: Guide for Education and Therapy--"Target"**- This is a psycho-educational program which teaches youth to manage the symptoms of complex trauma. While some clinicians at Long Creek and Mt. View are trained in, the TF-CBT model of trauma treatment, DOC chose to implement Target as it has been designated a promising practice by National Child Traumatic Stress Network, for use with youth in the juvenile justice system. It is basic enough that non-clinical staff is able to help implement it and because it does not require exposure therapy, it is anticipated that this model will be better suited to the sometimes re-traumatizing correctional setting. CBHS staff from Long Creek attended an intensive training and co-facilitated Target groups for girls in the facility. CBHS Mental Health Coordinators will also be attending this training to better understand which youth can benefit from this model.

- **Team meetings**- Mental Health Coordinators spend the bulk of their time in team meetings on individual youth. This provides the opportunity to educate teams on how the youth's mental illness may be interfering with their functioning and on treatment that is matched to their needs. Many of the youth are connected with

community mental health case managers, but even in this situation, having a person who understands the complexities between correctional and mental health needs is valuable. It offers someone who is not deeply involved in the day-to-day challenges of the case to be able to ask questions, and can most often help the team reframe some of their thinking and give hope to parents that their child and family's functioning can improve.

Systems Collaboration/Integration

- **Youth with Complex Needs-** This meeting of Child Welfare, DOC and CBHS Central Office staff and DOC facility staff was initiated because of concern over a number of youth with serious emotional disorders and developmental disabilities who had been detained. These youth did pose a high risk to the community because of aggressive behaviors, but treatment within a correctional system could have the unwanted effect of increasing their criminal risk. This collaborative problem-solving group has been instrumental in developing a systematic approach in considering youth under these circumstances, to include:

  Interagency Protocol for Detained Youth - This approach calls for a multidisciplinary team meeting on all detained youth with a joint recommendation to the court in order that the youth can be detained. It outlines steps to move the case to higher administrative levels when a joint agreement cannot be reached. Even with this improvement in the process, monitoring and enforcing, a multi-departmental protocol has proved difficult, highlighting the differences in management styles and expectations between the agencies.

  Interagency Case Review – Problematic cases are presented, dissected and reviewed with recommendation given for future changes in process.

- **Jurisdictional Team Planning**- JTP involves regional groups of multidisciplinary providers including attorneys, judges, mental health providers and correctional providers who meet on a regular basis to develop ways to avoid the use of secure detention and to increase evidence based practices. Efforts have been extremely fruitful, resulting in a significant decrease in the number of youth being detained and the length of time they are detained. Other tangible outcomes from this working model have included:

  - Resource Guide for parents who have youth in the Juvenile Justice System

  - Formal training protocol given to law enforcement officers at the Police Academy to educate them on responding to a crisis

  - Formal protocol for police responding to juvenile crisis to document and refer cases to crisis services for follow-up

- Developing a multi-system case review system for families with complex needs and who are involved with multiple providers and services.

- Developing a case review system to address family/ youth situations where multiple police responses have occurred. This is an offshoot of the juvenile reporting form and training that a local police officer spearheaded this past summer.

- Participating in workshop for families who have youth heading toward the JJ system—designed to help them understand modalities that are available to help and designed to get families to be more involved in the development of resources in their communities.

- Redesigning the initial juvenile intake form to identify natural supports and assets early in a youth's involvement with Corrections as a way to begin effective case planning, crisis planning and diversion.

- **Juvenile Justice Task Force**- In April 2009, Chief Justice Saufley, First Lady Karen Baldacci, and Dean Pitegoff of the Maine School of Law convened this task force of state agencies, branches of government and sectors of the non-profit agencies to reform the Juvenile Justice system. Goals included, "increasing educational attainment, access to community-based services, correctional practices, resource allocation and organizational structure and development." While similar to other initiatives such as JTP, Regional Children's Cabinets, the Juvenile Justice Advisory Group and Regional Wraparound Maine advisory boards, the Juvenile Justice Task force has the advantage of coming from the Governor's office and has been able to actively bring the Departments of Education and Labor to the table.

- **On April 7th, 2010, Governor Baldacci signed LD 1703 into law** – Resolve, To Implement the Recommendations of the Juvenile Justice Task Force – Reinforces the Juvenile Justice Task Force report from March 2010 that called on the state to make major changes to how it treats at-risk or troubled teenagers, proposing a list of goals aimed at keeping youth in school and out of correctional facilities. Since that time, the state has been divided into 8 geographical districts with each district inviting professional providers along with community members to develop a strategic plan for their district on how they will achieve the goals outlined.

- **Intensive Temporary Residential Treatment** "ITRT"- CBHS staff, and Child Welfare staff present and review youth to determine level of care, when this is a treatment option that is being considered

- **Sexual Behavior Treatment**- CBHS staff, along with DOC staff present cases to consultant Dr. Sue Righthand to insure youth get appropriate levels of treatment

- **Girls Case Management**- CBHS staff is working with DOC staff to develop and implement gender specific case management guidelines for girls in the correctional system. Currently there are two Juvenile Community Corrections Officers (JCCO's) who have all girl caseloads and are slowly implementing these practices. The group is also working on how to screen girls early in the process to identify mental health needs.

- **Substance Abuse Collaborative**—Mental Health Coordinators are members of this collaborative, aimed at improving system delivery to youth with substance abuse problems. The focus statewide of substance abuse treatment has been to have all providers capable in treating substance abuse in a co-occurring model

- **Aggressive Youth in Residential Treatment**-CBHS and DOC staff work together to ensure that residential treatment facilities respond appropriately when youth with dual mental health and correctional involvement become violent.

- **Mt. View Facility and Community Collaborative -** Monthly meeting where mental health staff from DOC and CBHS who work in the facility are joined by their counterparts in the community to help identify and plan for youth who are transitioning out of the Mt. View facility.

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 & 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.

Department of Education/CBHS

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. Presently, this committee is active in assisting providers in the redesign of their residential programs from long-term residential to shorter-term, family focused treatment programs with the goal of lessening length of out-

of-home placement and maintaining connections to a child's natural community and extended family.

The Department of Education is a frequent collaborator with the other child serving state agencies, either as a participant or as advisor to new initiatives, which involve multiple agencies. CBHS has been an active partner with DOE regarding specific behavioral health MaineCare services provided through DOE. CBHS staff has assisted in re-writing policy related to children in the educational system that included Day Treatment Services (Section 41) and Early Intervention Services (Section 27).

Child Development Services (DOE)/ Children's Behavioral Health Services

In FY12/13 Children's Behavioral Health Services will continue 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 CBHS. These connections can be identified through CBHS contracted case management agencies. Other objectives include training initiatives that provide a consistent and comprehensive overview of the CDS and CBHS missions and operations for pre-school/ early intervention services and to identify the assessment tools used by CDS and CBHS.

The Department supports a strengthened and enhanced relationship with CDS at the community level that will improve the coordination of care and service delivery to this population through vehicles such as team meetings and individual plan development.

MADSEC/BDS Liaison Committee

In an effort to support and implement the Memorandum of Agreement with DOE, a liaison committee was established in November of 2002 with statewide representation of the Maine Administrators of Special Education Services (MADSEC) and the Department of Behavioral and Developmental Services, Children's Services (BDS). The liaison committee meets monthly, its primary focus is to enhance the communication, and coordination among schools, CBHS contracted community case management provider agencies, and departmental staff on the local, regional, and state levels. CBHS central office and regional staff are active members of this committee.

Transitional Services for Adolescents and Young Adults

In October 2002, an interdepartmental protocol for the coordination and transition of children served by the former DHS and BDS was completed. This protocol covers youth with identified diagnoses of mental illness, youth with mental retardation and youth who are in need of adult protective services who will transition from youth services to adult services. This protocol also covers youth served by both Child Welfare and Children's Behavioral Health services systems.

Currently, both the Office of Elder Services (OES) and Office of Adults with Cognitive and Physical Disabilities (OACPD) within DHHS are committed to providing a close collaborative working environment in order to plan and work together and share common expertise to support youth and young adults who are consumers of State services. Elder Services provides adult protective services to youth who transition and OACPD provides services for adults with mental retardation. In setting forth this Protocol, the DHHS reaffirms its commitment to providing the best services and supports possible by building on the strengths of their mutual work. An interactive training module around guardianship was produced through the Muskie Institute in collaboration with Elder Services and OACPD at:
http://www.maine.gov/dhhs/guardianship/guide.shtml.

The purpose of this Protocol is to set forth expectations and agreements that form a pathway to guide this work together, acknowledging and building upon excellent regional collaboration. In helping youth transition to adult services, collaboration, consumer-focus, information sharing and planning are recognized as the most crucial components.

MOU between CBHS and OAMHS Regarding Transition Age Individuals

An important product of the *Moving Forward* Initiative (discussed later in this Criterion) has been the concurrent development of an updated Memorandum of Understanding between the Division of Children's Behavioral Health Services and the Office of Adult Mental Health Services (OAMHS). 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.

OAMHS and CBHS are committed to collaborative systems approaches to ensure timely access to needed services and continuity of care to ensure a seamless transition to adulthood. The mental health system of care will be family-driven, youth guided, culturally competent, strengths based, trauma informed and apply the principles of effective interventions for transition age individuals.

The MOU details the responsibilities of both parties and contracted provider agencies regarding joint tracking of individuals from the age of 16 who are expected to require mental health services and supports into adulthood and to engage consumers, families, providers and advocates in the development of state regulations to ensure that services are available and consistent across child and adult services and barriers to accessibility are eliminated. Staff from both state agencies will be cross-trained in the Transition to Independence (TIP) curriculum, as will community providers.

Provider contract obligations will ensure that relevant information for transition planning is exchanged with individuals, other treatment providers, family members and others involved in the planning process. Both offices agree to monitor provider outcomes in a coordinated fashion at the regional level, and coordinate on any corrective action plans with providers, and jointly monitor progress on plans.

CBHS and OAMHS will develop and implement training and support for case managers and clinicians in implementing effective transition planning, using TIP as the foundational approach to transition planning. Both parties agree to maximize existing and available resources to support individual needs, and to identify available funding and possible methods for integrating or enhancing funds related to individuals transitioning within the public mental health systems.

The policies and procedures developed under the MOU will be reviewed on a semi-annual basis by central office staff responsible for policy development and implementation, including the Directors of each Office. This review covers policies and procedures that in any way affect the system of care for transition age individuals. Data collected by each Office will be used to jointly evaluate the utility and benefit of the agreement by establishing performance measures to monitor the progress towards attainment of goals and to measure the level of progress.

Youth Transitioning from Foster Care

Children's Behavioral Health Services is one of several collaborators actively involved with Child Welfare Services to improve outcomes for youth leaving foster care, and to enhance opportunities to help these youth make a successful transition to adulthood.

Child Welfare Services has worked in collaboration with the University of Southern Maine, through the Jim Casey Youth Opportunities Initiative (JCYOI), and public and private partners on improving outcomes of youth transitioning from publicly funded foster care for the past 5 years.

This Collaborative, known as the Maine Youth Transition Collaborative (MYTC), with the help of JCYOI and The Finance Project, are identifying potential funding streams that could be used to assist youth in foster care to transition to adult life. This information will be used to prioritize youth transition services within the context of the following key goals: 1) Establishing permanent connections to family and other lifelong resources; 2) Ensuring economic stability- including education, employment, and housing; 3) Ensuring health and well-being.

With the knowledge and expertise of the working group, a broad range of resources are being categorized that will assist youth in accessing services and making informed choices as they prepare to leave the foster care system and improve their outcomes as adults. The entities helping to map out the options in a path to adulthood include staff from the Departments of Health and Human Services, Corrections, Labor, and Education. Other committed parties such as the Maine Youth Transition Collaborative, Common Sense Ventures, and Jobs join them for Maine Graduates.

As this initiative progresses the next steps will be to find local people, organizations or foundations that are "door openers" for these youth to find opportunities for independent living in Maine communities.

Additionally, as part of the Maine Youth Transition Collaborative, this public/private partnership, is also working on community engagement in York County. Implementing the network strategies of the Interactive Institute for Social Change, and in following the model of youth and adult partnership, Maine is focused on improving outcomes for youth transitioning from foster care in the areas of permanency, housing, education, and employment. Maine is looking this year to assist in similar network and community engagement efforts in Penobscot County as well.

Children's Behavioral Health Services and Child Welfare Services are also working in collaboration with the Office of Adult with Cognitive and Physical Disabilities (OACPD) to develop a protocol to assist in the smooth transition of young adults from the children's behavioral health system to the system-serving adults with intellectual and cognitive disabilities. Under this newly developed protocol, Child Welfare Services will continue to provide placement and other funding for youth on a Voluntary Extended Care Agreement, while they receive all case management services from OACPD.

Notably, Child Welfare Services and Children's Behavioral Health Services worked in collaboration with youth in care and formerly in care to revise the Child Welfare Youth Transition Assessment as well as the Child Welfare Youth Transition Policy, which includes an enhanced Voluntary Extended Support Agreement that will more fully address on-going transition planning with youth.

Intellectual Disabilities Services Transition

Strategies that were initiated prior to the merger of the two Departments included work with Children's Services and the former Adult Mental Retardation Services. 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. 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/OACPDS/DS/CommCaseManagement/CM_Manual/Eligibility.html

There will be a collaborative financial planning process when development of resources for children will affect the adult services system. Training in the adult mental retardation services has been delivered for all CBHS contracted case managers in all regions. Regional staff is meeting regularly to discuss planning efforts and ongoing collaboration. Finally, protocols for information sharing and resource development have been developed and agreed upon.

Wraparound Maine

Wraparound Maine is an initiative jointly funded through Child Welfare Services and Children's Behavioral Health Services that is operational in nine (9) sites in Maine. This state initiative focuses on school-aged children and youth with severe emotional disturbance who are involved with multiple child-serving agencies and are in residential treatment or at risk for residential placement. A statewide governing council and local collaborative boards consisting of child-serving agency representatives including personnel from the Office of Child & Family Services, Child Welfare Services, Children's Behavioral Health Services, the Department of Corrections, Juvenile Services, and Department of Education as well as local school systems and service providers oversee sites. Parents and youth who have experience with the wraparound process are valuable members of the governing council and they share equal status with the other membership.

The Children's Cabinet

The Children's Cabinet was established in 1995 to oversee and coordinate the delivery of services to children in Maine. The Children's Cabinet is composed of the Departments directly related to children and families: Corrections, Education, Health and Human Services, Public Safety, and Labor. The vision of the Children's Cabinet is that children's needs are best met within the context of relationships in the family and community.

The mission of the Children's Cabinet is to actively collaborate to create and promote coordinated policies and service delivery systems that support children, families and communities. The Children's Cabinet is chaired by the First Lady. In 2007, the Children's Cabinet selected 3 priorities that were Early Childhood Initiative; Adverse Children's Experiences (ACES) and Transition of children to other systems. In 2008, these priorities were expanded with greater definition and they work towards systems change. Initiatives include Early Childhood Systems and Supports, to sustain and enhance accomplishments in the juvenile justice system, to sustain and enhance permanency in Child Welfare, focus on children living in poverty or who are hungry, and a systemic approach to "Creating Safe, Fair, Healthy and Responsive Schools" training and supports.

The Children's Cabinet's approach includes a Shared Youth Vision Council for 18-24 year olds providing ongoing, cross-systems and stakeholder issues relating to youth in transition with a plan to replicate Trauma-Informed Systems of Care as an approach to Adverse Childhood Experiences.

Regional Cabinets, Communities for Children and Youth Coordinating Councils

In 1996, the administration created Regional Children's Cabinets, mirroring the composition of membership at the state level. Regional Children's Cabinets are the vehicle through which the initiatives from the Children's Cabinet flow, and are managed

and overseen at the local level. The Communities for Children and Youth (C4CY) is a statewide prevention and positive youth development initiative of the Governor's Children's Cabinet connecting 65 local communities throughout the State. This network also has strong ties with several local initiatives.

Keeping Maine's Children Connected

Keeping Maine's Children Connected (KMCC) is a program sponsored by the Maine Children's Cabinet in response to the rising incidence of school disruption. School disruption has reached alarming proportions not only in the State of Maine but also nationally, and is one of the major predictors of academic failure and school withdrawal. This program is an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement in-patient psychiatric care, and/or high mobility or combinations of the above.

The intent of the Keeping Maine's Children Connected is to simplify the process of transition to-and-from educational programs so that these students can stay connected or can re-connect to their education programs as soon as possible. Liaisons have been assigned statewide in regional state agency offices, juvenile corrections facilities, in-patient psychiatric facilities, residential treatment facility agencies and school districts. Children's Behavioral Health Services has been an active supporter of several "pilot" programs and members of a community training team with those programs. A very successful example is the Hospital to School Initiative model that has proven its value to children with serious emotional or behavioral needs and their families, and thus has since "graduated" from pilot status to become replicated in other areas of the state today.

KMCC received a planning grant from US Dept of Education to increase community capacity and coordination between school districts and mental health services. KMCC worked closely with CBHS on the implementation of the grant activities. For the first time in Maine, mobile crisis programs and the psychiatric hospital in Southern Maine are now tracking contacts with school districts. The initial data from the crisis programs showed a documented increase in the number of times crisis workers spoke with parents/guardians about coordinating with schools, and a marked increase in the number of contacts with schools. In regards to contact between schools and hospitals, data showed that hospital staff initially contacted schools 68% of the time, and data now shows that the number of contacts has risen to 81.5% of the time. As a result of the success of the pilot initiative, the tracking program will be expanded to mental health crisis programs statewide so school staff can more effectively support the mental health needs of their students.

Office of Adult Mental Health Services

OAMSH has long and successful history creating and managing a myriad of partnerships in pursuing recovery for persons with mental illness. These diverse partners enrich and inform the system of care by promoting an environment where ideas and best practices can be shared. These partners included sister state divisions and agencies, networks of consumers and family members, and provider agencies which include Community based mental health centers as well as primary and hospital care centers.

Examples of these collaborative partnerships include:

Through legislation, The Department of Health and Human Services consolidated Behavioral Health with the State Medicaid Agency. Combining these resources has enhanced both the sharing of information and ideas by and between Behavioral Health Program and Medicaid Policy.

A component of the OAMHS reorganization includes staffing for integrated services coordinator. An Adult Services Consortium was developed and memorandum of understanding executed for the sharing of information between Office of Adult Mental Health Services (OAMHS), Substance Abuse (OSA), Adult with Cognitive and Physical Disabilities (OACPDS) Office of Elder Services (OES) to address the needs of consumers that are complex and cut across multiply offices and services; and to provide a collaborative departmental wide approach to addresses these cases.

The Office of Adult Mental Health, Division of Community Forensic and Outreach Services is developing a memorandum of understanding with Department of Corrections, Adult Services, which, together, provide a continuum of services for those people who are qualified to receive services from both state agencies. DCFOS and DOC are committed to collaborative system approaches in an effort to individualize treatment/service plans for all adults, specifically joint assessment, planning, and implementation to target both mental health needs and criminogenic risk factors.
See DRAFT Document in Attachment Section titled: N. Support of State Partners_Adult MH MOU Dept. of Corrections and DHHS OAMHS.

Another long standing partnership exists between Maine State Housing Authority (MSHA) and OAMHS. We have formal data sharing agreements and meet regularly at both the program and executive level. OMAHS has influenced MSHA's Section 8 Administrative Plan by prioritizing persons on our Bridging Rental Assistance Program for Section 8 vouchers.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

IV: Narrative Plan

Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Monica Elwell	Individuals in Recovery (from Mental Illness and Addictions)	Common Ties/ MH/ PAIMI/CAG/AIN Bd of Directors	Newport, ME 04953	
Vickie McCarty	Individuals in Recovery (from Mental Illness and Addictions)	Common Ties/ MH/ PAIMI/CAG/AIN Bd of Directors	Bangor, ME 04401	
Karen Evans	Individuals in Recovery (from Mental Illness and Addictions)	Riverview QIC/Cemetery Proj/Cons Adv Bd/ PAIMI	Portland, ME 04101	
Sheldon Wheeler	Leading State Experts	DHHS/Office of Adutl Mentla Health Services	32 Blossom Lane, Marquardt Building Augusta, ME 04333 PH: 207-287-4243	
Cynthia McPherson	State Employees	DHHS/Office of Adult Mental Health Services	32 Blossom Lane, Marquardt Building Augusta, ME 04333 PH: 207-287-4243	
Steven Sherrets	State Employees	DHHS/Dept of Corrections	32 Blossom Ave, Marquardt Building Augusta, ME 04333 PH: 207-287-4243	
Ginger Robert - Scott	State Employees	DHHS/Division of MaineCare Policy	442 Civic Center Drive Augusta, ME 04333 PH: 207-287-4243	

Allison Trussell	State Employees	DHHS/Bureau of Rehabilitation Services	Augusta, ME 04333 PH: 207-287-4243
Kathy Tisdale	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Pittston, ME 04953
Virgina Jewell	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Canaan, ME
Margaret Carr	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Augusta, ME
Diane Bouffard	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Norridgewock, ME
Helen Jones	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Dover-Foxcroft, ME
Tonya Labbe	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Auburn, ME
Richard Ladd Sr.	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Barnard Twp, ME
Sherry Langway	Leading State Experts	DHHS/Office of Child & Family Services	State House Station #11 Augusta, ME 04333-0011 PH: 207-624-7910
Susan J. Parks	State Employees	Maine Dept of Education,Special Services	23 State House Sstation Augusta , ME 04333-0023 PH: 207-624-6646
Jennifer Oliver	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		South Bristol, ME 04568
Karen Glew	Leading State Experts	DHHS/Office of Continous Quality Improvement	State House Station #11 Augusta , ME 04333-0011 PH: 207-287-4210

Footnotes:

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IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	19	
Individuals in Recovery (from Mental Illness and Addictions)	3	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	8	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	11	57.89%
State Employees	5	
Providers	0	
Leading State Experts	3	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	8	42.11%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Office of Adult Mental Health Services

- OAMHS has reached out for public comment by posting the SAMHSA Block Grant on the Office of Adult Mental Health (OAMHS) home page: http://www.maine.gov/dhhs/mh/
  This link connects the public to the FY 2012-2013 SAMSHA Block Grant for review and opportunity to comment section.

- OAMHS has met with the QIC on three separate occasions to obtain their input and include their recommendation to the application. The Web site and link was also emailed to the QIC to share with other consumers and members.

- OAMHS sent letters out to State of Maine Tribal community directing them to the OAMHS home page and link to the Block Grant application and comment sections. We also invited the tribal community at their request to set up a meeting to discuss their recommendation and input.

- The QIC have reached out to the Maine Tribal community for their representation and membership on the QIC.

- OAMHS sent out an email to MH community providers requesting that this link and site be shared with providers, family, consumers etc.

P. Comment on the Plan

The Children's Committee of the Quality Improvement Council took an active role in the review of the Block Grant submission guidance beginning with the first release of the document.

The Children's committee dedicated several meeting to the review and development of the plan.

Children's Committee Recommendations for 2012/2013 Plan

This year the Children's Committee worked on standardizing the content of the Transformation Award proposals.

The Children's Committee discussed in detail recommendations for the award of block grant funds for new initiatives and for continuing support of funding for programs. The committee expressed a strong commitment to transformation in considering funding with block grant dollars, accountability for programs that have received block grant funds, and certainty that funding would be used for children with high emotional/ behavioral needs. The committee discussed some examples of transformational priorities such as new and innovative approaches to reaching these children and youth, family driven care, youth development and evidence-based practices.

On several occasion in July 2011 the Children's Committee met to review the four transformation initiatives seeking continuation of support or for a new initiative using FY12 Block Grant funding. As in the previous year, each applicant presented its accomplishments, progress and goals and measurable objectives for the coming year. The Children's Committee reviewed and voted to approve or disapprove the proposal. If a proposal was disapproved and opportunity was given to the applicant to meet with the committee and discuss the reasons why the proposal was rejected. An opportunity to revise and resubmit the proposal was given. Two proposals were rejected and revised to meet the requirements that the services be transformational in nature.

After committee discussion with each presenter, and specific suggestions for change, emphasis or addition, all three proposals were recommended for funding.

Memorandum of Understanding Between
Maine Department of Corrections, Division of Adult Services
And
Maine Department of Health and Human Services, Office of Adult Mental Health, Division of Community Forensic and Outreach Services

Statement of Purpose

This memorandum of understanding applies to the continued collaboration between the Maine Department of Corrections, Division of Adult Services and the Maine Department of Health and Human Services, Office of Adult Mental Health, Division of Community Forensic and Outreach Services which, together, provide a continuum of services for those people who are qualified to receive services from both state agencies.

It is the purpose of this memorandum of understanding to summarize and clarify the responsibilities of the Maine Department of Corrections, Division of Adult Services, herein referred to as "DOC," and Maine Department of Health and Human Services, Office of Adult Mental Health, Division of Community Forensic and Outreach Services, herein referred to as "DCFOS," to provide a clear framework for the continuum of service that affords safety, supervision, and clinically appropriate level of care in the least restrictive setting to the common population served.

Population of Concern

Adult or emancipated minor, with serious and persistent mental illness, related symptomotology and significant disability, that is disconnected from social services and supports, including Social Security and MaineCare, and who is homeless or incarcerated.

Authorities

The Office of Adult Mental Health is the lead authority responsible for the development and implementation of a system of care for adults with mental illness. DCFOS is a division within the Office of Adult Mental Health responsible for the provision of intensive case management services to adults with serious and persistent mental illness who are involved in the criminal justice system and/or experiencing chronic homelessness.

The Department of Corrections, Division of Adult Services is responsible for monitoring adults who are sentenced to correctional supervision by the State of Maine.

Operating Principles

The Departments jointly recognize that many adults in the criminal justice system have a combination of mental health and correctional needs and agree to work together to address these needs in a unified system of care including criminogenic risk reduction and mental health recovery.

DCFOS and DOC are committed to collaborative system approaches in an effort to individualize treatment/service plans for all adults, specifically joint assessment, planning, and implementation to target both mental health needs and criminogenic risk factors.

Research at the national and state level has identified a large percentage of adults in the criminal justice system with mental health needs. Adults in this system may not have had access to community mental health services for a variety of reasons and, in some cases, may have been confined to correctional facilities. The goal of this agreement is to assure that adults under the jurisdiction of the DOC who have a serious and persistent mental illness, related symptomotology, and significant disability are brought to the attention of DCFOS for consultation and support in case planning, and accessing appropriate services and resources.

Responsibilities

The Department of Corrections will provide space for DCFOS staff in each of the area offices and access to electronic and hardcopy records.

Division of Community Forensic and Outreach Services will provide a single identified contact for each DOC regional office and state correctional facility, screen referrals for program eligibility, provide consultation, and intensive case management services.

Department of Corrections and the Division of Community Forensic and Outreach
Services will jointly:

A. Screening Methods:

DOC and DCFOS staff will administer screening tools and use other procedures to identify mental health service needs as specifically agreed to by DCFOS and DOC.

B. Collaborative System of Care:

DOC and DCFOS will work collaboratively to review and enhance systems and resources to identify adults with mental health needs, provide appropriate mental health services across settings, increase functional status of adults, use existing services, reduce risk of recidivism, identify gaps and barriers, and develop services and resources to address gaps and barriers.

C. Outcome Measures:

DOC and DCFOS will collect data and jointly develop a method to evaluate the utility and benefit of this agreement. DOC and DCFOS will identify performance measures to monitor progress towards attainment of goals and develop a data collection system to measure the level of progress

Goals to be achieved by this agreement include:

1. Effective implementation of the agreement.
2. Identification of adults with mental health needs.
3. Provision of appropriate mental health services across settings.
4. Assessment of systemic needs.
5. Increased functional status of adults in recovery.
6. Maximum utilization of appropriate existing services and resources.
7. Reduction of the risk factors for recidivism.
8. Identification of service gaps.
9. Development of services and resources to address gaps.
10. Appropriate use of funding.

D. Training and Education:

DCFOS and DOC will jointly develop and implement appropriate cross-training curricula for staff of the two Departments in an annual training plan. Cross training will include but not be limited to: procedures, and impact of release from incarceration and mental illness. The parties will communicate about training needs and provide trainings in a timely manner.

DOC will provide DCFOS staff stationed in the correctional facilities all American Corrections Association (ACA) trainings required to keep DCFOS staff and DOC facilities in compliance with ACA Accreditation.

DCFOS and DOC will work together to develop and deliver trainings as needed for community partners and others as identified in the annual training plan.

All trainings will be consistent with training requirements of DOC and DCFOS.

DOC will provide space, telecommunications, information technology, and support to DCFOS staff as necessary.

E. Exchange of Information and Confidentiality:

DOC and DCFOS will hold confidential all personal data or information accessed by either agency in accordance with applicable state and federal laws, and regulations.

Memorandum Management Process

Every reasonable effort shall be made by the parties to resolve conflicts at the regional level. In the event that the parties are not able to reach a resolution through regional staff within a reasonable period of time (not to exceed ten (10) business days) of both parties having had the opportunity to address a conflict, the parties have an obligation to present the dispute to the Associate Commissioner for Corrections Adult Services and the Director of DCFOS or their designee(s) for resolution within a reasonable period of time no later than seven (7) business days from the date of presentation of the issue.

Monitoring and Evaluation

On a quarterly basis, DOC and DCFOS regional staff will bring cases to review at a statewide meeting and document the reviews. The purpose of this case review will be to process and learn about the effectiveness of the system and service provision.

This agreement will be carried out under the direction of a Monitoring Committee that will consist of the Associate Commissioner of Adult Services, the Director of DCFOS, and others as needed. The Monitoring Committee shall meet on a quarterly basis to ensure that the terms of the agreement are being met. The committee shall also review data collection and cases that have a statewide impact.

Effective Date

This agreement will be n effect as of and will continue unless terminated earlier by either party. This agreement may be amended at the request of either party and by mutual agreement of both parties

signatures

Maine Centers for Disease Control and Prevention

Department of Health and Human Services Maine

Injury Prevention Program

DRAFT

Plan for the Prevention of Suicide Among Adults in Maine

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 215 of 398

Draft Adult Suicide Prevention Plan Maine

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

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Introduction

Suicide is the tenth leading cause of death among Maine citizens, and the leading cause of violent death. From 2004 to 2008, an average of 160 people died by suicide every year in Maine, and this number seems to be increasing. Eight times more than Mainers die by suicide than by homicide. Suicide and suicidal behaviors occur across all age groups, ethnic backgrounds, and socioeconomic groups. The financial cost of suicide and suicidal behaviors from medical care and lost productivity is in the millions of dollars every year. The emotional cost to family, friends, and communities is incalculable.

All too often, suicide is surrounded by silence: silence from the suffering person contemplating suicide, and silence from the larger community whose members do not know how to recognize and respond. The perception that suicide is a *private* tragedy about which nothing can be done hinders public awareness of warning signs, and inhibits coordination among state agencies, service systems, and treatment providers to identify and treat people at risk of suicide. Stigma and fear of discrimination surrounding suicide create reluctance to confront suicide openly; stigma can be so strong that it can keep people from seeking help.

> "Suicide gets whispered about more than it gets talked about. I think that's why so many people are still dying from it. In 2006 there were 33,300 reported suicides [in the United States]. We have to address this epidemic out in the open, without shame. That's why I'm sharing my story. I'm doing it for you, Dad."
>
> Michelle Ray Smith, whose father died by suicide on September 29, 2003

The good news is that when suicide is approached as a *public* health problem, suicides can be prevented. Nationally, innovative programs and rigorous research are beginning to demonstrate that suicide rates can be reduced. In Maine, the nationally recognized Maine Youth Suicide Prevention Program (MYSPP) is beginning to see a reduction in suicidal behaviors among Maine youth.

The goal of this Plan is to reduce the suicide rate for adults in Maine ten percent by 2020 – the same target set by *Healthy People 2020*[1] – by engaging Maine's citizens and governmental entities in proven public health suicide prevention strategies. The Plan establishes priorities for action over a five year period, recognizing that prevention strategies will need to be expanded into other areas in future years. It seeks to build on existing networks of services where suicide prevention is most likely to have the biggest initial impact.

A Public Health Approach To A Public Health Problem

Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. The central mission of public health programs is to improve the health of our communities. Suicide, a leading cause of premature death, is antithetical to this mission.

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Although researchers have identified risk factors for suicide, trying to prevent suicide solely by targeting people at risk is not as effective as using a broad-based public health approach. A useful analogy is to seatbelt use. Most people who drive are never going to be in a potentially fatal auto
accident, but to achieve the health benefits of seatbelts, everyone must wear them.

Research from the suicide prevention program undertaken by the Air Force in the 1990s greatly influenced our understanding of how a public health program can prevent suicide. The Air Force program made suicide prevention the responsibility of everyone, implementing a multidimensional approach that included: leadership responsibility at every level of the organization; education of all Air Force personnel; accessible prevention and crisis services in the community; integrated treatment services; commanders tasked as "gatekeepers" with responsibility for referring personnel to needed services; and risk assessment in every Air Force unit. Over a four year period, deaths by suicide decreased by 33 percent. Significant changes in other indicators of community health were realized as well: severe family violence decreased by 54 percent, homicides by 51 percent, and unintentional injury deaths by 18 percent.[2]

The federal suicide prevention initiative began in 1999 with the *Surgeon General's Call to Action to Prevent Suicide,*[3] and further developed in 2001 with the *National Strategy for Suicide Prevention*.[4] Subsequently, forty-eight states implemented public health suicide prevention programs. The *National Strategy* currently is under revision to further guide effective suicide prevention across the nation.

Maine's Public Health Approach to Youth Suicide

Maine became a leader in youth suicide prevention even before the federal initiatives. In 1995, in response to an increase in Maine's adolescent suicide rate, Governor Angus King created a Task Force to study the problem and recommend action. An extensive planning process led to the creation in 1998 of the Maine Youth Suicide Prevention Program (MYSPP), which continues to be coordinated by the Injury Prevention Program of the Maine Center for Disease Control and Prevention, Department of Health and Human Services. Other state agencies that serve families, including the Departments of Education, Labor, Corrections and Public Safety, conduct youth suicide prevention activities. This work was furthered in 2005 when Governor Baldacci issued an Executive Order directing Children's Cabinet agencies to strengthen the MYSPP. Among other efforts, this resulted in a strategic planning process to bring Maine's plan into alignment with federal recommendations for action.

The MYSPP has been nationally recognized for its work, winning numerous awards. It has secured competitive federal grant awards from the National Center for Disease Control and the Substance Abuse and Mental Health Services Administration that have supported youth suicide prevention projects in over thirty Maine communities. MYSPP activities are supported currently with state and federal Maternal and Child Health and federal Preventive

Health grant funds. Other state agencies contributing to MYSPP activities use various sources of support. Core activities include a statewide Information Resource Center, statewide crisis hotline, a website with extensive resources, materials development, professional training, public awareness education, prevention and intervention protocols for schools, and school-based Lifelines Program. Detailed information about the MYSPP is in Appendix C.

> "A benign community ought routinely to provide immediate postventive mental health care for the survivor – victims of suicidal deaths."
> Edwin Shneidman

Although the evaluative work necessary to establish a definitive causal connection between MYSPP efforts and youth suicide behavior would be prohibitively costly, statistics suggest that the MYSPP seems to be having an impact. The number of suicides among Maine youth fluctuates annually, but the suicide rate appears to be declining slightly. The Maine Youth Risk Behavioral Survey shows a reduction in suicidal behaviors between 2001 and 2007. (The uptick in 2009 in students considering and attempting suicide is troubling, and underscores the importance of sustaining efforts to prevent suicide.)

Maine Youth Risk Behavior Survey Results			
Year	Considered Suicide	Planned Suicide	Attempted Suicide
2001	18.6%	16.5%	9.2%
2007	9.2%	12.9%	4.8%
2009	13.8%	11.8%	9%

A Public Health Network for Suicide Prevention Across the Life Span

Multiple state and local, public and private, organizations exist in Maine that are ideal for implementing adult suicide prevention activities. These organizations offer the opportunity to reach tens of thousands of Maine citizens through existing communication networks. Under the leadership of the MYSPP, many of these organizations work together now on suicide prevention for youth,

The MYSPP has an Advisory Council that provides guidance and feedback to the MYSPP, identifies opportunities to collaborate among member agencies and groups, and actively promotes and advances the work of MYSPP. Those involved in the MYSPP also connect with other organizations through mutual participation on boards and committees, and by providing training and technical assistance to a wide variety of public and private organizations. A partial list of groups with whom MYSPP works includes: schools and universities; state agencies that serve children and families; media organizations; police and sheriff departments; primary care physicians and mental health practitioners; Native American tribes; child welfare agencies; sexual minority youth; and the Veteran's Administration. As a result, an infrastructure is in place today to begin suicide prevention for adults.

Many of these organizations recognize the need for suicide prevention programs for adults. In 2010, a needs assessment conducted by the Division of Family Health of the Maine CDC identified suicide prevention as a priority.[5] Reducing the suicide rate for youth *and* adults is a goal of *Healthy Maine 2020*.[6] **[CHERYL: the 2020 Healthy Maine goals and objectives have been removed from the internet. What's the status of Healthy Maine 2020? If unpublished, the above sentence should be deleted. Need a cite for the needs assessment in the second sentence– put in endnote 5. If no cite, delete endnote 5.]**

The challenge is this: no organization now has a comprehensive program for adult suicide prevention. Rather, efforts are ad hoc and uncoordinated, dependent on the interests and expertise of interested individuals. The Maine CDC Injury Prevention Program, which administers the MYSPP, has identified the need to collaborate with organizations that have an interest in preventing suicide among adults. This Plan seeks to guide prevention efforts focused on preventing suicide among adults that builds on the work of the MYSPP and its partner organizations.

Planning Process

The impetus for extending suicide prevention from youth to the entire age span is a recent increase in the suicide rate among middle-age adults, creating awareness that the rate of people dying by suicide in Maine will likely increase as Maine's population ages. Because suicide affects everyone, personally or through its financial cost; and because some people in every societal grouping will think about, attempt, or die by suicide; the planning process was designed to consider adult suicide prevention as broadly as possible, and then to establish initial priorities.

Staff in the Injury Prevention Program first recruited a Steering Committee to guide the planning process. Steering Committee members exchanged information about their experiences with suicide among the adults served by their organizations and about opportunities for implementing prevention strategies into their current work. Additional information was gathered from four sources:

- Data on suicidal behavior and deaths in Maine;
- Literature reviews of published studies on suicide deaths and effective prevention programs;
- Interviews with leaders in Maine organizations essential to suicide prevention, with survivors of suicide, and with clinicians who provide treatment; and
- Review of information posted on national suicide prevention internet sites, and of the suicide prevention plans of the other forty-nine states.

This information was reviewed by the Steering Committee, which then guided development of the Plan's focus and strategies. Certain guiding principles – based on research, effective prevention practices, and experience – further shaped the strategies. (The guiding principles are

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listed on page 17.) The final step was Steering Committee and DHHS review of strategies, objectives, and recommended activities.

Plan Priorities

During the planning process, Steering Committee members worked to articulate a vision for suicide prevention across the life span in Maine. The overarching vision was a declining suicide rate and the improvement of mental health among all Maine citizens. Other elements were development of an integrated and accessible system capable of effective and appropriate screening, assessment, and intervention for people at risk of suicide; many people, such as educators and medical, mental health, public safety, emergency service providers, trained to recognize and respond effectively to suicidal behaviors; enhanced evaluation and research capabilities to inform program development; and a staffed and funded Office of Suicide Prevention with many state and local partners.

As work proceeded, the Steering Committee and Injury Prevention Program began to narrow the focus to what could be achieved during a five year period. The overall vision stayed the same: a reduction in the suicide rate in Maine. This became the Plan's goal. Priorities were recommended that met four criteria: they can be implemented through existing networks of DHHS offices and partner agencies; they reflect the research on effective prevention programs; there is at least some direct experience in Maine that the strategies are effective; and they are economically feasible. These priorities are reflected in the Plan's Strategic Directions. The Steering Committee and Injury Prevention Program staff considered other approaches as well, such as working with faith communities and in work places and correctional facilities. After careful consideration, the decision was made that an initial five-year plan attempting to implement suicide prevention in all settings where adults gather was overly ambitious. Future plans should, however, extend adult prevention programs into other arenas.

Role of the Maine Injury Prevention Program, Maine CDC

The MYSPP, administered by the Injury Prevention Program, targets ten to twenty-four year olds, and has primarily focused its efforts on middle and high school aged youth. This plan targets post-secondary youth, middle age adults, and older adults. The Maine CDC intends to integrate the two plans, creating a comprehensive public health approach to suicide prevention across the life span. The Injury Protection Program will:

- Staff the combined suicide prevention programs;
- Provide leadership and collaborate with organizations, professionals, schools, families, and individuals;
- Link partner organizations to prevention information, education, and evidence-based resources;
- Provide training and implementation assistance to integrate effective suicide prevention strategies into the work of partner organizations;
- Promote public awareness of suicide and its prevention; and

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- Obtain and interpret data to monitor suicide rates and the effectiveness of Plan strategies.

The Cost of Suicide

Suicide deaths have immediate and long-term financial, emotional, and social consequences. The cost 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, twenty-five to one hundred others attempted suicide.[7] The single best predictor for dying by suicide is a previous attempt at suicide. Prevention programs aim to reduce costs by identifying and helping people at risk of suicide, 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 of these costs are known: for example, the costs of emergency room visits and
hospitalizations for self-inflicted injuries; others are hidden: for example, the cost of police officers who investigate suicide deaths. The available economic data are startling, but they underestimate the true cost of suicide deaths and attempts.

Direct and Indirect Economic Costs

- The annual medical cost of deaths by suicide in Maine averages $560,000 (in 2004 dollars).[8]

- The annual medical cost of suicide attempts requiring hospitalization in Maine averages
  $8,400,000 (in 2005 dollars). [9]

- The annual lost productivity cost for deaths by suicide in Maine averages $175,160,000 (in 2004 dollars).[10]

- The annual lost productivity cost for suicide attempts requiring hospitalization in Maine averages $7,833,000 (in 2005 dollars).[11]

Emotional and Social Costs

As with financial cost, the emotional burden of suicide spreads through the layers of our communities, as families, friends, teachers, employers and co-workers, health care professionals, and public safety officials question what they might have done differently. The most immediate and severe burden, of course, is experienced by family and friends. A conservative

estimate is that there are six survivors for every person who dies by suicide;[12] thus in Maine, almost one thousand citizens
become survivors of suicide every year.

> "The person who . . . [dies by] suicide puts his psychological skeleton in the survivor's emotional closet."
> Edwin Shneidman

The death of a loved one by suicide is itself a risk factor for suicide. Survivors (family members and friends of those who died by suicide) frequently report difficult problems and challenges
following the death of a loved one. These include:[13]

- 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 that loved Joe so much."
> Cheryl Morin

Suicide and Suicidal Behavior

The suicide rate in Maine – 15.00 per 100,000 people – is higher than the national rate of 12.86, and the second highest in New England. This is most likely a reflection of Maine's demographic composition. Suicide rates vary by age, ethnicity, and gender, and are highest among older, white males.[14] According to census data, Maine has the highest percentage of white non-Hispanic people

One Year in Maine (2007) . . .

191 people died by suicide

1,094 people were hospitalized and another 1,911 people were treated in the emergency department for self-inflicted injury

6,700 high school youth and 27,000 adults reported considering suicide

in the country, and the most rapidly aging population.[15]

Historically, the number of people who die by suicide in Maine has been fairly steady. Recently, however, there has been an increase in the number of deaths, from an average of 166 per year from 2003 to 2007, to 186 deaths in 2008 and 187 deaths in 2009.[16] **[CHERYL: FTN 16 IS FROM ERIKA LICHTERS PRESENTATION AT THE JUNE SYMPOSIUM. I CAN'T FIND HER PRESENTATION ON YOUR WEBSITE. THIS DATA IS IMPORTANT. COULD YOU POST IT SO WE CAN FOOTNOTE IT?]** Although it is too soon to know whether this increase will become a trend upwards in the suicide rate, it is cause for concern.

Suicide as Cause of Death

An average of 170 people die by suicide each year in Maine. Suicide is the leading cause of violent death,[17] killing eight times as many people each year as homicide. For all ages, suicide is the tenth leading cause of death. Suicide, however, is the second leading cause of death for youth and adults age 15-34, the fourth leading cause of death for adults age 35-54, and the eighth leading cause of death for adults age 55-64. Suicide is not among the top ten causes for adults age 65 and older.

The highest suicide rate is among adults age 85 and older. The greatest number of deaths, however, is among adults ages 45-54, followed by adults age 35-44.

Suicide Deaths in Maine 2003-2007[18]			
Age	Number	Rate per 100K	% of Total Suicide Deaths
10-14	2	0.47	0.24
15-24	100	11.88	12.01
25-34	108	14.40	12.98
35-44	150	15.21	18.02
45-54	187	17.49	22.47
55-64	133	16.76	15.98
65-74	75	15.40	9.01
75-84	47	13.95	5.64
85+	30	22.72	3.60
Total	**832**	**14.29**	

Eighty percent of people who died by suicide are male; rates are highest among men over age 65 years. Among women, the highest suicide rates are those 35 to 64 years of age. There have not been significant changes in suicide rates by gender over time. The best single explanation for the higher suicide rate for men is that twice as many men as women use firearms as the means of death.

Suicidal Behavior as Cause of Injury

Some suicidal behavior that does not result in death comes to the attention of health care professionals, but much does not. Experts estimate that for every death by suicide, another 25 to100 people attempt suicide.[19] Maine survey data confirms that a significant number of youth and adults consider suicide every year. During 2006-2007, three percent of Maine adults surveyed reported thinking about, planning, or attempting suicide in a twelve-month period.[20] During 2009 among high school students, 13.8% reported thinking about suicide, 11.8% planned their suicide, and 9% reported attempting suicide.[21]

The average number of hospitalizations in Maine for self-inflicted injury is 1,075 per year. The rate of hospitalizations per 10,000 population remained fairly steady from 2000 to 2006, from a rate of 8.3 in 2000 to a rate of 10.0 in 2008. Outpatient visits to hospital emergency departments for self-inflicted injury, however, increased significantly from 2000 to 2008. The actual number of emergency department visits more than doubled during that time, and the rate of visits rose from 6.8 in 2000 to 18.0 in 2008 (per 10,000 population).

Youth and young adults between ages 15 and 34 have the highest rates of hospitalization and emergency department visits. The rates of both hospitalizations and emergency department visits decrease sharply after age 44.

Hospital Care for Self-Injury in Maine, 2008[22]

Age Group	Hospitalization Rate/10,000	Outpatient Rate/10,000
10-14	4.8	10.5
15-19	18.0	57.0
20-24	17.1	46.6
25-34	13.5	28.0
34-64	9.5	9.1
65+	2.2	0.6

While men are four times more likely to die from suicide, women are three times more likely to attempt suicide.[23] Women also are more likely to be hospitalized for self-injurious behavior.

Hospital Care for Self-Injury by Gender in Maine, 2008[24]

Gender	Hospitalization Rate/10,000	Outpatient Rate/10,000
Female	12.2	20.5
Male	7.7	15.3

Means and Location of Suicide and Self-Injury

Firearms are the most common method of suicide across all age groups, and account for more than half of all suicide in Maine. From 2002 to 2006, a firearm was used in 60 percent of male
suicides and 29 percent of female suicides. Because men die by suicide at a higher rate that women, the result is a firearm suicide death rate that is ten times higher for males than females.

Poisoning and suffocation (hanging) are the next most common causes, each accounting for about 19 percent of all suicides. Suffocation is more prevalent among younger people and among males, while poisoning is more prevalent among older people and among females.

Methods for self-inflicted injury requiring hospital care are those that are less likely to result in death. The most prevalent self-injury method is poisoning, followed by cutting and other forms of self-injury. This is true for both men and women.

Maine does not yet compile statistics on the location of suicide deaths, but federal data[25] indicate that almost all suicides occur at home or in public places (88.7%). Very few people die in supervised settings such as schools or colleges, jails, hospitals, or health care facilities (2.7%). Data from the Maine Violent Death Reporting System,[26] **[CHERYL: NEED CITE. IF CITE NOT AVAILABLE DELETE FOOTNOTE BUT NOT DATA]** a pilot program of the MYSPP that reviews deaths for youth between the ages of 10 to 24, align with the 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."[27] Suicide is the result of many complex factors, with new research indicating that suicide requires mental preparation for a person to become capable of taking his or her life.[28] Although suicide or suicide attempts may seem impulsive, when individuals are examined more closely they generally have a vulnerability toward suicide, including active suicidal thoughts for some time before an attempt or death by suicide.

Researchers have focused on identifying risk and protective factors, but even this poses a paradox: for example, most people who die by suicide have a mood disorder such as depres-

sion, 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.[29] Risk factors, examples of which are listed below, can be divided into various domains:[30]

- Biological: age, gender, ethnicity.;
- Psychiatric: mood disorders, drug or alcohol use, suicide attempts, etc;
- Psychological: hopelessness, lack of coping skills, impulsivity, etc;
- Medical: chronic physical illnesses such as HIV/AIDS, Huntingtons, central nervous system diseases; renal disease, malignant neoplasms, multiple sclerosis; recent release from inpatient psychiatric care, etc.;
- Social: financial or relationship loss, social isolation, family history of suicide, history of trauma or abuse, legal problems, easy access to lethal means, barriers to accessing health care, exposure to suicide through media or the influence of others, etc.

It is important to note that 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; simultaneously, knowing who is most at risk helps to identify the most effective interventions.

> "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."
>
> Sandy Fisher

Groups at Increased Risk of Suicide

The greatest risk of suicide is posed by people who have made a **previous suicide attempt**. Between 12 and 30 percent of people who have made an attempt will make subsequent attempts within a year.[31] A similar but lesser risk is thinking about or planning suicide.

Ninety percent of people who die by suicide have **depression** or **other diagnosed mental illnesses**.[32] Suicide is the leading cause of early mortality among people who have schizophrenia.[33]
Depression and other mood disorders (including anxiety) are, however, the most common diagnoses. Research indicates that between 60 and 85 percent of people who die by suicide suffer from depression.[34] In study after study, 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 robust 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, demographic groups, and social positions. Almost 21 million adults – 9.5% of the population over age 18 – have a mood disorder, often co-occurring with anxiety and substance abuse. Depression is appearing at earlier ages than in the past, with an average onset at age fourteen.[35] 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.[36] One study estimated that if major depressive episodes were effectively treated in older adults, the suicide rate would decrease 75 percent in this group. [37]

Most people across the spectrum of suicide behaviors do not receive treatment for either mental illness or substance abuse. Currently, crisis centers and mental health resources miss most people who need help.[38] Eighty percent of adults with a diagnosable mental illness who died by suicide were untreated at the time of their death (the figure is 90% for youth).[39] 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.[40]

Substance abuse increases the risk of suicide for adolescents, young adults, and middle-age adults.[41] Alcohol, the most common substance used, facilitates suicide attempts. At least one third of people who die by suicide have an alcohol use disorder;[42] 25 percent of people were intoxicated at the time of their suicide.[43] 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.[44]

The suicide rate is highest among **older adults**, with a rate of 25 per 100,000 deaths among adults age 85 and older. Again, mental illness is a significant factor for older adults. Between 71 and 95 percent of adults age 65 and older who die by suicide have a mental illness, primarily a mood disorder (54-85%).[45] There is also added risk for suicide from most chronic physical illnesses.[46] Although most older adults seen in primary care practices who subsequently died by suicide brought physical complaints to their physicians, it was actually mental health factors that were associated with their deaths.[47]

People living in rural areas may have a greater risk of suicide. The 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.[48] 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.[49]

Race and ethnicity also contribute to suicide risk. In Maine, the highest rates of sui-

cide deaths are among white, non-Hispanic males. Nationally, American Indians and Native Alaskans have the second highest suicide rate.[50] Suicide statistics related to American Indians are considered to be unreliable because of either small population size or the small number of reported suicide deaths. Suicide is, however, the leading cause of death among American Indians and Alaskan Natives between ages 15 and 24.[51]

A recent report from the Department of Defense 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.[52] The Veterans Administration estimates that as many as 5,000 **veterans** die by suicide every year.[53] 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.[54]

> "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 would shame. There is no shame."
>
> Sandy Fisher

Lesbian Gay Bi-Sexual Transgender (LGBT) status has been considered a risk factor in the past, principally because of the increased presence of depression in this group. This may be changing. Younger LGBT adults have a lower incidence of depression than older LGBT adults,[55] although studies have found that LGBT youth have a higher rate of suicide attempts than others in their age group.[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]

<u>Warning Signs and Triggering Events: Knowing When to Intervene</u>

Knowing who is at risk of suicide increases the possibility of obtaining help before an individual is in crisis. Because most people in at-risk groups, however, will not attempt suicide, knowing what may precipitate suicidal behavior and the warning signs that often precede a suicide attempt are an important part of prevention.

Triggering events are those that lead to humiliation, shame or despair. The event includes real or anticipated loss of relationships, a change in financial status, or a change in health status.[58]

Warning signs are the earliest observable signs that indicate a person is at risk of suicide in the near term: minutes, hours, or days.59 The overt and acute signs of a suicidal crisis requiring immediate intervention are:

- Threatening to hurt or kill one's self;
- Seeking the means to kill one's self, such as a gun, rope, or pills; or
- Talking or writing about death, dying, or suicide.

A second set of warning signs indicate the need for a prompt mental health assessment, but not necessarily emergency intervention. These are:

- Dramatic changes in mood;
- Excessive or increased alcohol or drug use;
- Withdrawal from friends, family, or society;
- Anxiety or agitation;
- Dramatic changes in sleep patterns;
- Reckless behavior;
- Feelings of hopelessness, rage, being trapped, or loss of sense of purpose in life.

There are almost always warning signs when a person is thinking about or planning suicide. Effective suicide prevention programs address the recognition of risk factors and responding to triggering events and warning signs in helpful ways.

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 plans are multidimensional, using a variety of proven or promising strategies. 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.

Three types of programs have strong evidence of effectiveness from more than one study.[60] They are screening and treatment for depression in primary care practices, Gatekeeper education, and restriction of highly lethal methods of suicide. All three of these programs are included in this Plan's prevention strategies. Promising programs range from inexpensive follow-up methods 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 psychothe-

rapies.[61] This Plan also includes follow-up methods in a variety of settings. Increased access to mental health treatment, other than that integrated into primary medical care, needs to be considered in future Plans.

Integrating Suicide Prevention into Primary Health Care Settings

Primary care health providers are in a unique position to assess suicidality in their patients.[62] It is a patient-centered medical home that already uses a chronic disease management model, suitable for assessing for depression and the more than twenty-five other medical 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 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.[63] People who have 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.[64] The numbers are even more striking for older adults, who infrequently use mental health services. For older adults who died by suicide, 20 percent visited a physician within 24 hours of their death, 41 percent within one week, and 75 percent within one month.[65]

The greatest need perceived by people experiencing suicidal thoughts is for therapy or counseling.[66] 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.[67]

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.[68] 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.[69] 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.[70]

An example is the PROSPECT (Prevention of Suicide in Primary Care Elderly) pro-

gram,[71] which focused on primary care patients 60 years and older who were diagnosed with major or minor depression. Trained case managers helped physicians recognize depression, made treatment recommendations and offered psychotherapy, monitored 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.

Gatekeeper Programs

Gatekeepers "open the gates" to help for people at risk of 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 referral for help. 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 thinking about suicide.

An evaluation of Maine's Gatekeeper program implemented in public schools – a one day program that includes skills practice – was conducted in 2001-2002 and showed significant increases in respondents' knowledge of warning signs and risks factors as well as comfort in their ability to intervene. Respondents maintained the effects at six months. To date, over five thousand Gatekeepers have been trained in Maine, and qualitative data indicate that students who are thinking about suicide are being identified earlier, before the crisis point has been reached. Most training participants reported that they had received little or no prior coursework in suicide prevention.

Similar to Maine, most studies of Gatekeeper training programs have focused on high school and college age youth. These studies demonstrate that Gatekeeper training successfully increases participants' knowledge, changes attitudes about suicide, and develops intervention skills. Programs also demonstrate some evidence of a reduction in the rate of suicidal behaviors.[72] 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.[73]

There are different models of Gatekeeper training; programs that do not include skill training have been less 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.[74] Gatekeeper programs may be ineffective if there are inadequate services to treat people thinking about suicide, or if Gatekeepers are unaware of where and how to refer.

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.[75] Some of the 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.[76] 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.

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.[77]

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.[78] 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.[79] 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 also increases the effectiveness of crisis telephone lines. Crisis lines are used by seriously 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. [80]

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.[81] 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: emotional literacy, problem solving, crisis management, and 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.

An Example of a Prevention Program Using Multiple Approaches[82]

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.

From 1984 to 2005, two thousand 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 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.

Maine Plan for Suicide Prevention

This Plan sets a ten year goal, establishes priority strategies for the next five years, identifies interim benchmarks to evaluate progress, recommends actions at state and local levels, and identifies next steps that should be considered in future plans.

Some recommended actions are intended for state and local government agencies, some for collaboration with organizations representing people at risk of suicide and suicide survivors, and some are intended for the participation of all citizens interested in suicide prevention. During our lifetimes almost all of us will know someone who has died by suicide, so all of us need to be part of the solution.

Goal

Draft Adult Suicide Prevention Plan Maine

To prevent suicides and attempted suicides among Maine residents at risk using public health methods that implement effective programs and practices through collaboration with state and local organizations.

Baseline: Maine suicide rate of 15.0 per 100,000 population (average from 2004-2008)
Target: Ten percent reduction, to a suicide rate of 13.5 per 100,000 population in 2020.

Guiding Principles

- Suicide affects 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.
- Using existing information-sharing networks saves resources and reaches more people. Existing partnerships are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.
- Expectations are realistic. State and local leaders are encouraged to implement activities that match available resources. Small efforts are worthwhile.
- Using existing information-sharing networks saves resources and reaches more people. Existing partnerships are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.

"As it says on our t-shirt this year, A single suicide in our community is one suicide too many."
Sandy Fisher

Methods

- Research indicates that prevention activities must be sustained over time, so the Plan recommends strong state leadership and partnerships with local government and community organizations.
- The plan builds on Maine Youth Suicide Prevention Program activities, knowledge, resources, and partnerships, especially its connections within the Maine Center for Disease Control and the Maine Department of Health and Human Services.
- Resources are maximized by integrating suicide prevention activities into state and local programs and organizations dedicated to improving the health of Maine's people.
- People in groups at high risk for suicide are identified within prevention activities.
- Prevention activities are evidence-based or follow promising practices. Priority is given to activities with the greatest evidence of success:
    - Integration of suicide prevention into primary health care

  - Gatekeeper-style programs
  - Suicide hotlines
  - 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.

Implementing Agencies

State Agencies, especially the Department of Health and Human Services:

Center for Disease Control and Prevention:
Maine Injury Prevention Program
Office of Local Public Health, and Office of Rural Health and Primary Care
Public Health District Offices
Office of Adult Mental Health Services
Office of Consumer Affairs
Office of Substance Abuse
Office of Elder Affairs
Adult Protective Services

Partner Organizations

Area Agencies on Aging
Association of Family Practice Physicians
Association of Osteopathic Physicians
Catholic Archdiocese of Maine
Consumer Affairs Council
Episcopal Diocese of Maine
Equality Maine
Federally-Qualified Community Health Centers
Healthy Maine Partnerships Maine
Adult Protective Services Maine
Association of Social Workers
Maine Association of Substance Abuse Programs
Maine Chiefs of Police Association Maine
Coalition Against Sexual Assault Maine
Coalition to End Domestic Violence Maine
Council of Churches
Maine Criminal Justice Academy
Maine Department of Corrections
Maine Department of Education
Maine Domestic Violence Review Panel
Maine Emergency Management

Maine Emergency Medical Services
Maine Funeral Director's 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 Minority Health Office
Maine National Guard
Maine Nurse Practitioner Association
Maine Osteopathic Association
Maine Primary Care Association
Maine Psychiatric Association
Maine Quality Counts
Maine Sheriffs Association
Maine State Police
Maine Veterans' Administration Suicide Prevention Program
Medical Examiner's Office
Mental Health Association of Maine
National Alliance on Mental Illness/Maine
Office of the Attorney General
Office of Elderly Services
Office of Substance Abuse
Pathways to Excellence
Peer Support Programs
Penobscot Suicide Prevention Coalition
Physicians for Social Responsibility
Wabanaki Mental Health

Strategic Direction #1

Build a Statewide Structure to Support and Sustain Suicide Prevention

Purpose

Build a structure of state and local organizations to coordinate and maximize resources, to increase knowledge of suicide prevention, and to facilitate integration of suicide prevention into existing health programs.

Opportunities and Barriers

A relatively small amount of stable funding has enabled the Maine Youth Suicide Prevention Program to provide training, education, data, and links to resources. Similar funding will need to be found for staff to coordinate implementation of this Plan.

Development of a network of individuals and organizations interested in adult suicide prevention was begun during the planning process. Network participants have agreed to disseminate suicide prevention information through their information-sharing mechanisms, such as state-wide email lists and web sites.

Training opportunities into which adult suicide prevention programs can be integrated already exist in key state and local agencies. Some agencies already have agreed to incorporate adult suicide prevention programs into their staff training classes.

Suicide by adults is not yet widely understood to be a public health problem requiring public health solutions.

Objectives

Objective 1: Build a state-level sustainable coalition of people committed to suicide prevention.

Objective 2: Identify, develop, and coordinate existing resources to be used for suicide prevention.

Objective 3: Publicize suicide prevention programs that use best practices methodology and monitor their implementation.

Objective 4: Improve understanding of suicidal behaviors among Maine residents.

Objective 5: Promote and support research on suicide and suicide prevention.

Benchmarks

1. A state-level coordinating body broadly representative of state and local agencies, groups representing at-risk individuals, clinicians and service providers, and survivors of suicide. To be achieved by the end of Plan Year 1.

2. Clearly delegated shared responsibility for oversight of implementation and evaluation. To be achieved by the end of Plan Year 1.

3. Documentation of existing resources dedicated to suicide prevention and development of new resources as needed. To be achieved by the end of Plan Year 2.

4. State-level staff tasked to coordinate Plan implementation. To be achieved by the end

of Plan Year 2.

STATE: Recommended Actions

Form a state-level partnership of Maine CDC and DHHS offices, Veterans organizations, professional and community organizations, groups representing at-risk persons, and survivors of suicide to coordinate implementation of activities and dissemination of information through their networks.

Identify resources within partnership organizations that can be used for suicide prevention activities.

Develop and use information-sharing technologies to coordinate and publicize Plan activities and research.

Update the MYSPP web site o include adult suicide prevention resources.

Establish a research and evaluation committee to provide expertise and evaluation to local prevention programs.

Review nationally-published research on suicide prevention and disseminate findings.

Collect monthly suicide data from the Medical Examiner's Office.

Continue to include suicide related questions on statewide MIYHS[SPELL THIS OUT] and Behavioral Risk Factor Surveillance System surveys, and analyze and disseminate findings.

Update the Maine Suicidal Behavior Surveillance documents and Fact Sheets on an annual basis.

Establish representation with the appropriate death and serious injury review panels in Maine.

Advocate for ongoing suicide case review and release of information for prevention planning purposes.

LOCAL: Recommended Actions

Designate a liaison within each Maine CDC Public Health District to identify and link to local resources, and coordinate with local prevention programs to integrate suicide prevention activities.

Identify local leaders among clinicians, service providers, community organizations, groups representing at-risk persons, and survivors who will coordinate staff training disseminate information about suicide and suicide prevention in Maine.

Next Steps

Prepare for expansion of suicide prevention activities into other arenas where adults gather, such as faith communities and businesses, by forming partnerships with the Maine Council of Churches, Maine Department of Economic and Community Development, Maine Chamber of Commerce, and Maine Association of Employee Assistance Programs.

Establish specific evaluation criteria for prevention programs implemented through this Plan and prepare for evaluation.

Establish a fellowship program in suicidology in one of the public universities in Maine.

Develop, in collaboration with university partners, a five year suicide research agenda that builds
on the work on the MYSPP.

Strategic Direction #2

Integrate Suicide Prevention and Treatment into Primary Medical Care

Purpose

Research demonstrates 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. Intervention – screening, assessment, treatment, and referral – through primary care and emergency department practices has the most potential for identifying and assisting the greatest number of people across the lifespan who have attempted or are contemplating suicide.

Opportunities and Barriers

Research-based screening tools and protocols have been field-tested with demonstrated success. Toolkits, training, and other resources for primary care physicians are available.

Maine and national initiatives actively are promoting the integration of mental health assessment and treatment into primary health care. Maine's twenty federally-qualified health centers are in the process of implementing this approach.

Federal legislation to extend health insurance to 30 million uninsured citizens and to remove preexisting condition restrictions will make primary health care and mental health and substance treatment available to many more citizens in Maine.

Primary care practices and emergency departments (other than the federally-qualified health centers) have not received training and do not have uniform protocols for screening for depression and suicidality and for referral to mental health and substance abuse treatment.

Limits on health insurance coverage make it difficult to refer people contemplating suicide for effective mental health and substance abuse treatment Adults with public insurance have funding but often face lengthy waits for treatment and lack of continuity once treatment begins. Adults with private insurance have more timely access, but often have insurance-imposed limits on the type and length of treatment.

Objectives

Objective 1: Educate primary care practitioners on the efficacy of and methodology for suicide screening and treatment referral.

Objective 2: Partner with the Maine Primary Care Association to integrate suicide prevention screening, assessment, and treatment within mental health care in Maine's federally-qualified Community Health Centers.

Objective 3: Partner with the Maine Hospital Association to implement uniform screening and referral protocols in hospital emergency departments for people at risk of suicide.

Objective 4: Support work that increases the availability of primary care and mental health and substance abuse treatment.

Benchmarks

1. Suicide prevention protocols and behavioral health treatment are integrated into fifty percent of the federally-qualified Community Health Centers. To be achieved by the end of Plan Year 5.

2. Suicide prevention protocols and behavioral health/substance abuse treatment referral protocols are integrated into fifty percent of hospital Emergency Departments. To be achieved by the end of Plan Year 5.

3. Thirty percent of primary care practitioners unaffiliated with Community Health Centers or hospital-based practices have receiving training and/or materials on suicide prevention methods and protocols. To be achieved by the end of Plan Year 3.

STATE: Recommended Actions

Survey primary care practices to determine to what extent screening (for depression, trauma, and

suicide), suicide prevention protocols, and behavioral health care are part of primary health care practices.

Conduct a symposium with Community Health Centers and other key stakeholders to establish a common vision for suicide prevention in these centers, to increase understanding of needs and barriers, to build relationships and to develop and implement collaborative activities.

Research available best practices for integration of suicide prevention within primary care, such as the Suicide Prevention Resource Center/Western Interstate Commission for Higher Education Primary Care Toolkit.

Develop a website that has information for use by primary care and emergency department personnel, such as state mental health laws regarding commitment, mental health admissions policies, mental health resources, Medicaid rules, and state and local resources.

Partner with the Maine Health Care Access Foundation to determine unmet needs and effective responses for people contemplating suicide with underlying mental health and substance abuse issues.

Provide data and cost information on suicide to organizations that advocate for insurance parity between insurance reimbursement for mental health and substance abuse treatment and other types of health care.

LOCAL: Recommended Actions

Identify professional training opportunities for primary care and emergency department personnel, and offer training and materials on suicide prevention at these events.
Partner with the Maine Primary Care Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in primary care provided by Federally Qualified Community Health Centers.

Partner with the Maine Hospital Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in primary care provided by practices affiliated with Maine hospitals.

Partner with the Maine Medical Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in unaffiliated primary care practices.

Partner with Pathways to Excellence to distribute to primary health care providers information on suicide prevention research and advances in suicide prevention in Maine primary health care practices.

Develop, in conjunction with primary care providers, appropriate postvention strategies for medical settings.

Identify feasible methods to obtain and compile data from primary care and emergency department personnel on the number of referrals to mental health and substance abuse treatment for people contemplating suicide.

Identify feasible methods to obtain and compile data from mental health and substance abuse treatment programs on the number of people referred by primary care and emergency departments because of suicidality who subsequently received treatment.

Next Steps

Identify the primary care practices and emergency departments that have not implement suicide prevention protocols.

Develop Maine-specific materials and presentations on the impact of integration of suicide prevention and behavioral health treatment into primary care practices, and prepare to disseminate widely throughout the state.

Reassess unmet needs for behavioral health and substance abuse treatment in Maine for people contemplating suicide.

Strategic Direction #3

Implement Priority Suicide Prevention Programs in Department of Health and Human Services State and Community Offices

Purpose

Community DHHS programs provide services in a variety of settings to people who may be at high risk for suicide. Leadership from state DHHS offices is necessary to decide which priority programs are preferred for particular settings. Community programs are in the best position to deliver services and supports to people who have attempted or are contemplating suicide.

Opportunities and Barriers

Other than primary medical care, human service agencies offer the best opportunity to reach adults at risk of suicide.

State DHHS offices have clearly defined opportunities and resources for training state and local service providers. During the planning process, state DHHS personnel indicated a high level of willingness to use their resources to integrate suicide prevention training and programs into their current work.

An easily adaptable web site, resource library, training curricula and materials, and expert data collection and analysis on youth suicide prevention are in place in the Injury Prevention Program and in the Office of Substance Abuse Information Resource Center.

Maine already operates suicide hotlines for people in crisis and warmlines for people with behavioral health needs.

As State funds contract during this difficult economic environment, employees are being asked to do more work with fewer resources. Suicide prevention training programs must be replicable with the least amount of effort necessary for success.

Suicide prevention is not now a priority in the education of mental health and substance abuse professionals. Pre-employment training programs do not include suicide prevention in their curricula, nor is suicide prevention training a requirement for state certification or licensing. As a result, most mental health and substance abuse professionals enter practice with little information about suicide or how to prevent it.

Objectives

Objective 1: Provide data, leadership and resources to support integration of priority suicide prevention strategies into state agencies and state-sponsored programs.

Objective 2: Increase the number of clinicians and support personnel trained in the skills needed for suicide screening, risk assessment, and response.

Objective 3: Implement community Gatekeeper programs in local DHHS-affiliated programs.

Objective 4: Implement follow-up activities for people who have been identified in DHHS-affiliated programs as attempting or contemplating suicide.

Benchmarks

1. Training materials on depression and suicide screening, risk assessment, and follow-up response are available and used to train one hundred DHHS-affiliated clinicians and support personnel. To be achieved by the end of Plan Year 4.

2. Twenty-five percent of people receiving services through the Offices of Adult Mental Health Services, Substance Abuse Services, Elder Services, and CDC public health nurses are screened for depression and/or suicide and referred for appropriate treatment. To be achieved by the end of Plan Year 5.

3. Suicide prevention materials and protocols reflecting best practices for gatekeeper programs, hotlines, and follow-up activities are available for implementation. To be achieved by the end of Plan Year 2.

4. Community Gatekeeper programs are implemented in four local or regional programs serving clients of DHHS who are in at-risk groups for suicide. To be achieved by the end of Plan Year 5.

5. Hotline and Warmline programs provide follow-up activities to all callers who are identified as at risk of suicide. To be achieved by the end of Plan Year 2.

6. Psychiatric hospitals and in-patient psychiatric units in general hospitals provide follow-up activities upon discharge to all people hospitalized because of suicide attempts or risk of suicide. To be achieved by the end of Plan Year 2.

STATE: Recommended Actions

Screening and response

Survey behavioral health programs, substance abuse programs, elder residential and home health care programs, public health nurses, and licensed clinical social workers to determine a baseline of the number trained in depression and suicide screening, risk assessment, and response; the type of training; and perceived need for training.

Gather current materials on best clinical practices for suicide screening, risk assessment and response and post on the Maine Suicide Prevention Program website. With state leaders, develop a uniform protocol for depression and suicide screening, response, and referral.

Identify opportunities to train clinicians and services providers in state DHHS and contract agencies, specifically public health nurses, substance abuse prevention programs, elder services assessors, adult protective service workers, nursing and residential care facilities workers, hospital-based and community behavioral health care staff, and peer support personnel.

Gather data on the number of people screened for depression and/or suicide, and the subsequent action taken by the screeners.

Follow-up activities

With state leaders, develop a protocol for follow-up activities after contact with DHHS-affiliated programs and services associated with suicide prevention or behavioral health treatment.

Gatekeeper programs

With state leaders, determine the methodology for best developing gatekeeper programs through local and regional DHHS offices and Public Health Districts.

Determine the types of gatekeeper programs best suited to specific local and regional offices and the clients served.

Modify the selected Gatekeeper protocols and materials for use by Maine programs serving groups at risk of suicide.

LOCAL: Recommended Actions

Screening and response

Partner with the Maine Psychiatric Association and Mental Health Association of Maine to offer presentations and exhibits at professional meetings on suicide risk assessment and response.

Partner with the Maine Association of Substance Abuse Programs (specifically the Maine Alliance for Addiction Recovery) to include suicide prevention in their annual Recovery Works day.

With the assistance of the DHHS State Education and Training Unit and community agencies, provide training to clinicians and service providers on depression and suicide screening and response.

Integrate the uniform screening and response protocol, modified as necessary for specific at-risk groups, into public health nursing nurse programs, adult protective services programs, substance abuse programs, elder care programs, and behavioral health programs.

Pilot the Nursing Homes Suicide Prevention Toolkit from the national Suicide Prevention Resource Center in five Maine nursing homes.

Follow-up activities

Implement the follow-up protocol for callers of hotlines or warmlines who disclosed suicidal thoughts or plans.

Implement the follow-up protocol for patients with suicide attempts or thoughts after discharge from inpatient mental health treatment.

Gatekeeper programs

With state and local leaders, survey local agencies that serve groups at risk for suicide for suitability and interest in Gatekeeper programs.

Identify four community agencies serving groups at risk of suicide and implement Gatekeeper programs in those agencies.

Next Steps

Partner with the University of Maine social work, counseling and education departments to develop and implement curriculum modules teaching suicide awareness and intervention and assessment skills to undergraduate and graduate clinical students.

Sponsor demonstration programs in two Maine public health districts to integrate suicide prevention into multiple aspects of community life.

Strategic Direction #4

Increase Awareness of and Competency in Suicide Prevention

Purpose

Awareness about suicide warning signs and methods for reducing access to lethal means of suicide, by family, friends, and first responders, but also by the general public, can help to prevent suicide. Organizations other than those directly related to health and human services also reach people at risk of suicide and need accurate information about suicide and its prevention.

Opportunities and Barriers

Healthy Maine Partnerships, a network of community organizations dedicated to improving the health of Maine citizens, offer the opportunity for widespread dissemination of information about suicide warning signs and suicide prevention.

The Maine Youth Suicide Prevention Program has written materials and other resources on suicide warning signs, intervention, and prevention methods easily adapted to adults.

The Veteran's Administration in Maine has a suicide prevention program that successfully collaborates with the Maine Youth Suicide Prevention Program.

Training on suicide is available now through the Maine Criminal Justice Academy, and with additional resources could be expanded to reach public safety officers throughout the state.

Reducing access to lethal means, such as locking firearms, removing unused prescription drugs, or placing safety barriers around bridges, has reduced suicide rates in communities where these methods have been used.

Constitutional rights and cultural norms make restricting access to lethal means, especially firearms, difficult.

Objectives

Objective 1: Increase the number of adults who know what to do when they or someone they know is contemplating or has attempted suicide.

Objective 2: Integrate lethal means education and counseling into public safety programs, primary medical and emergency department care, and behavioral health consumer organizations.

Benchmarks

1. A web site with current information on suicide prevention programs in Maine and resources for behavioral health and substance abuse treatment is widely publicized and linked to implementing and partnership organizations. To be achieved by the end of Plan Year 1.

2. Through an email network of this Plan's partnership organizations, bi-annual updates on suicide prevention and treatment resources are distributed to these organizations' membership. To be achieved by the end of Plan Year 1.

3. Information about suicide warning signs and how to get help is distributed through the Healthy Maine Partnership network to two hundred community organizations throughout the state. To be achieved by the end of Plan Year 3.

4. Training on reduction of access to lethal means is available annually to public safety and emergency medical services personnel. To be achieved by the end of Plan Year 2.

STATE: Recommended Actions

Partner with the Maine Minority Health Office and Tribal leaders, with input from minority populations, to modify materials and training programs and resources to improve cultural competency.

Revise the MYSPP website to encompass suicide prevention across the life span. Encourage other state agencies and partnership organizations to link to this site.

Partner with the Office of Substance Abuse to include resources for suicide across the lifespan in the OSA Information Resource Center library.

Develop a master email list of partnership organizations willing to distribute suicide prevention updates to their members. Bi-annually update materials on suicide facts, recognition of

warning signs, risk and resiliency factors, prevention programs, referral for intervention and postvention services, and training opportunities. Post these on the program web site and disseminate widely through email.

Partner with the Maine Veteran's Administration Suicide Prevention program and Maine National Guard to disseminate information about the elevated risk for suicide among veterans, services at the VA and other veterans' organizations, through the MSPP website, conference presentations and other outreach efforts.

Continue to collaborate with the Maine Criminal Justice Academy to maintain training on suicide prevention in the police academy and to require that public safety officer training be updated annually.

LOCAL: Recommended Actions

Collaborate with Healthy Maine Partnerships to post written materials and links to electronic resources on suicide warning signs and treatment referral sources in communities statewide.

Post written and materials and links to electronic resources, including information on warning signs and referrals for treatment in primary health care offices, mental health treatment program offices, private therapist and counselor offices, substance abuse treatment program offices, and hospital emergency departments.

Train Public Health District staff in all eight districts on suicide warning signs, prevention, and treatment resources.

Partner with the Maine Emergency Medical Services Office to offer training to emergency medical technicians and other first responders on suicide warning signs and intervention methods.

Partner with the Maine State Police, the Maine Chiefs of Police Association, and the Maine Sheriff's Association to establish and widely distribute protocols for public safety organizations on removing or securing firearms and other lethal means of suicide.

Partner with the Maine Primary Care Association, Maine Hospital Association, And Mental Health Associates of Maine to provide information on the importance of and methods to assess the availability of lethal means of suicide in the homes of potentially suicidal individuals.

Institute practices to counsel patients and family members on securing or removing lethal means from the home for all patients who are treated in primary health care practices, emergency departments, and mental health practices for suicidal behaviors.

Partner with Peer Support programs of the Adult Mental Health Office of Consumer Affairs and NAMI/Maine and to disseminate information on what family members and friends can

do to safely remove or secure lethal means from individuals who exhibit warning signs for suicide.

Next Steps

Partner with the Department of Labor to determine feasible strategies to reduce suicide through prevention programs in Employee Assistance Programs and other workplace services.

Partner with other state agencies and organizations, such as the Attorney General's Office, Maine Council of Churches, Domestic Violence Coalition, and the Sexual Assault Coalition, to explore development of feasible strategies for suicide prevention programs in their organizations.

Strategic Direction #5

Promote Help-Seeking for Adults in Need

Purpose

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. Opening a societal discussion about the prevalence of suicide and its causes, and improving the availability of effective treatment can begin to break down these barriers.

Opportunities and Barriers

Depression is more widely understood and discussed in our society than in the past. Public figures continue to come forward to explain their experience with and recovery from depression.

Effective treatment for depression, substance abuse, and other forms of illness contributing to suicide are available now.

Stigma associated with mental illness, substance abuse, and suicide continues to exist, preventing adults from seeking treatment. Our society must continue to learn how to discuss these issues without shame.

Objectives

Objective 1: Determine unmet needs for behavioral health and substance abuse treatment for people contemplating suicide.

Objective 2: Provide information on suicide and unmet treatment needs to organizations seeking increased access to and funding for behavioral health and substance abuse treatment.

Objective 3: Educate individuals on how to advocate for their own and their family's mental health care.

Objective 4: Reduce the stigma associated with suicide, mental illness, and substance abuse.

Objective 5: Improve reporting and portrayals of suicide in mass media.

Benchmarks

1. Data on the availability of effective treatment for the underlying causes of suicide, use of treatment, and unmet treatment needs is compiled and reported to the Maine Health Care Access Foundation and other organizations whose mission is to improve use of treatment resources. To be achieved by the end of Plan Year 2.

2. Education materials have been distributed to one thousand adults on how to intervene and seek treatment for people at risk of suicide. To be achieved by the end of Plan Year 5.

3. Education events featuring speakers who are survivors of suicide have been attended by one thousand adults in a wide variety of community settings. To be achieved by the end of Plan Year 5.

4. Seventy-five percent of media outlets in Maine have adopted and use protocols for appropriate reporting of suicides. To be achieved by the end of Plan Year 4.

STATE: Recommended Actions

Survey clinicians and consumer groups to determine the most effective behavioral health and substance abuse treatments for people at risk of suicide.

Conduct focus groups with suicide survivors (both those who have survived their own attempts and those who have lost a loved one to suicide) to understand prevention and treatment needs.

Partner with DHHS Offices of Adult Mental Health Services, Elder Affairs, and Substance Abuse, and the Maine Health Care Access Foundation to compile data on the availability of and unmet needs for effective behavioral health and substance abuse treatment.

Develop or adapt materials for suicide survivors for use in mental health and primary medical care, emergency department, behavioral health, and substance abuse treatment settings.

Partner with NAMI/Maine, the Offices of Adult Mental Health Services and Substance Abuse, and the Maine Health Care Access Foundation to develop materials on where to obtain behavioral health and substance abuse treatment and how to pay for it.

Partner with NAMI/Maine, Peer Support programs, behavioral health and substance abuse treatment programs, and Area Agencies on Aging to establish a speaker's bureau of adults of all ages who once contemplated suicide and have returned to health. Develop screening process and select those who are several years out from their attempt and able to deliver a prevention message.
Recruit and train these individuals to speak to community groups about their experiences with treatment and recovery and about suicide prevention.

Review and adapt as necessary protocols for appropriate reporting on and portrayals of suicide in mass media.

LOCAL: Recommended Actions

Collaborate with Healthy Maine Partnership programs to provide education event in local communities using the speaker's bureau participants. Publicize the message that behavioral health and substance abuse treatment are used by people of all ages and social status, and that treatment works to prevent suicide and promote the return to health.

Partner with NAMI/Maine to offer training events on how to negotiate with treatment providers and insurance companies to obtain appropriate behavioral health and substance abuse treatment.

Sponsor an annual suicide prevention forum for media, public health and behavioral health professionals, and survivors of suicide.

Routinely respond to media portrayals of suicide so that media recognize and use safe reporting practices.

Work with news reporters to ensure that information on helping resources are always listed in relevant stories.

Next Steps

Evaluate the effectiveness of education materials and training events, modify as needed, and expand into additional community settings.

Appendix A

Glossary of Terms

Adolescent: A person between the ages of 14 and 24.

Aftercare treatment programs: Programs that provide treatment and support recovery after an initial episode requiring residential or hospital treatment.

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: Is the optimum functioning and development of a individual in all important spheres of his/her life including family and peer relationships, involvement with school and community, physical health, and play or recreational pursuits.

Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.

Bisexuality: Being attracted to members of both sexes.

Cognitive behavioral approach: Cognitive Behavioral Treatment is a treatment method that focuses on here and now behaviors, thoughts and responses and uses a 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.

Consumer: A person who currently receives mental health services or who received such services in the past.

Contagion: A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Coroner: A public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes.

Crisis response plan: A document that spells out the procedures to be followed in the event of threatening situations.

Crisis team: A group of individuals trained and assembled for the purpose of responding to the needs of other during and after a crisis event/situation. All schools in Maine are required to have a crisis response team and plan.

Appendix B

Culturally competent: A set of values, behaviors, attitudes, and practices reflected in the work
of 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 somatic signs and symptoms, including
sustained sad mood or lack of pleasure.
Disconnected youth: Youth, through age 24, who are out of school, out of work, often homeless, and/or have aged-out of child welfare and state benefits, including the foster care system, and generally not consistently connected to healthcare and/or treatment services.
E-codes: External cause of injury codes are diagnostic categories, using the 9th revision of the International Classification of Diseases (ICD-9). E-codes provide data on the cause, rather than the type, of injury. Example: a traumatic head injury, coded with an N-code, could result from a
car crash or gunshot wound, both coded with different E-codes.
Effective: Prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group.
Epidemiology: The study of statistics and trends in health and disease across communities.
Evaluation: The systematic investigation of the value and impact of an intervention or program.
Evidence-based: Programs that have undergone scientific evaluation and proven to be effective.
Executive order: A document issued by the Governor requiring certain actions to be taken.
First responder: 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 routinely in direct contact
with a specified target audience 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 proportion of the population.
Help-seeking behavior: Actions taken by a person who utilizes different sources of informal (parent and peers) and formal (counselors, teachers, or mental health professionals) support.
Homicide: The killing of one person by another.
Appendix B
Homosexuality: Sexual desire for and/or sexual activity with others of one's own sex.
Incarcerated youth: Refers to young people who are detained and being housed in a prison, jail,

detention center, etc.

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.

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 intentional injuries.

Intervention: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

Insomnia: Chronic inability to sleep.

Lethal means: Any instrument or object utilized to carry out a self-destructive act (i.e. firearm, poison, medication, rope, chemicals and/or other hazardous material).

LGBTQ: Lesbian, gay, bisexual, transgender, questioning youth.

Long gun: A gun with a long barrel that is fired from the shoulder - (rifle or shotgun)

Means: The instrument or object whereby a self-destructive act is carried out (e.g. firearm, poison, medication).

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 a government unit to ascertain causes of deaths, especially those 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% coverage for physical illness then they would have to provide the same percentage 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 cognitive, emotional or socials abilities.

MIPP: Maine Injury Prevention Program – the Maine Injury Prevention Program is housed within the Maine Center for Disease Control and Prevention and serves as the lead agency in the state for injury and suicide prevention in Maine. In addition to coordinating the MYSPP, the MIPP also addresses suicide across the lifespan, among other leading causes of injury. The MIPP provides training, data, and links to prevention resources statewide.

Mobile crisis team: Mental health clinicians trained to perform suicide assessments/evaluations in multiple places such as an emergency room 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: The relative frequency of death, or the death rate, in a community or population.
MYSPP: Maine Youth Suicide Prevention Program – the MYSPP employs a public health approach to address youth suicide. The MYSPP is based upon collaboration among state agency leaders and staff. The long-terms goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine children, teens, and young adults.
National Strategy for Suicide Prevention: A comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. This document was issued in 2001 and contains 11 goals and 68 objectives designed to be a catalyst for social change.
Appendix B
Non-fatal suicidal behavior: Another term for suicide attempt.
Outcome. A measurable change in the health of an individual or group of people that is attributable to an intervention.
PHQ-9: The Patient Health Questionnaire (PHQ-9) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria.
Post traumatic stress disorder: When a person has experienced a traumatic event in which he/she were both threatened and experienced intense fear or helplessness and: a) re-experienced
symptoms of the trauma; b) persistently avoid reminders of the trauma; and c) experience increased arousal or tension.
Postvention: A coordinated and comprehensive set of specific interventions to be implemented
after a crisis or traumatic event 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 health condition divided by the total number of people in the population. (For less common conditions, prevalence is often expressed per 100,000 people, for example, rather than as a percentage.)
Primary Care Providers: Health professionals serving in a primary care setting, including physicians, physicians assistants, nurse practitioners, and nurses who are chosen by an individual to serve as his or her health care professional. A Primary Care Provider is responsible for handling a variety of health-related problems, keeping a medical history and medical records on the individual, and/or referring the person to specialists as needed.
Prognosis: A prediction of the probable course and outcome of a disease.
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: Guideline for actions to take. MYSPP developed a Protocol document that helps schools be better prepared to address suicide prevention, intervention, and postvention.
Public health: Regulatory and voluntary focus on effective and feasible risk management actions at the national 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. See Appendix C for additional information.

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 health outcomes.

Risk factor: Long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death.

School-based: Services provided on school grounds by either school personnel or by community organizations that have arrangements with schools.

Screening. Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Self harm or self-injury: The various methods by which individuals injure themselves, such as cutting, self-battering, taking overdoses or deliberate recklessness.

Sexual minority: Refers to gay men, lesbian women and bisexual and transgendered persons. These groups are considered to be "minority" because of several commonalities with other minority groups—including separate cultural norms, idiosyncratic use of language and terminology, and the reality of being discriminated against of their social minority status. Appendix B

Sexual orientation: Refers to a complex web of emotions, behaviors, fantasies, attitudes and attractions. There are three possible sexual orientations: heterosexual, homosexual and bisexual (attracted to both males and females).

Social support. Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services, and support from family, friends, religious communities and other affiliation groups.

Stakeholder: Entities, including organizations, groups and individuals, who are affected by and contribute to decisions, consultations and policies.

Stigma: Stigma is 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. Stigma leads the public to avoid people with mental disorders. It reduces access to resources and leads 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 substance abuse.

Suicide: Self-inflicted death with evidence (implicit or explicit) of the intent to die.

Suicide attempt: A 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: Thoughts about dying by suicide are clinically referred to as "suicidal ideation".

Suicide survivor: Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with
timely dissemination of findings.

Survivors. Family members, significant others, or acquaintances who have experience the loss by suicide of someone in their life.

Trauma survivor: Refers to a person who has experienced trauma.

Warning sign: The earliest, observable signs that indicate the risk of suicide for an individual in
the near-term (within minutes, hours, or days).

Years of potential life lost (YPLL): A measure of premature mortality (early death). YPLL provides insight into the impact of injury-related death on society compared to other leading causes of death.

Appendix B

Young adults: Persons aged 20-24

Youth Risk Behavior Survey: A biennial survey of middle and high school students conducted
as part of a national effort by the U.S. Centers for Disease Control and Prevention to monitor health-risk behaviors of the nation's students.

Appendix B

Resources

Section 1: Crisis and warm lines, state first, national second

Section 2: Maine web sites. Indicate that these sites have links to many others, including national and Maine specific data, and suicide fact sheets and prevention materials

MIPP
MYSPP
OSA IRC
NAMI Maine

Section 3: National resources, specifically

SPRC
SPAN
AAS American Association of Suicidology
WISQARS
National Violent Death Reporting System (NVDRS)
http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm

Warmline

Warmline offers telephone support services for non-crisis situations, including, but not limited to: Support, social connection, sharing personal victories, overcoming fear, grief or sadness, developing effective strategies for the future, assistance with referrals to community resources, talking to someone when feeling sad, lonely, discouraged a place to learn about access to recovery programs, a place to connect with peers who have experienced mental illness and recovery.

- **The Maine Warmline toll free number is: 1-866-771-9276 or 1-866-771 (WARM)**
  This is a peer staffed warmline operated by Amistad 5pm to 8am daily
- **Portland**
  Amistad offers a peer staffed Warmline open from 5pm –8am daily.
  Local number: 207-772-9276
- **Brunswick**
  The Learning & Recovery Center at Sweetser operates a peer staffed Warmline
  (207)373-4278 or 1-800-434-3000 x4278
  Staffed 24 hours seven days a week.

- **Penobscot, Piscataquis , Washington and Hancock Counties.**
  CH&CS sponsors the Northeast Crisis Services Warm Line, for people with mental illness and their family and friends who are seeking someone to talk with in a non-emergency situation.
  For callers in the local calling area for Bangor, the number is (207)945-5625.
  Callers outside of the local calling area can call toll free, (800) 490-8748.
- **Aroostook County**
  (207)768-3304
  Staffed 24 hours seven days a week.

The NAMI Maine help line, 1-800-464-5767 - is a confidential non-crisis help line, available Monday through Friday, between 8:00 am and 4:30 pm. NAMI also be reached at 207-622-5767.

We will help you:

- navigate the mental health or criminal justice systems
- understand your rights
- talk through the issues that are of concern
- figure out where to get the assistance you need or who to talk to next
- find a service in Maine or elsewhere
- get information about a law, a program, or a policy

Just ask and we will either advise you immediately or do some research and get back to you!

Appendix C

Maine Youth Suicide Prevention Program

Include a paragraph at the beginning on the MYSPP.

Statewide Crisis Hotline 1-888-568-1112

A statewide crisis hotline operated by the DHHS Behavioral Health Office connects callers to crisis service providers in their area. This line is for all individuals in need of immediate local
assistance in any crisis situation and is accessible statewide 24/7.

MYSPP Web Site wwwmaine.gov/suicide

The web site is managed through the DHHS Office of Substance Abuse. It contains extensive information on MYSPP programs, suicide statistics and research, prevention initiatives, directions for how to get help, and links to other state and national resources.

Statewide Information Resource Center http://www.maine.gov/dhhs/osa/irc/index.htm

The DHHS Office of Substance Abuse Information Resource Center distributes a wide selection of suicide prevention information materials for adults and adolescents. Resources include print and audio-visual education materials, Maine and national data and other information.

Data and surveillance activities

Suicide data are routinely monitored and analyzed by the MYSPP. Special studies are done to gather specific information on the nature and causes of suicide among Maine's youth.

School-based Suicide Prevention, Crisis Intervention, and Postvention Protocol Guidelines

MYSPP protocol guidelines help school administrators establish crisis intervention and suicide prevention procedures, a crucial tool for advanced planning to prevent suicide, manage a crisis, and intervene effectively in various crises occurring in a school setting.

Training

Through funding from the Maine Injury Prevention Program, Maine CDC, DHHS, a contract with Medical Care Development, Inc. supports multiple suicide prevention training programs. To date, the MYSPP has trained over 19,000 adults and youth in schools, other human service agencies, and private and public organizations. Training includes the following

programs.

- *Gatekeeper Training* is a one day basic introduction to suicide prevention that builds intervention skills. Participants learn how to recognize suicidal behavior, the importance of responding and how to respond effectively, and where to find helping resources.

- *Training of Trainers* is a four-hour program that prepares individuals who have a basic suicide prevention background to offer a 60-90 minute suicide prevention awareness session in their school, organization or community.

- *Lifelines Training* has two components: a day long session that prepares health teachers to
  deliver *Lifelines Student Lessons;* and interactive lessons delivered by these trained teachers to that teach students how to identify suicidal behavior, respond appropriately, and obtain help for their friends and themselves. In December 2009, Maine's work on the Lifelines Student Lessons was placed on the National Registry of Evidence-based Programs.[83]

- *Suicide Prevention Protocol Development Workshop* is offered on-line with assistance available once the coursework is completed. The likelihood of schools or youth serving agencies
  encountering a suicidal youth is real and few events are more painful or potentially disruptive. Protocols provide guidance on steps to take in order to safely assist youth and staff by providing them with direction, structure and support.

- *Suicide Assessment for Clinicians* is a day-long workshop designed to prepare a new or seasoned therapist to understand the risk of suicide in a variety of populations and how to approach and complete an effective suicide risk assessment.

  Transitions Training for Educators is built on the concepts presented in the Lifelines lessons and provides "booster" sessions and additional resources to help high school seniors cope with upcoming changes. To assist educators to present these lessons, a one day training, which includes practice, is required.

- *Beyond the Basics of Suicide Prevention Conference*: this annual conference features state and
  national speakers who provide in-depth information on topics relevant to suicide prevention.

Through funding from the Maine Injury Prevention Program, Maine CDC, DHHS a contract with the University of Maine supports Restorative Justice training programs and technical assistance to Maine schools.

Appendix D

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Appendix E

Suicide Prevention: The Public Health Approach

INSERT description.

Appendix F

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Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Office of Adult Mental Health Services
Quality Management Plan/Community Based Services
April 2008

Purpose

On an ongoing basis, the Department of Health and Human Services, Office of Adult Mental Health Services (OAMHS) strives to:

- Improve overall quality and integrity of services provided to its customers
- Ensure programs and services are responsive to consumer needs
- Comply with the terms of the *Bates v. DHHS Consent Decree*

The purpose of the Office of Adult Mental Health Services Quality Management Plan is to describe its office-wide quality management initiatives that will support ongoing learning within the system, data-based decision making and rapid identification and resolution of quality problems; and ensure that:

- New processes are well designed
- Data is systematically collected, and
- Data is used for ongoing monitoring and improvement activities.

Scope

This plan presents the framework for the quality management processes for services that OAMHS provides to adults who are eligible for mental health services supported by the state in the following service areas:

- peer services;
- crisis services (including crisis stabilization units);
- community support services (currently includes community integration, assertive community treatment, daily living skills, skills development and day support services);
- outpatient services
- medication management services;
- vocational services;
- inpatient services (community based);
- residential treatment services; and
- housing.

Quality Management in these areas focuses on access to services, continuity of care, treatment planning processes, consumer rights and systems monitoring. Quality management includes both quality assurance and performance improvement activities. Quality assurance is a monitoring activity that reviews pertinent data against standards designed to promote quality care, with a frequency that assures sufficient confidence in the ongoing delivery of quality care. Performance improvement is the process that defines problems identified through the quality assurance process, analyzes data in greater depth, and evaluates and improves processes and systems of care to improve quality. To be effective, performance improvement activities need to include a process to assure that the performance improvement is maintained.

This plan, together with the Quality Management Reports grid, provides an outline of the quality management process. Details for each data collection or quality assurance process appear in the written procedure or policy for that process or in the Performance and Quality Improvement Standards attached to the October 2006 Consent Decree Plan.

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Responsibility for OAMHS Quality Management Activities

Quality management within the OAMHS involves both central office and regional administrative staff, with all OAMHS staff carrying a responsibility for assuring quality care for the people served by the office. However, it is the Director of the Office of Adult Mental Health Services and the senior management of the office who are responsible for the overall effectiveness of the quality management system and ensuring the adequacy of information feedback and the ability of the system to make adjustments based on the ongoing analysis, review and interpretation of information. The senior management team is also responsible for promoting the integration of performance improvement methodology and philosophy into the daily work of all OAMHS staff.

The OAMHS Director of Policy is charged with carrying day to day responsibility for the implementation and management of the quality management system. The Director of Policy and the policy team serve as the hub for receiving and distributing data to internal and external stakeholders on a prescribed schedule, as well as tracking recommendations and quality improvement activities as they are initiated. It is the Director's role to close the loop between data collection and measurable, sustained, and continuous performance improvement. This involves:

- reviewing quality information on a routine basis
- interpreting, summarizing and making recommendations on specific actions or improvement priorities that may be warranted based on the review
- assuring follow-up action and development of necessary improvement plans
- monitoring of quality management systems, including the assurance that all new initiatives include quality measures and are part of the quality management system and
- communicating of findings to all pertinent stakeholders

OAMHS coordinates and collaborates with the DHHS Office of Quality Improvement to assure that processes for the two offices are complementary, not duplicative, and build on each others strengths.

Structure and Process for Information Flow, Review, Feedback and Action

Quality management processes are designed to assure that information will flow to and from all levels of OAMHS staff, as well as to external stakeholders, with issues having statewide or regional significance or policy implications reviewed by and meaningful input sought from all appropriate parties, including consumers. Data will be reported to and discussed with the specific groups or committees most directly responsible for the data. Information will also flow from OAMHS to the Integrated Management Team in the Commissioner's office as needed.

Data is collected and analyzed monthly or quarterly for trends. Documentation of quality management activities will be kept in minutes of meetings where quality data and recommendations are discussed and through quarterly or annual reports that delineate the data collected and activities to assure reliability, as well as how the quality management data is used to develop policy and system improvements.

Quality Management Process

When the performance of a quality assurance indicator meets a threshold for a more detailed review, the appropriate group, identified in the quality improvement policy, reviews it to determine what further action may be necessary. The process used for analyzing causes, taking action to improve performance,

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and implementing preventative actions and mechanisms is dependent on the situation. After the group identifies and prioritizes performance improvement activities, actions will be taken aimed at improving performance, measuring the success of those actions and tracking performance to endure that improvements are sustained. Performance improvement will include evidence of stakeholder involvement and education.

Consent Decree Compliance Reporting

The quality assurance system must document that OAMHS is achieving and maintaining compliance with the Settlement Agreement requirement to develop a 'comprehensive system of internal monitoring, evaluation, and quality assurance' (¶ 279). While the OAMHS quality management system is one that allows for 'macro' level data that provides an overall perspective of how the system is operating, the Settlement Agreement requires monitoring of compliance with a large number of quality assurance audit and data collection details at the 'micro' level. This requires increased data collection and reporting requirements on system participants, including private providers. The quality management system therefore is designed to be sufficiently broad system while capturing adequate 'detail/data' for consent decree compliance. Consent Decree data needs are defined within the October 2006 Plan and the October 2007 Compliance Standards.

Annual Review

The OAMHS Quality Management Plan will be updated at least annually by the OAMHS Director of Policy and reviewed and approved the Senior Management Team of the Office.

Quality Management Focus

Access to Services: Data elements from the following sources/reports will be selected and used to assess the level of access to services

Unmet needs (RDS data)
Agency Community Support Census/Staffing (ACS Report, caseload ratio data)
Rapid Response (access to hospitalization)
Selected standards from the October Plan Performance and Quality Improvement Standards
Selected Standards from the Consent Decree Compliance Standards
APS HealthCare/MaineCare Data
Crisis Contract Performance Indicator Data
Annual Class Member Survey
Annual DIG Survey

Continuity of Care: Data elements from the following sources/reports will be selected and used to assess the level of continuity of care between components of the mental health system, in particular between crisis, the community support system and hospitals with psychiatric units:

24/7 Access to Community Support Information
Utilization Review Nurse Reviews of Involuntary Admissions funded by DHHS
APS HealthCare
Utilization Review Nurse Reviews of Involuntary Admissions funded by DHHS
Crisis Contract Performance Indicator Data
Annual Class Member Survey
Annual DIG Survey

Treatment Planning Process: Data elements from the following sources/reports will be selected and used to assess whether planning meets required components, is individualized and assisting consumers to meet their needs:

Consent Decree Treatment Planning Review
Compliance Standards
Annual Class Member Survey
Annual DIG Survey
RDS data
Procedure for Interruption or Discontinuation of Services to Class Members

Consumer Rights: Data elements from the following sources/reports will be selected and used to assess how well consumers understand their rights and the system is upholding their rights.

Grievance Tracking
Class Member Survey and DIG Survey data
Protocol for Obtaining the Informed Consent of Class Members to Live in Homes with Greater than 8 Beds (Settlement Agreement ¶ 96)
Quarterly Letters to Class Members (Request for No Contact
Utilization Review Nurse Reviews of Involuntary Admissions funded by DHHS
Inappropriate Use of Blue Papers
Compliance standards (see 'report card')

Systems Monitoring: Data elements from the following sources/reports will be selected and used to assess how the system is working.

Licensing
Contract Reviews (Agreement review checklist)
Enrollment/RDS
Critical Incidents
Fidelity Reviews (not routine)
Annual Report of Expenditures and grant funds expended broken down by service area
Bi-annual review of crisis standards
Vocational Data
Targeted site investigations (as indicated)
Aggregate Critical Incident Reporting (to be developed)

Treatment Outcomes: Data elements from the following sources/reports will be selected and used to assess treatment outcomes utilizing individually based data.

Enrollment
APS Healthcare
Outcome Reviews

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Department of Health and Human Service
Office of Adult Mental Health Services
Quality Management Reports
April 2008

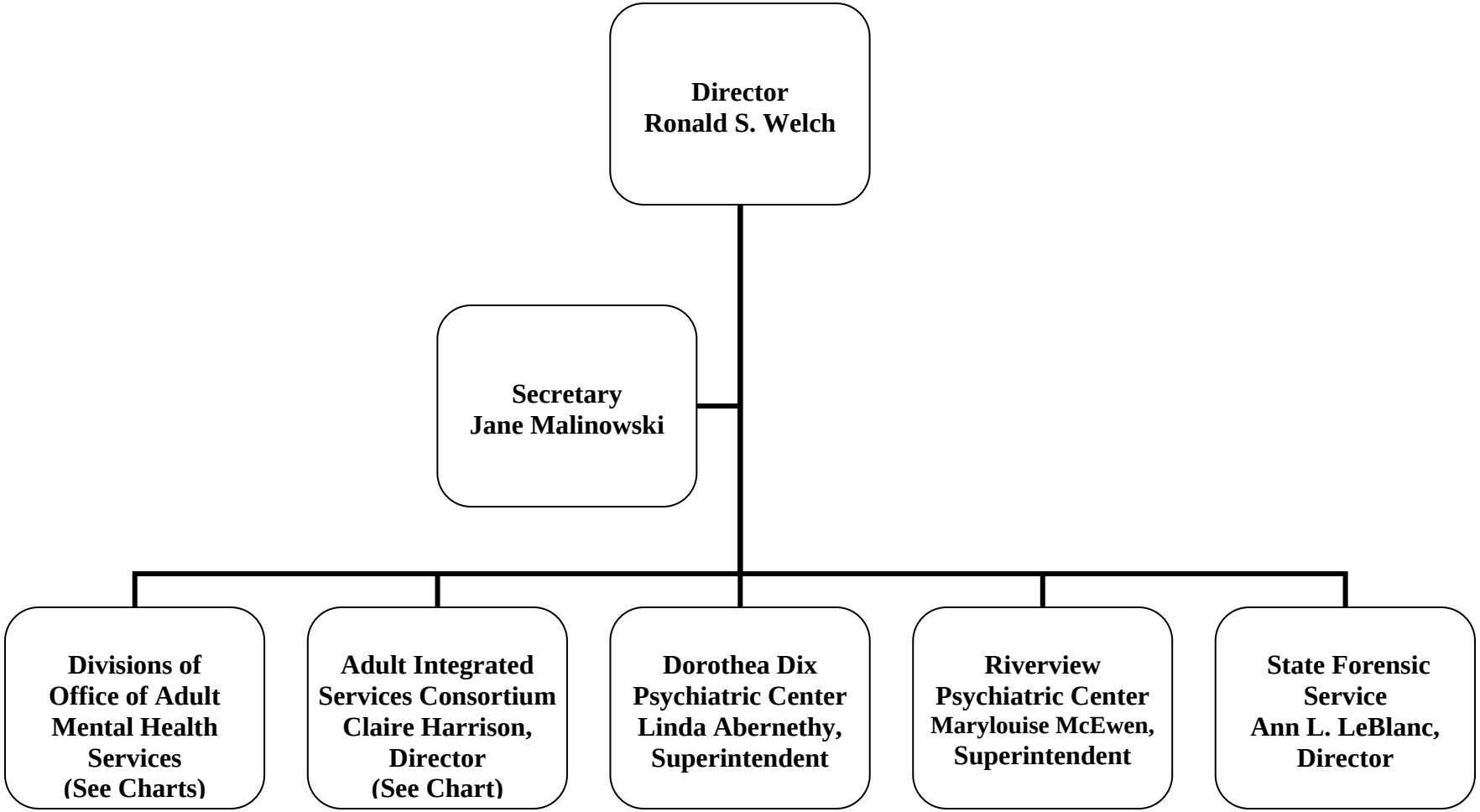
Report	Frequency	Reported to	Comments
Quarterly Compliance Report to the Court (including Consent Decree Performance and Quality Improvement Standards and ongoing Consent Decree October 2006 Plan Tasks)	Quarterly: February 1, May 1, August 1 and November 1	Court Master; CSNs; Commissioner's Office; Consumer Councils; the QIC; Joint Committee on Appropriations and Health and Human Services; Mental Health Team; posted on DHHS website	multiple data sources
Class Member Survey	Annual Survey/Spring	Reported to DHHS OAMHS, the QIC, the Consumer Council System of Maine and CSNs re: crisis plans and corrective actions; reported on within some CD Quarterly Report Standards; posted on the office's website	Process managed by the DHHS Office of Quality Improvement;
Consent Decree Treatment Planning Review	Quarterly	Reported to DHHS OAMHS; reported on within some CD Consent Decree Performance and Quality Improvement Standards	Data collected quarterly by Consent Decree Coordinators (February, May, August and November)
Agency Community Support Census and Staffing	quarterly	MHTLs, Director of Community Systems; reported as a performance and quality improvement standard within the quarterly compliance report	
Grievance Reports	Bi-annually: January-June report and July-December report	Reported to DHHS OAMHS and reported on within CD Quarterly Report Standards	
Unmet Needs (includes annual matrix of resource needs for core services and reliability of unmet needs data)	Quarterly and Annually	DHHS management team and stakeholder groups (CSNs, QIC, Consumer Council, etc.) for planning and budgeting; included as a component of the quarterly compliance report	(Includes: paragraph 74, and RPC/DDPC)/reported within CD quarterly report
EIS/Enrollment: Activity Reports (#s, overdue, missing, data issues, etc.)	Monthly (beginning of month)	CSS Agencies; Mental Health Team Leaders; OAMHS Operations Director	OAMHS (ongoing with direct data entry from provider agencies)

Report	Frequency	Reported to	Comments
APS Healthcare and PNMI database reports	Varies according to specifications listed in attachment to the APS Healthcare contract	Data flow/distribution currently in process of design.	
BRAP	Quarterly	Director of Systems operations; submitted as part of quarterly compliance report	OAMHS, Director of Housing;
Paragraph 96 (class members informed consent to reside in facilities greater than 8 beds)	Annual: January	reported on within some CD Consent Decree Performance and Quality Improvement Standards	By protocol, data is to be collected in January; process (running EIS data, compiling lists for review) will begin in November
Utilization Review of State Funded Involuntary Admissions	Quarterly	Mental Health Team/CSNs/Maine Hospital Association, Mental Health Council; reported on within some CD Consent Decree Performance and Quality Improvement Standards	
Inappropriate Use of Blue Papers	Monthly	Mental Health Team/CSNs/Maine Hospital Association, Mental Health Council (Director of Community Systems and OAMHS Director); on an ongoing basis, the Division of Licensing and Regulatory Services receives reports as potential deficiencies are noted.	UR Nurses and MHTLs: collected on an ongoing basis/overall report of findings (Director of Community Systems and OAMHS Director)
Contract Reviews	annually; reported in 4th quarter	Licensing on as needed basis; CSNs; quarterly updates to QIC, MAPSRC, Consumer Councils	MHTLs, Director of Community Systems
Crisis Contract Performance Indicator Data	monthly and quarterly	Crisis teams and OAMHS monthly; informs OAMHS quarterly CD reporting	QI team collects and produces data
Supported Employment Data/Maine Medical Center	quarterly	CSNs; Mental Health Team	
Licensing/Completed Surveys	As licensing reviews are completed	Director of Policy who copies to MHTLs	Reported within CD Quarterly Report/DLRS/# of past due surveys/brief explanation/etc.

Department of Health and Human Service
Office of Adult Mental Health Services
Quality Management Reports
April 2008

Report	Frequency	Reported to	Comments
Licensing/List of Agencies reviewed by month	Monthly (beginning of month)	MHTLS; Plaintiffs Counsel: upon request	
MaineCare Data	annually, 3rd quarter; as needed	OAMHS	array of services/service encounter data/Reported within CD Quarterly Report/QI team/Core Service Related Data; statewide comparisons
Report of MaineCare Expenditures and grant funds expended, broken down by service area	Annual	Reported as a component of the quarterly compliance report	
Data Infrastructure Grant Survey	Annual	OAMHS Team; reported on within some CD Consent Decree Performance and Quality Improvement Standards; posted on the office's website	Data collected in the fall of each year by the Office of Quality Improvement
Public Education Data	Quarterly	Reported within CD Quarterly Report	Director of Training and Best Practices
24/7 Access to CSS Information	Monthly and Quarterly	Monthly to the Director of Policy; Quarterly within the quarterly compliance report as indicated	
Rapid Response Reports	Monthly	MHTLs, Director of Community Systems, CSNs as indicated	
Consent Decree Location Efforts	Quarterly	Director of Policy	
Crisis Standards Review	Every other year (1st, Nov/Dec 2007)	MH team, agencies surveyed	
Fidelity Reviews	as needed	MH team, agencies surveyed	

Office of Adult Mental Health Services within the Maine Department of Health and Human Services



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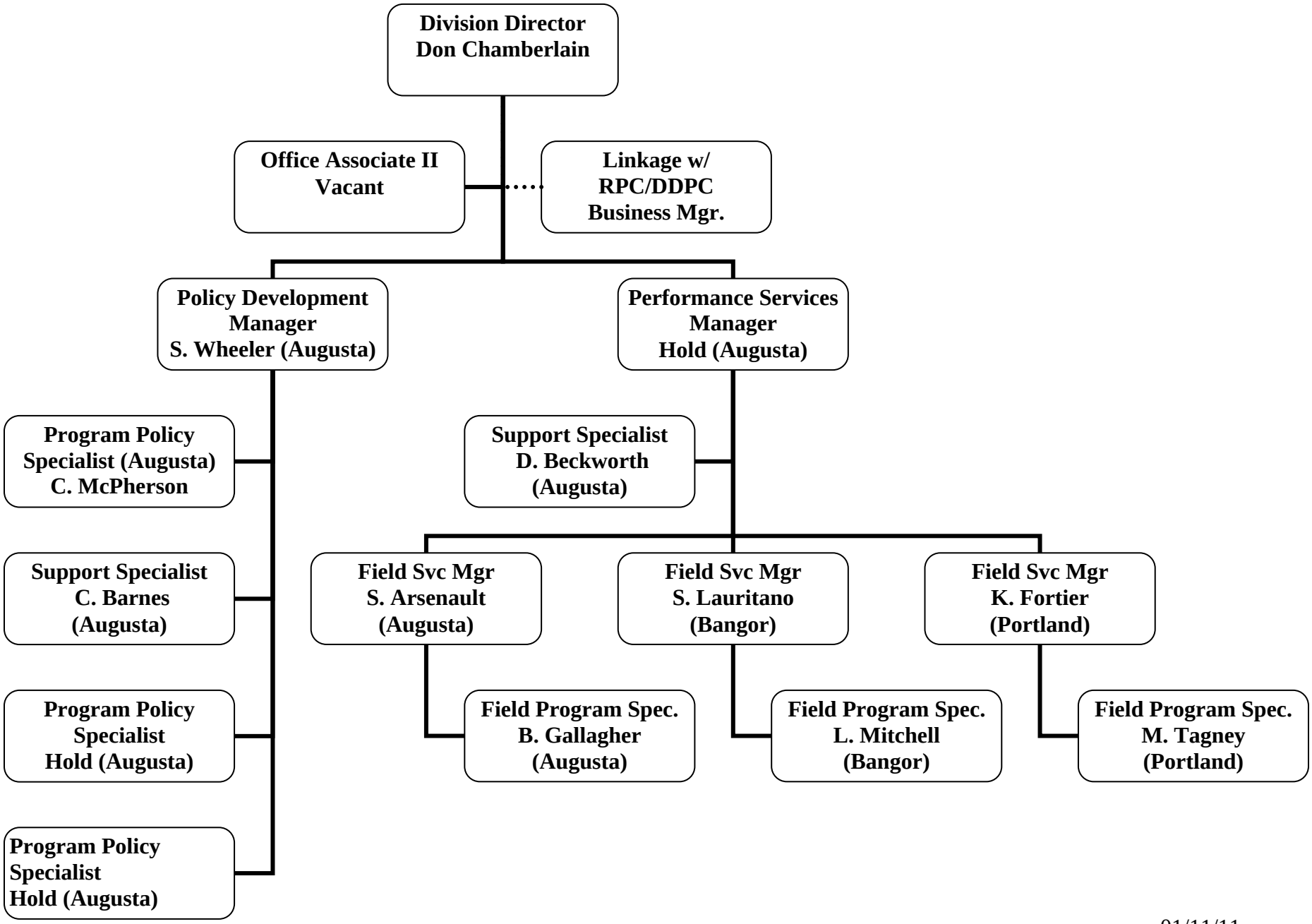
Division of Systems Operations



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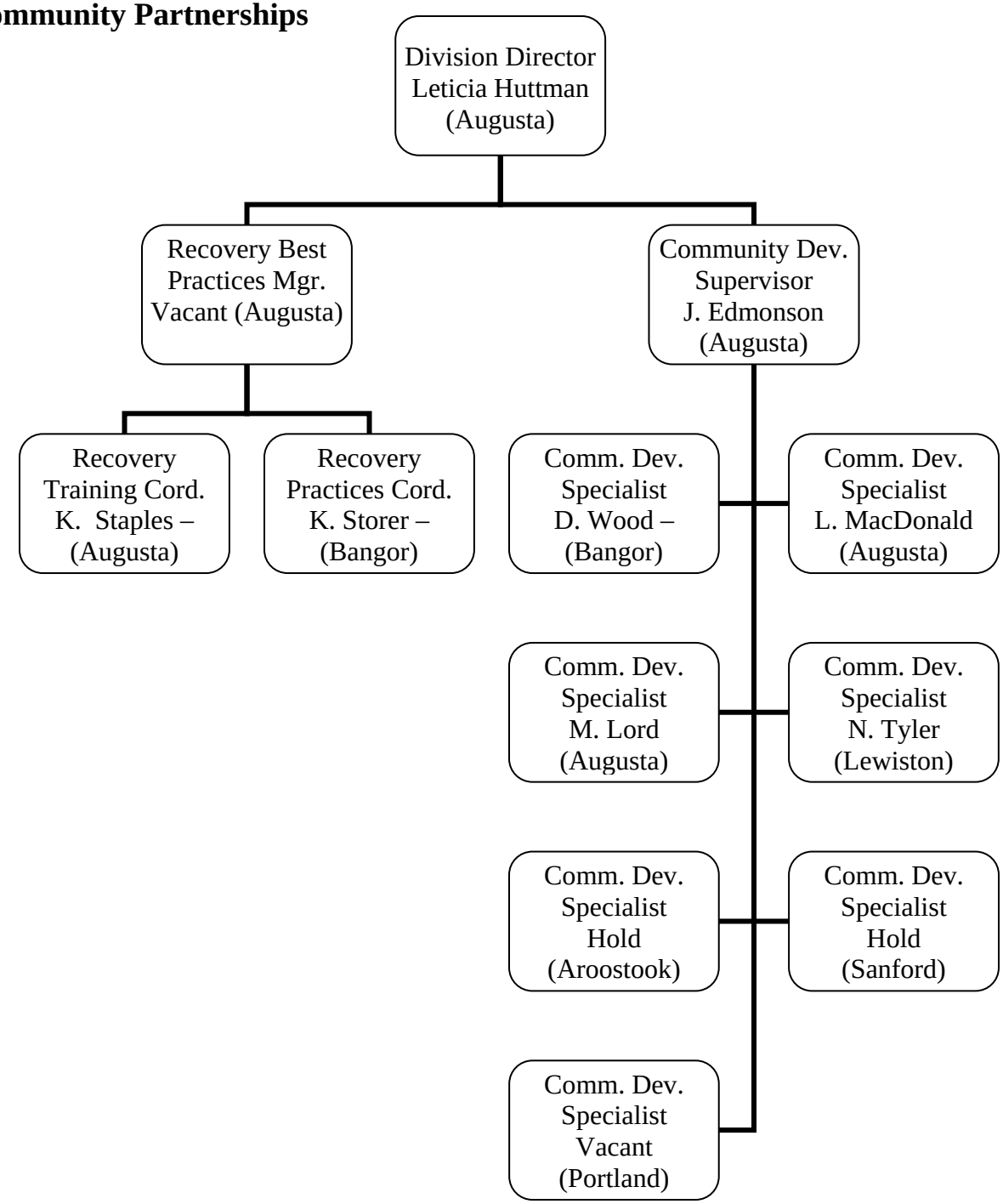
Division of Community Partnerships



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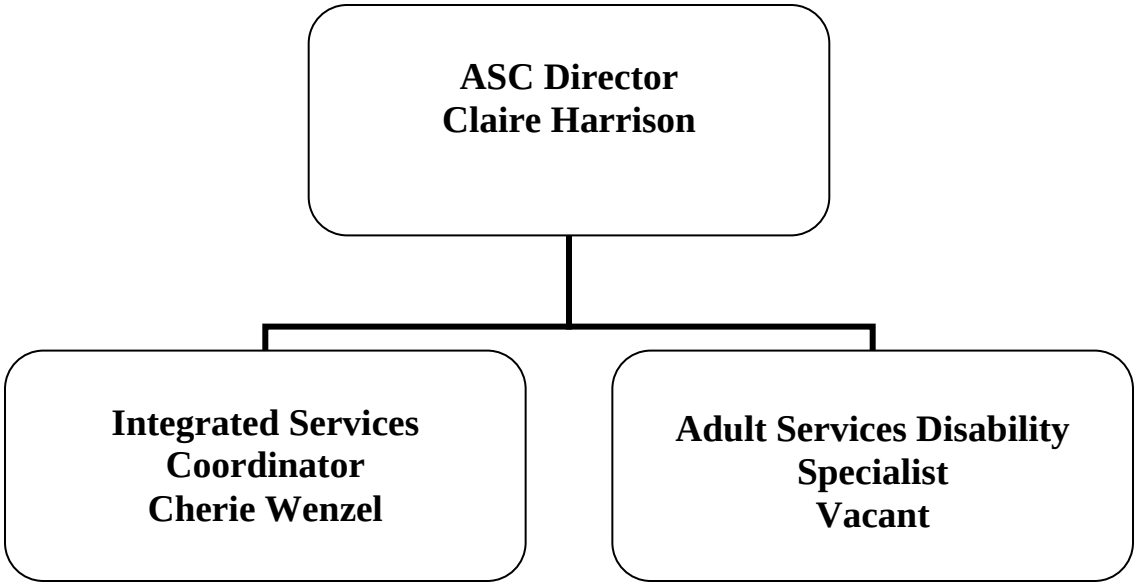
Adult Services Consortium

(Membership consists of the Office Directors listed below, with participation from additional Office Directors as needed.)

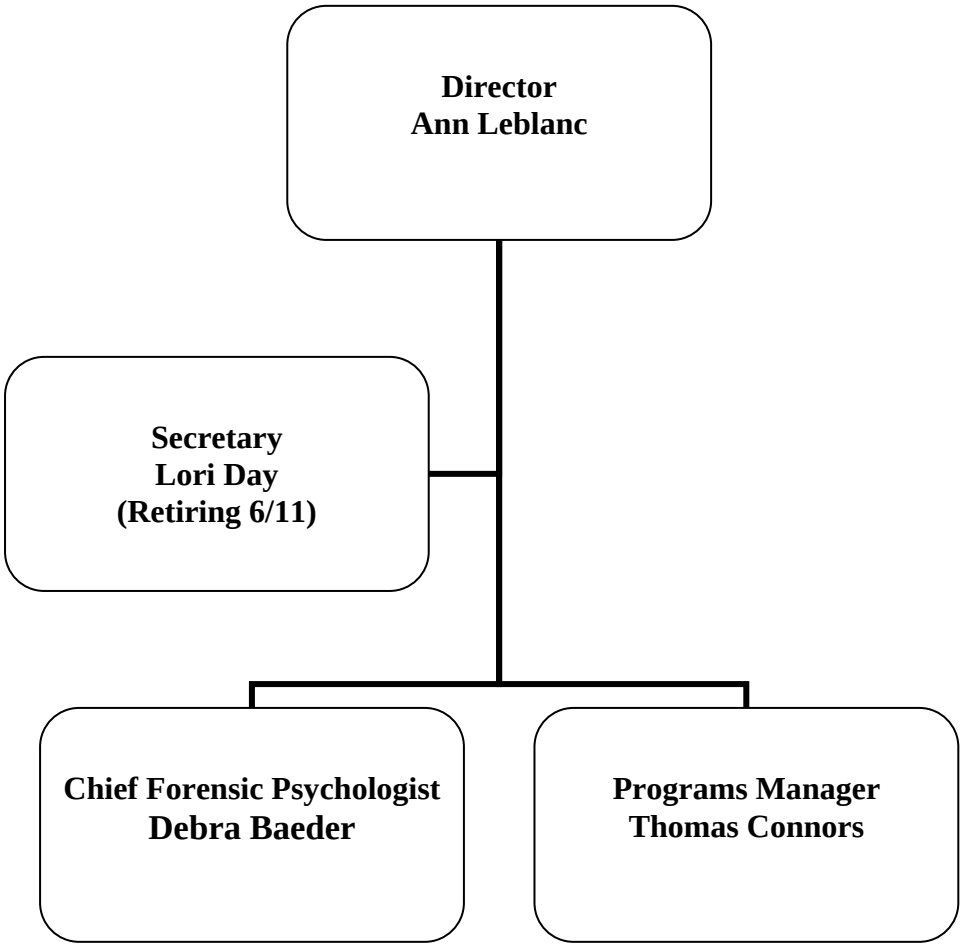
Standing Office Directors from:

Office of Adults with Cognitive and Physical Disability Services,
Office of Adult Mental Health Services,
Office of Elder Services,
Office of Substance Abuse

ASC staffing is diagramed below:



State Forensic Services



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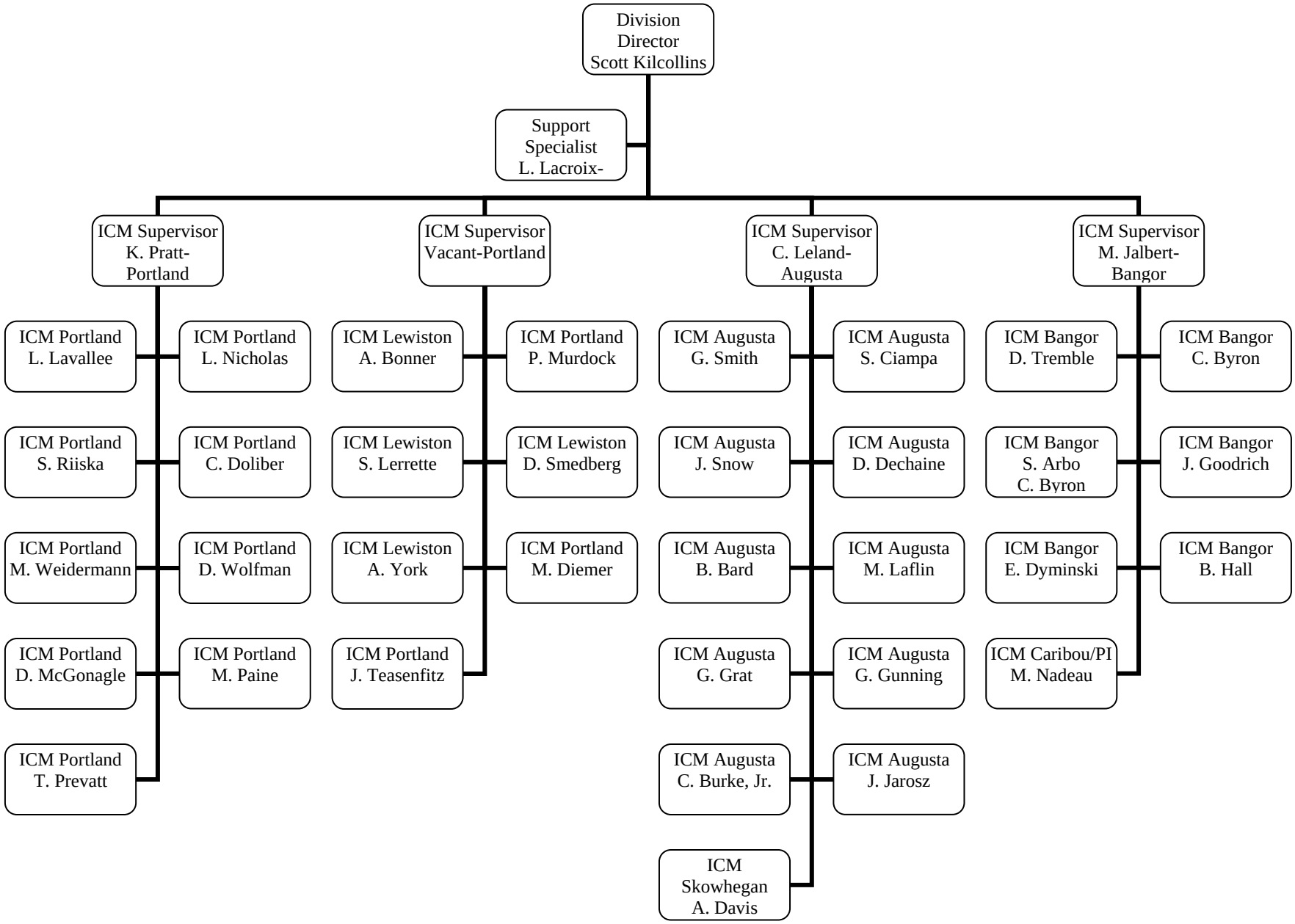
Division of Community Forensic and Outreach Services



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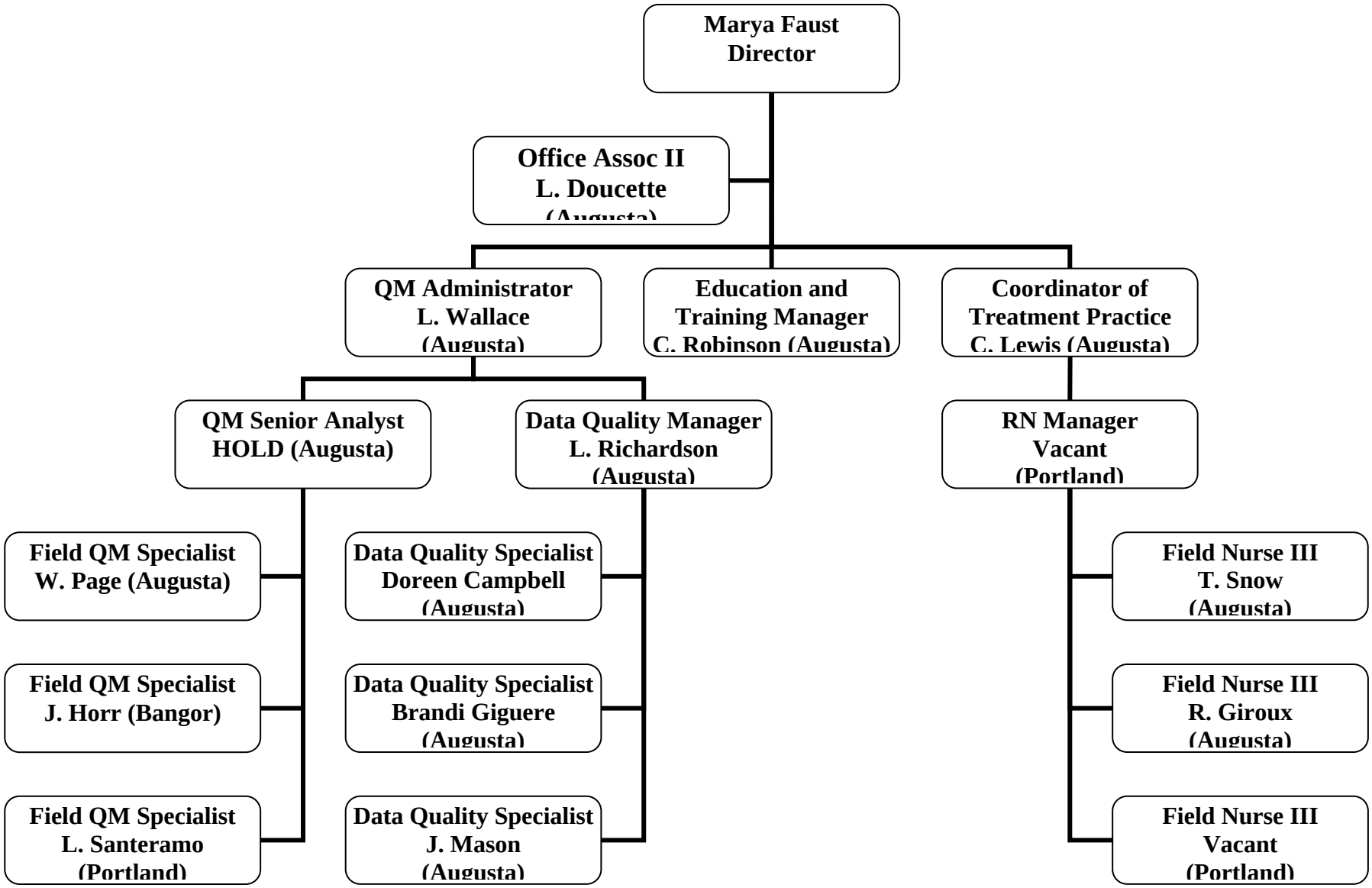
Division of Quality Management



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Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

Maine Center for Disease Control And Prevention

Maine Youth Suicide Prevention Program Plan

September 2007

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

Developed by the Maine Youth Suicide Prevention Program and MYSPP Committee members

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MYSPP PLAN EXECUTIVE SUMMARY

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. In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention emphasizing 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. The evidence for effective suicide prevention programs is limited, but growing. Maine is one of the states at the forefront of implementing and evaluating youth suicide prevention programs.

The Maine Youth Suicide Prevention Program (MYSPP) is a multi-agency effort coordinated by the Injury Prevention Program in the Maine Center for Disease Control and Prevention (Maine CDC), Division of Family Health in the Department of Health and Human Services. The long term goal of the MYSPP is: *To reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth ages 10-24.*

In 1997, the original MYSPP plan was created through an extensive process that included input from suicide survivors, youth, and a wide variety of clinicians and professionals statewide as a result of a task force established by Governor Angus King. Since that time, there has not been an appreciable reduction in the youth suicide rate in Maine. *However, reports of suicidal behavior among high and middle school students show a steady, measurable decline from 1999 to 2007.* MYSPP activities have yielded concrete interim results, most notably in training gatekeepers and in implementation of the comprehensive school-based Lifelines Program[1] in Maine high schools. Both of these activities have been evaluated and have been shown to increase adult confidence in identifying those at risk for suicide and in boosting student's help-seeking behaviors.[2]

In 2005, Governor John Baldacci issued an Executive Order to strengthen the MYSPP. A strategic planning process to improve the program plan was initiated by Maine's First Lady, Mrs. Karen Baldacci, who charged stakeholders, both within and outside of state government, with participating in the process.

This document represents a comprehensive plan with ten goals mirroring the National Strategy for Suicide Prevention. The objectives and activities contained within the plan goals represent the thoughtful recommendations of approximately 100 individuals who engaged with the MYSPP in this strategic planning process. As resources dedicated to implementing the recommended activities are limited, it is not possible to implement all recommendations made herein. However the plan provides a useful guide to the program and its partners in advancing youth suicide prevention efforts into the future and funding will be sought to support key priorities.

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[1] Kalafat, J. Underwood, M. *Lifelines: A School Based Adolescent Suicide Response Program*. Kendall/Hunt Publishing Co., Dubuque, IA. 1989.
[2] Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. An Evaluation of Maine's Comprehensive School-based Youth Suicide Prevention Program. 2007

Suicide and Self-Inflicted Injuries in Maine

Suicide is the 2nd leading cause of death for Maine residents ages 15-24, and the 3rd leading cause of death for 10-14 year olds.* Between 2000-2004, 115 Maine youth ages 10 – 24, or an average of 23 youth per year, died by suicide. In that five year period, Maine youth ages 10 –24 died by suicide at a higher rate, 8.8 per 100,000, than the Northeast regional rate of 5.3/100,000 and the national rate of 7.0/100,000. Due to the high rates of suicide among the young, suicide is the fourth leading cause of years of potential life lost in Maine.

Non-fatal self-injuries, suicidal ideation and suicide attempts, are larger problems among youth than in the adult population. From 2001-2005, 1,677 youth ages 10-24 were hospitalized for self-inflicted injuries, the 2nd leading cause of injury hospitalizations in this age group after motor vehicle related injuries. The 2001-2005 rate of self-injury hospitalization among youth ages 10-24 was 12.7 per 10,000 compared to 8.6 per 10,000 among those over age 25.

It is estimated that there are 25 to 100 suicide attempts by adolescents and young adults for every death by suicide. In the Maine 2005 Youth Risk Behavior Survey, 13 percent of Maine high school and 19.8 percent of middle school students reported seriously considering suicide in the past year. Six percent of high school and 8.5 percent of middle school students reported making at least one attempt.

The national Suicide Prevention Resource Center (SPRC) estimates medical cost per suicide in Maine at $3,780. Due to the high incidence of suicide at young ages, the estimated work loss cost per suicide is $1,079,323.

Maine Youth Suicide Prevention Program Plan

The plan presented herein was created in direct response to Governor Baldacci's Executive Order and will be adjusted and implemented as new resources become available, activities are completed and objectives are achieved. Flexibility must be maintained so that the program can respond to emerging issues in Maine and new research in the field of suicide prevention. The plan will be used to guide program implementation. Any revisions made will seek to honor the contributions of those involved in crafting the objectives and activities contained within the plan.

The MYSPP Plan contains ten goals that mirror those in the National Strategy for Suicide Prevention. During the strategic planning process, objectives were prioritized and ordered accordingly under each goal and possible lead departments and potential partners were identified. It was not possible to engage all stakeholder groups concerned about suicide prevention in this planning effort. To implement this plan, ongoing outreach is necessary to the potential leaders and partners identified in the plan. Specific activities to meet objectives are described in a separate working document for use by those directly involved in carrying out the activities.

*The leading cause of death to this age group is motor vehicle crashes.

The long-term goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among *Maine youth aged 10-24.*

To attain this goal, a comprehensive and sustained approach is necessary. The ten goals for enhancing the MYSPP are in alignment with the National Strategy for Suicide Prevention:

GOAL 1: Increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.

GOAL 2: Increase public awareness that suicide is a preventable public health problem.

GOAL 3: Develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and to increase help-seeking behaviors.

GOAL 4: Increase the number of Maine schools and communities statewide that implement effective youth suicide prevention activities.

GOAL 5: Support initiatives to decrease the risk of youth suicides by reducing access to lethal means.

GOAL 6: Implement training for recognition of at-risk behavior and appropriate response to a variety of audiences statewide.

GOAL 7: Develop and promote effective clinical and professional practices.

GOAL 8: Improve access to and community linkages with mental health, substance abuse, and suicide prevention services.

GOAL 9: Improve media reporting practices to reduce the potential of suicide contagion.

GOAL 10: Improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.

INTRODUCTION

MAINE YOUTH SUICIDE PREVENTION

PROGRAM PLAN

OVERVIEW

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 programs is limited, but growing. The U.S. Surgeon General issued the 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 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.

Maine is one of the states at the forefront of implementing and evaluating evidence-based youth suicide prevention programs. Current Maine Youth Suicide Prevention Program (MYSPP) activities include: 1) Statewide Information Resource Center; 2) Statewide crisis hotline; 3) Web sites for adults and youth; 4) Gatekeeper training and technical assistance for multiple audiences; 5) Awareness education programs and resources; 6) Training of trainers to conduct awareness education; 7) Annual suicide prevention conference; 8) School protocol guidelines and a protocol development workshop to help schools establish administrative protocols for suicide prevention, intervention and crisis management in the event of a suicide 9) Training for high school health educators in teaching "Lifelines" student lessons; 10) Training for instructors in the Coping and Support Training (C.A.S.T.) curriculum for high risk youth; 11) Education on restricting access to lethal means; 12) Media contagion education and guidelines; 13) Fact sheets, information booklets, and other resource materials; and 14) Suicide and self-inflicted injury data monitoring and analysis. In addition, the MYSPP is currently working on improving several program components and resources to increase effectiveness with specific populations at risk.

MYSPP HISTORY

The MYSPP was developed as an initiative of the Governor's Children's Cabinet which includes the commissioners from the departments of Health and Human Services, Education, Corrections, Labor and Public Safety. The MYSPP is housed within, and coordinated by, the Division of Family Health in the Maine Center for Disease Control and Prevention of the Department of Health and Human Services. Since inception, the program has been advised by a Steering

Committee that provides guidance to program development and implementation. Membership includes government and private stakeholders.

Since 1998, the MYSPP has employed a public health approach to address youth suicide. The program is based upon the assumption that collaboration among state agency leaders and staff, along with significant input from service providers, youth, suicide survivors and others, is necessary to plan and conduct youth suicide prevention activities. The long-term goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth ages 10-24.

The original program plan was created in 1997 through an extensive process that included input from suicide survivors, youth, and a wide variety of clinicians and professionals from around the state. Many activities in the initial plan are still being implemented.

When program implementation began in 1998, every Children's Cabinet agency was instructed to include youth suicide prevention as a priority area using existing agency funds. Each agency was asked to assume leadership in implementing specific portions of the plan in order to build and sustain a state level infrastructure. In 1999, the Children's Cabinet provided some start-up funds to initiate program activities.

The MYSPP has received regional and national recognition for its efforts and has given numerous presentations at state, regional and national conferences. Maine has contributed to the national suicide prevention evidence base through its work, most notably through implementing and evaluating the Lifelines Program, a promising school-based program, with a grant from the Centers for Disease Control and Prevention (CDC).

This project was implemented in 12 Maine high schools from 2002-2006. In September 2005, the MYSPP was awarded a Garrett Lee Smith Memorial Act grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year youth suicide prevention project. In 2006, an additional grant award to conduct an in-depth evaluation of the SAMHSA project was obtained.

STRATEGIC PLANNING PROCESS

In February 2005, following consultation with key stakeholders, the Governor's Office issued an Executive Order directing Children's Cabinet agencies to strengthen the MYSPP. Two things happened in direct response to the Executive Order. First, the Children's Cabinet created an ad hoc *Safe School and Community Climate Committee* to increase the implementation of effective positive youth development approaches, anti-bullying, anti-harassment, and anti-discrimination policies and procedures to foster safe school and community environments for Maine youth. This work resulted in legislation requiring all Maine schools to establish or modify their policies and procedures to address bullying and harassment and the development of model policies for school systems.

Second, the MYSPP initiated a strategic planning process. A full day retreat was held at the end of March 2005 with facilitators from the National Suicide Prevention Resource Center (SPRC), the Centers for Disease Control and Prevention (CDC) and the Children's Safety Network (CSN). A diverse group of stakeholders, from within and outside of state government, participated in the retreat and were given their charge by Maine's First Lady, Mrs. Karen Baldacci. Four new committees were launched to begin a process of identifying gaps and selecting strategic priorities to strengthen the MYSPP plan.

The committees were formed to align with the goals of the National Strategy for Suicide Prevention and included: 1) *Public Awareness*; 2) *School and Community-based Suicide Prevention*; 3) *Effective Clinical and Professional Practice*s; and 4) *Lethal Means Restriction*. Co-leaders, one from a state agency and one external to state government, worked with their committee members to produce recommendations to the MYSPP. A fifth committee, the *Data and Evaluation Committee*, met once outside of the retreat and drafted recommendations for improving data collection and analysis.

Development of the plan would not have been possible without the many hours spent by those who participated at and since the retreat. Almost 100 individuals participated in the process of revising the MYSPP plan. Drawing on their diverse knowledge and experience, these individuals reviewed national goals and applicable research, and participated in multiple meetings to discuss and develop recommendations for action to the MYSPP. While significant program strengths were noted, gaps were identified and priorities were set to indicate where new program efforts could be directed.

The Steering Committee provided oversight of the process by reviewing the work submitted by the committees. Steering Committee members offered valuable insight in further developing some of the goals, and identifying leaders, potential partners and possible resources for the new program plan. A report containing a response to the Executive Order and a 2006 MYSPP workplan was issued in December 2005.

SUPPORTS AND CHALLENGES TO SUICIDE PREVENTION IN MAINE

Supports

The MYSPP is fortunate to have the endorsement and support of the DHHS, the Governor's Office and the Children's Cabinet for this very important work. Collaboration is key to the success of any public health initiative and many public as well as private stakeholders have partnered with MYSPP. Schools from throughout the state continue to exhibit strong interest in learning more to enhance their prevention infrastructure and plan for effective responses to suicidal behavior.

The program has a modest amount of consistent funding, which it uses to good advantage, supporting a part-time coordinator and a training contract. More than 500 training programs have been provided across the state to over *15,000* people. The MYSPP has established strong relationships with local schools, mental health providers, colleges and universities and other key organizations. The state level infrastructure allows the program to disseminate its messages and interventions to receptive audiences, using resources efficiently.

With two federal grants acquired by the program, the MYSPP has expanded prevention initiatives to 20 Maine communities, bringing resources and programs, and generating new information on effective strategies in rural youth suicide prevention to the field.

Challenges

Suicide prevention, like any public health issue, faces multiple challenges.

The following are some of the more salient barriers in the suicide prevention field:

- Public awareness that suicide is a health problem that can be prevented is not widespread.
- Stigma surrounds obtaining services for mental health and substance abuse conditions, particularly in rural areas where the suicide rates are the highest.
- Waiting time to access non-crisis mental health services is often lengthy.
- Pre-service (college) education in effective suicide prevention and intervention strategies for professionals entering the fields of education, health care, public safety and other fields is not widely available.
- Suicide behavior is not widely perceived by the healthcare community as a problem that they can recognize and address.
- Restricting access to lethal means around suicidal individuals is not widely understood and accepted as an important method of reducing suicide.
- Suicidal behaviors are complex. Strong, evidence-based research for effective suicide prevention, intervention and treatment is not well developed.
- Reaching older youth and disconnected youth at risk, who are not in school settings, is difficult.

Some specific challenges faced in Maine:

- Timely access to and in-depth analysis of morbidity and mortality data to improve understanding of the youth suicide problem and trends in our state are lacking.
- State agency staff involved in the program consistently experience multiple competing demands on their time.
- Few school or community based suicide prevention programs exist in the state.
- Resources to implement best practice suicide prevention activities statewide are limited.

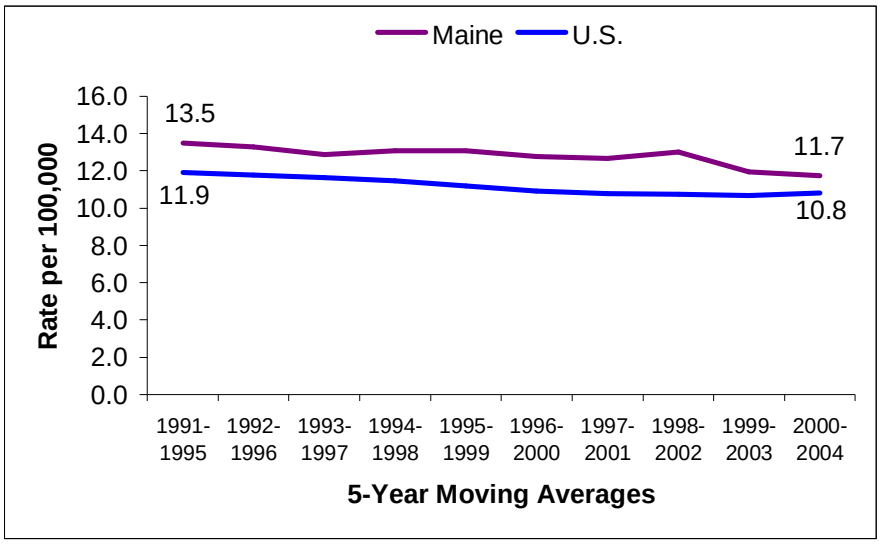
SUICIDE AND SELF-INFLICTED INJURIES IN MAINE

Suicide is a significant public health problem in the United States and in Maine, impacting families, friends, school systems and entire communities.

Suicide is the 11th leading cause of death in the United States, claiming over 32,000 lives annually. It is the leading cause of intentional injury death for persons ages 10 and over in Maine and was the 10th leading cause of death overall for Maine residents from 2000-2004, the most recent five-year period for which data are available. In the same period, the Maine suicide rate of 11.7 per 100,000 population was ranked 27th highest age-adjusted suicide rate in the United States for all ages; higher than the national average rate of 10.8 per 100,000 and the Northeastern rate of 7.7 per 100,000.

Overall, suicide rates in Maine and the U.S. have decreased since the early 1990s. The average suicide rate for 1991-1995 in Maine was 13.5 per 100,000. For 2000-2004, the rate was 11.7 per 100,000. Over this same time period, the U.S. rate declined from 11.9 per 100,000 in 1991-1995 to 10.8 in 2000-2005.

Age-adjusted suicide rates in Maine and the U.S., 1995-2004, all ages



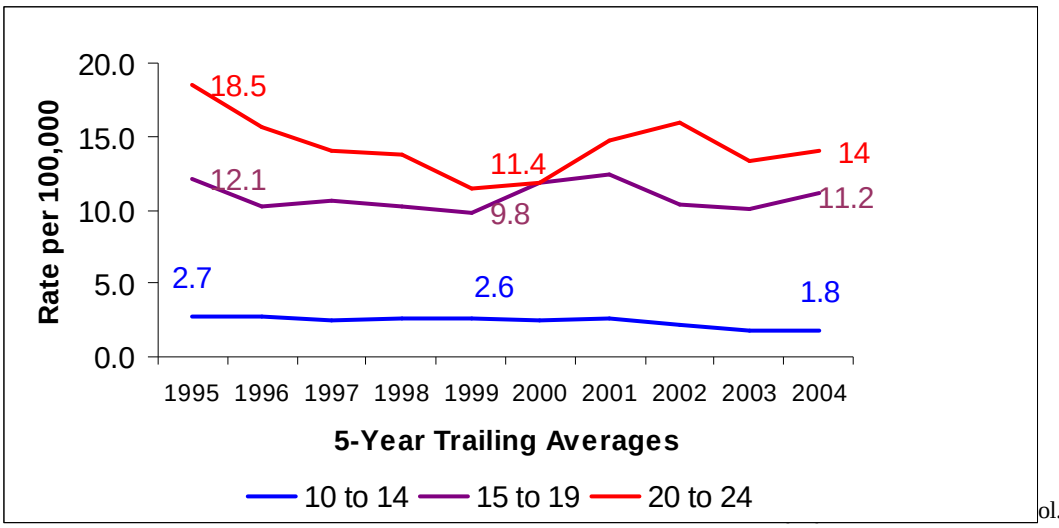
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

From 2000 through 2004, 789 Maine residents died by suicide, an average of 158 each year. Eighty-five percent (674) of these suicides were persons over age 24; 15 percent (115) were youth aged 10-24 (eight youth aged 10-14; fifty-two 15-19 year olds; and fifty-five young adults aged 20-24). Suicide is the 2nd leading cause of death for Maine residents ages 15-34; the 3rd leading cause of death for 10-14 year olds and the 4th leading cause of death for those ages 35-54.

The MYSPP focuses upon suicide prevention among 10-24 year olds. Between 2000-2004, Maine's suicide rate among youth and young adults ages 10-24 was 8.8 per 100,000. This is higher than the Northeast regional rate of 5.3/100,000 and the national rate of 7.0/100,000.

Among youth in Maine, especially those between 15-24, the suicide rate declined between 1991-1999, but has since varied with no discernable trend. The average suicide rate among Maine youth 10-24 was 10.9 per 100,000 in 1991-1995. Between 2000-2004, this average had dropped to 8.9 per 100,000.

Suicide death rates among youth age 10-24 years in Maine, 1995-2004



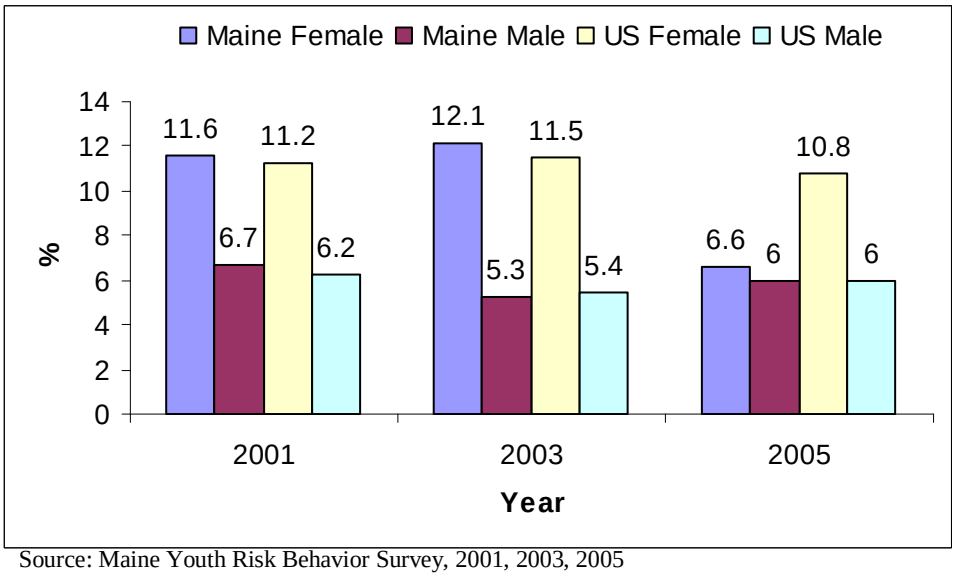
ol. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

Suicide claims more lives of young people than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined. Due to the high rates of suicide among the young, suicide is the fourth leading cause of years of potential life lost in Maine. More young people in our state die by suicide than homicide. There are four to five suicides for every homicide among Maine youth.

Suicide deaths, though very tragic, are the tip of the iceberg particularly among youth. Rates of suicidal behavior among youth are thought to be far higher than in adult populations. It is estimated that there are 25 to 100 suicide attempts by adolescents and young adults for every youth suicide.

Self-reported suicide attempts in Maine have decreased over time, especially among girls, according to data from the Maine Youth Risk Behavior Survey (YRBS), a representative survey of high school students in Maine. In 2001, 11.6 percent of Maine high school girls reported attempting suicide within the past year; in 2005, this dropped to 6.6 percent. Among boys we did not see a similar large decline over this 5-year period; 6.7 percent reported attempting suicide in 2001, compared to 6 percent in 2005. Suicide ideation has also decreased in Maine youth over time. In 1997, 30 percent of Maine middle school students reported considering attempting suicide within the previous 12 months. This number decreased to 19.8 percent in 2005.

Self-reported suicide attempts among Maine and U.S. High school students by sex, YRBS 2001-2005

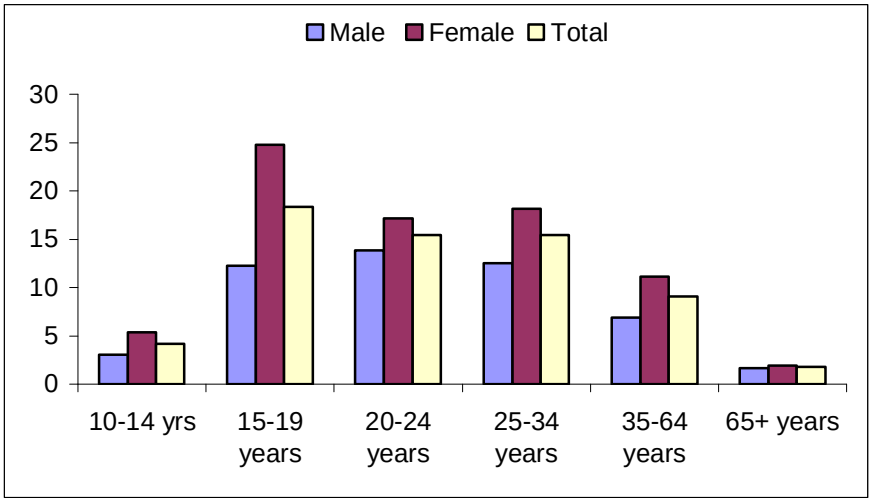


Source: Maine Youth Risk Behavior Survey, 2001, 2003, 2005

Despite the decline in self-reported suicide attempts, youth in Maine are more likely than adults to be hospitalized for self-injury. In Maine, from 2001-2005, 1,677 youth under age 24 were hospitalized for self-inflicted injuries.

Adolescent girls age 15-19 have consistently exhibited the highest rate of self-injury hospitalization in the state. The 2001-2005 rate of self-injury hospitalization among youth ages 10-24 was 12.7 per 10,000 compared to 8.6 per 10,000 among those over age 25. Intentional self-inflicted poisoning was the 3rd leading cause of injury hospitalizations in all ages combined.

Age and Gender-Specific Rates of Hospitalization (per 10,000) for Self-Inflicted Injury in Maine, 2000-2004



Source: Maine Uniform Hospital Discharge Database, Maine Health Data Organization

Risk Factors

Suicidal behavior is complex. When someone is suicidal, it is usually due to a combination of external stressors, internal conflicts, and biological dysfunction. There is no one set of risk factors that fits all suicidal individuals or accurately predicts the imminent danger of suicide for a specific individual. Several studies and data from Maine reveal that suicide rates vary by demographic characteristics such as gender, race/ethnicity, and sexual orientation. Other prominent risk factors for suicide include a family history of suicide, living alone, being unemployed and owning a gun. Trauma, depression, anxiety, conduct disorders, substance abuse, and lack of personal skills or supportive resources also contribute to the possibility of suicide, but they do not, by themselves, cause suicide.

Race/Ethnicity

Across the U.S., white, non-Hispanic males experience the highest rates of suicide. The second highest rate is among American Indians and Native Alaskans. Maine's suicide rate among white, non-Hispanics is higher than the Northeast region's white, non-Hispanic rate, but is not significantly higher than the national white non-Hispanic rate. Racial/ethnic differences do not account for Maine's elevated suicide rates.

Gender

Four of five suicide victims in Maine are males. Of the 789 suicides in Maine from 2000-2004, 640, or 81 percent, were males, with those ages 20 though 59 representing more than half (54 percent) of Maine's suicides.

Females are more likely than males to be hospitalized for intentional self-injury. Between 2000 and 2004, the rate of hospitalizations for self-inflicted injury was higher for females in every age group to age 64 when compared to males. The highest rate of hospitalization for intentional self-harm is among females ages 15-19.

Data from the 2001-2005 Maine Youth Risk Behavior Surveys reveal that high school girls are more likely than boys to report considering or planning a suicide attempt. Between 2001-2005, almost 1 in 4 (23.6 percent) high school girls and 1 in 6 (16.1 percent) high school boys reported considering or planning a suicide attempt. Girls were also more likely than boys to actually attempt suicide (10.0 percent vs. 6.0 percent).

Sexual Orientation

Some research suggests that suicide risk is higher among homosexual youth due to the challenges many face when dealing with the stigma of homosexuality. In Maine, high schools students who report same sex or bisexual contact are more likely than youth who reported opposite sex or no sexual contact to report both suicide ideation and attempts. Based on data from the 2001-2005 YRBS, almost 40 percent of youth who reported same sex/bisexual contact considered suicide or planned an attempt in the previous 12 months compared to 21 percent of youth who had opposite sex contact only and 15 percent of youth who had never had sexual contact. Almost than 1 in 4 (23 percent) youth who reported same sex/bisexual contact attempted suicide in the past year.

Mental Illness

It is widely believed that from 60 percent to 90 percent of suicide victims meet the criteria for some form of mental illness, most commonly severe depression or other mood disorders and anxiety or conduct disorders. According to the 2005 Maine Youth Risk Behavior Survey (YRBS), 1 in 5 (20.6 percent) adolescents reported symptoms of depression in the past year. Between 2001-2005, 53 percent of the adolescents who reported depressive symptoms considered or planned a suicide attempt and 22 percent reported attempting suicide. Based on hospitalization data from 2001-2005, 83 percent of individuals hospitalized for intentional self-injury had a co-occurring mental disorder diagnosis.

Substance Abuse

Substance use is highly related to mental illness, suicide ideation, and suicide attempts in both youth and adults. In both the U.S. and Maine, substance use, especially alcohol use, is common among adolescents. According to the 2005 YRBS, 43 percent of Maine and U.S. high school students consumed alcohol and 1 in 4 had five or more drinks in a row within the past month. Twenty-two percent of Maine high school students used marijuana and 3.2 percent used cocaine within the past month. Among Maine high schools students, smoking any cigarettes in the past month is associated with suicide ideation (Maine YRBS, 2001-2005); more than 1 in 3 (36 percent) youths who smoked 20 days or more reported suicide ideation in the past year. Youth who smoked were about three times more likely than non-smokers to report attempting suicide in the past year. Youth who reported suicide ideation and attempts were also more likely to report recent binge drinking and use of illegal drugs, such as marijuana, cocaine, heroin, steroids, and unauthorized prescription medication.

Trauma/Victimization

Several studies have found that a history of sexual assault, ongoing domestic violence, and experiencing other traumatic events increase one's risk of attempting suicide. Using data from Maine's 2001-2005 Youth Risk Behavior Surveys, high school students who report being the victim of dating violence in the past year were two times more likely than non-victims to report suicide ideation (37 percent vs. 17 percent) and suicide attempts (17 percent vs. 7 percent) in the past year.

Almost half (46 percent) of students who had been the victims of sexual assault during their lifetime reported suicide ideation in the past year compared to 17 percent of non-victims; 1 in 4 sexual assault victims attempted suicide in the past year.

Being the target of racially offensive remarks, and those who had been attacked based on their race or ethnicity, at school, or on the way to school, also increased the risk for suicide ideation and attempts. The same held true for victims of comments or attacks based on sexual orientation. About one-third of victims of racial harassment/attacks and 44 percent of victims of harassment/attacks based on sexual orientation considered or planned a suicide attempt in the past year. One in 5 victims of harassment based on sexual orientation attempted suicide in the past year.

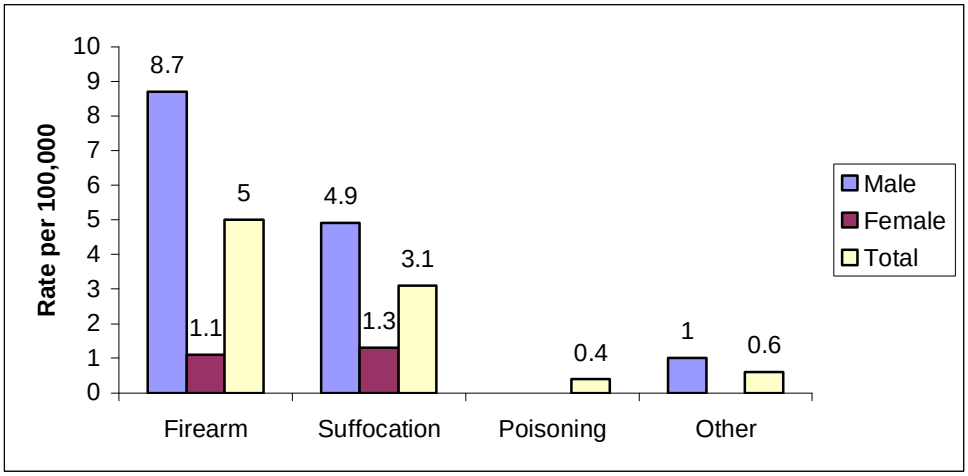
Nearly half of students (43 percent) who reported staying home from school in the past year because they felt unsafe considered or planned a suicide attempt and 27 percent actually attempted suicide.

Method

The lethality of the method determines the difference between a non-fatal attempt and a death by suicide. Firearm and hanging victims have less chance for survival than those using a less lethal method, such as poisoning.

Access to firearms is a significant factor in youth suicide, because most suicide attempts by firearm are fatal. From 2000 to 2004, a firearm was used in nearly 6 of 10 youth suicides, almost 60 percent of male and 40 percent of female youth suicides. The second leading method of youth suicide during this time was hanging, accounting for nearly 4 of 10 suicides. Between 2000 and 2004, hanging accounted for 34 percent of male suicides and 44 percent of female suicides among youth ages 10 to 24.

Causes of suicide by gender among 10-24 year olds in Maine, 2000-2004

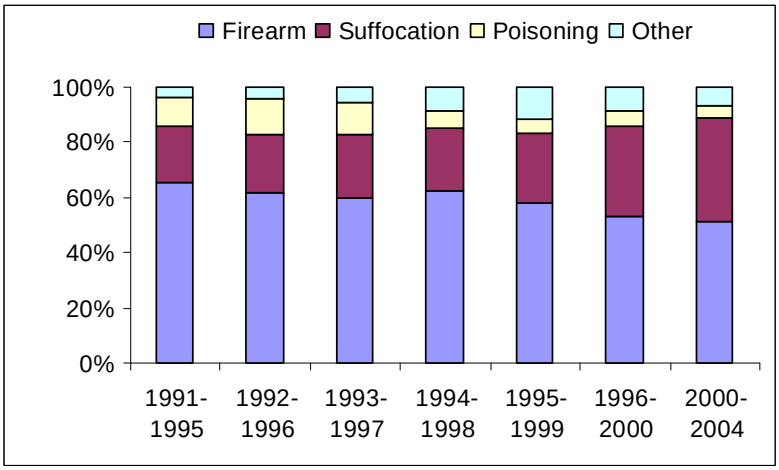


Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

Over time, there has been a gradual shift in the methods used by youth who die by suicide. In a recent national MMWR report[3], national data revealed that there has been a recent increase in suicides among girls in the U.S., and the primary method of suicide shifted from firearms to hanging/suffocation. In Maine we are unable to examine the gender breakdown by method due to small numbers, but since the early 1990s, firearm suicides among youth ages 10-24 have declined, while suicides by hanging/suffocation have increased. Between 1991-1995, hanging suffocation accounted for 20 percent of suicides among youth ages 10-24; between 2000-2004, almost 1 in 3 (32 percent) suicides among young were committed by hanging/suffocation.

[3] Lubell KM, Kegler SR, Crosby AE, Karch D. Suicide trends among youth and young adults age 10-24 years - United States - 1990-2004. *MMWR*, 56(35): 905-908.

Percent of suicide methods among 10-24 year olds in Maine, 1991-2004



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Injury Costs

In 2000, the total national burden of suicide was estimated at $125 billion. This includes direct health care costs and indirect costs related to the loss of productive life. The national Suicide Prevention Resource Center (SPRC) estimates medical cost per suicide in Maine at $3,780. Due to the elevated incidence of suicide at young ages, the estimated work-loss cost per suicide is $1,079,323. For non-fatal suicide attempts, the estimated medical cost per suicide is $11,200 and the estimated work-loss cost per case is $10,867.

MAINE YOUTH SUICIDE PREVENTION PROGRAM PLAN

The plan contains the goals, objectives and activities recommended by the numerous stakeholders who engaged in the planning process with the Maine Youth Suicide Prevention Program (MYSPP) in response to Governor John Baldacci's 2005 Executive Order. It represents the best thinking of those involved and is intended to strengthen and guide the MYSPP and partners into the future. *It is acknowledged that all recommendations made cannot be implemented given current resources.* Nevertheless, this plan provides a collection of goals, objectives and activities to be given consideration as resources become available.

The plan will be adjusted as research in the suicide prevention field progresses and as activities are implemented and objectives are achieved. Any revisions made will seek to honor the contributions of those involved in crafting the plan activities and objectives.

The plan contains 10 goals that align with the National Strategy for Suicide Prevention. During the strategic planning process, objectives were prioritized and ordered accordingly under each goal. In addition, descriptions are provided for all of the goals and a rationale is given for each of the objectives. Where possible, lead departments and potential partners were identified, though every organization named as a potential partner has not yet been approached. Specific activities are described in a separate working document to guide those directly involved in implementing them. Several of the activities are being implemented and evaluated with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), or have been evaluated previously. Evaluation plans for most objectives have been drafted, and will be utilized as funding becomes available. Evaluation plans are not contained within this document.

The MYSPP appreciates the significant and thoughtful efforts of those involved in the process of developing the plan, and gratefully acknowledges their contributions. It is important to note that the input gained from this process reflects the ideas and work of those who engaged in the process. It was not possible to engage all stakeholder groups concerned about suicide prevention in this planning effort. Much work remains to be done. In some cases, the groups or organizations named as potential leaders or partners have yet to be contacted. In other cases, defining baselines and planning feasible and effective activities to meet identified objectives needs to occur.

Continued and strengthened involvement of the state agencies of the Governor's Children's Cabinet with health, mental health, education, and safety personnel in the field, families and communities all around the state is necessary to achieving results. With resources dedicated to implementing the plan over a sustained period of time, Maine's efforts to prevent youth suicide will be significantly enhanced and the goal of reducing youth suicide and suicidal behaviors among Maine children, teens and young adults realized.

Maine Youth Suicide Prevention Program (MYSPP) Goal 1

Increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.

Background:

Suicide has been widely recognized as a public health problem in the United States in recent years, requiring national attention and urgent action. In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention. This publication characterizes suicide as a major public health problem, which can only be reduced through integrated efforts by government, public health, education, human services and other public and private partners. Because there are many paths to suicide, prevention must address psychological, biological, and social factors in order to be effective. Leadership, collaboration and coordination across a broad spectrum of agencies, institutions, and groups are necessary to ensure that prevention efforts are effective.[4]

Description:

Objectives under this goal are designed to solicit and support leadership, improve coordination of activities and increase collaboration among stakeholders at the state, regional and community levels in order to enhance support and integration of suicide prevention activities. Outreach to increase partnerships with unique populations to develop culturally competent suicide prevention resources is also an identified priority.

Objective 1.1: Increase leadership, coordination and collaboration across disciplines and with public and private stakeholders at the state, regional and community levels in order to enhance support for, and implementation of, youth suicide prevention activities.

Population Focus:

Youth-serving private and public organizations
Children's Cabinet agencies

Rationale:

While several state agencies and private stakeholders are active in youth suicide prevention efforts, improved collaboration and coordination is necessary to ensure that suicide is understood as a statewide problem and that limited resources are used efficiently. The knowledge and resources that each contributes has the potential to significantly enhance the prevention efforts of individual agencies and the MYSPP as a whole. Consistent commitment and enhanced collaboration among Children's Cabinet agencies will lead to increased integration of suicide prevention efforts into each agency's mandates, priorities and activities. Partnerships will help establish momentum for the plan and will provide continuity over time, as well as legitimacy through the involvement of key groups.

[4] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 50.

Lead Department:

- Department of Health and Human Services (DHHS), Maine Center for Disease Control & Prevention (Maine CDC)

Potential Partners:

- Children's Cabinet Agencies
- MYSPP Steering Committee members

Objective 1.2: Enhance collaborations and partnerships with groups and organizations that reach youth populations at increased risk of suicidal behaviors.

Population Focus:
Groups and organizations working with or providing services to high risk youth

Rationale:
Some youth are at increased risk for suicidal behavior. The MYSPP intends to reach out to specific groups and organizations that are in a unique position to assist high-risk youth. Expanding partnerships is intended to increase awareness and extend the reach of suicide prevention resources to high-risk youth.

MYSPP committees recommended that collaborations be cultivated with three specific groups: faith communities, Native American tribes and organizations serving lesbian, gay, bi-sexual, transgendered and questioning (LGBT) youth.

Faith Communities
Faith communities offer support and guidance to their members and communities at large during stressful times. Because of their unique position, faith leaders can also play an important role in suicide prevention by de-stigmatizing mental illness, substance use problems, suicidal and other related health risk behaviors. Preparation of members of the faith community in basic suicide prevention knowledge and skills will increase the effectiveness of their response to persons at risk of suicide and to the needs of survivors of suicide.

Native American Tribes
Across the U.S., American Indian and Alaskan Natives have the highest rate of suicide among the 15 to 24 age group.[5] Studies of American Indians and Alaska Natives in other parts of the country have indicated that social and cultural changes and the pressure to conform to "white" culture are linked to higher suicide rates.[6]

The vast majority (98.5 percent) of Mainers are white and the native population is relatively small (0.5 percent). There are 8,576 American Indians [7] living in or near five small rural communities in Aroostook, Penobscot, and Washington Counties. The small absolute number of American

[5] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (producer). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Available online from: http://www.cdc.gov/ncipc/wisqars/default.htm. (2004).
[6] Goldsmith, S. K., Pellmar. T. C., Keinman. A. M., Bunney, W. E., Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002; p 49.
[7] US Census, American Community Survey Summary Tables, http://factfinder.census.gov. 2003.

Indians in Maine makes reliable data collection and analysis of suicidal behaviors among these youth in the state difficult. However, we know from a study in Maine, from 1993-1997, the age-adjusted mortality rate due to suicide for American Indians in Maine at that time was 30 percent higher than that of the overall population.[8] In order to better understand the extent of suicidal behaviors and corresponding needs among Native youth, collaboration with the Tribes in Maine is essential to build culturally competent responses.

Providers and Organizations Serving Lesbian, Gay, Bi-sexual, Transgendered and Questioning Youth (LGBTQ)

The evidence that LGBTQ youth disproportionately engage in suicidal behaviors is strong. The public health, medical, and social science research literature is compelling in demonstrating an association between sexual orientation and suicidal behaviors. A growing body of research concludes that LGBTQ youth are more likely than heterosexual youth to contemplate and attempt suicide.[9] [10] [11] The 1999 Surgeon General's Call to Action to Prevent Suicide states that that there is growing concern about an association between suicide risk and bisexuality or homosexuality for youth, particularly males. It is vital to reach out to sexual minority youth with information and education by partnering with schools, health care providers and other organizations serving these youth.

Agencies Serving High Risk Youth

It is widely believed that from 60 percent to 90 percent of suicide victims meet the criteria for some form of mental illness, most commonly severe depression or other mood disorders, and anxiety or conduct disorders. These conditions often occur in combination with substance abuse.[12] According to the 2000 National Household Survey on Drug Abuse, youths who reported use of any illicit drug other than marijuana were three times more likely than youths who did not use these substances to be at risk for suicide.[13] Also at high risk are youth in the juvenile justice system. Of the more than 11,000 incarcerated youth in the nation, over half suffer from diagnosable, yet untreated mental illnesses.[14] Within this group, more than 17,000 incidents of suicidal behavior are recorded in juvenile facilities each year.[15] Efforts will be made to engage agencies serving high risk youth as resources permit.

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[8] Health Status and Needs Assessment of Native Americans in Maine: Final Report, Kuehnert, P., Maine Bureau of Health, January 15, 2000.

[9] Remafedi, G. Sexual Orientation and Youth Suicide. *JAMA: Journal of the American Medical Association*, Volume 282, Number 13. 1999; p 1291-1292, http://ejournals.ebsco.com.prxy3.ursus.maine.edu/direct.asp?ArticleID=471CBCAD04516A0E2010

[10] Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., Goodman, E. Sexual Orientation and Risk of Suicide Attempts Among a Representative Sample of Youth. Archives of Pediatrics & Adolescent Medicine, 153. 1999; p 487-493.

[11] Leah, R., Brener, N. D., Donahue, S. F., Hack, T., Hale, K., Goodenow, C. Associations Between Health Risk Behaviors and Opposite-, Same-, and Both-Sex Sexual Partners in Representative Samples of Vermont and Massachusetts High School Students. Arch of Pediatrics & Adolescent Medicine, 156. 2002; p 349-355.

[12] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service. 2001.

[13] National Household Survey on Drug Abuse; The NHSDA Report: Substance Use and the Risk of Suicide Among Youths; Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), July 12, 2002.

[14] Teplin, L. A. & McClelland, G. *Psychiatric and Substance Abuse Disorders among Juveniles in Detention: An Empirical Assessment.* Paper presented at the convention of American Psychological—Law Society, Redondo Beach, CA. March 1998.

[15] Hayes, L. M. Juvenile Suicide in Confinement: A National Survey. *Corrections Today, 26.* July 2000; p 26.

Lead Department:

- DHHS:
  - Maine CDC
  - Children's Behavioral Health Services (CBHS)
  - Office of Substance Abuse (OSA)

Potential Partners:

- MYSPP Steering Committee
- Training contractors
- Faith communities/associations
- Office of Minority Health
- Native American Tribes
- Organizations serving LGBTQ youth
- Maine Youth Action Network (MYAN) and other organizations directly serving Maine youth
- National Alliance for the Mentally Ill of Maine (NAMI Maine)
- Health care and social service providers

Objective 1.3: Annually, increase the number of youth-serving programs statewide, including state-based efforts, professional and voluntary organizations, and others, that integrate suicide prevention and intervention activities into their programs.

Population Focus:

Staff from organizations, agencies, institutions and other groups statewide that have a youth focus or special interest in youth, or are in a position to observe suicidal behavior and take action when necessary

Rationale:

Considering the known risk and protective factors for suicidal behaviors, a public health approach implemented at multiple levels is necessary to prevent youth suicide. Violence prevention depends upon the collaboration of government, business, civic, religious, and cultural organizations. Maine has many programs designed to build protective factors and/or address various youth risk behaviors. These programs and systems help to reduce the possibility of suicide. However, in order to identify and refer youth at risk for suicide, it is essential that program staff, school personnel, peers, parents, service providers and others in local communities who regularly interact with youth, acquire specific suicide prevention knowledge and basic intervention skills. Though partnerships with schools, substance abuse prevention programs, and mental health crisis agencies are expanding, a more systematic approach to suicide prevention is needed within these and other agencies and systems. Connections must be strengthened with the foster care system, correctional system, programs for youth in transition, and programs for out of school youth.

Many programs attempt to address multiple issues simultaneously, but may not have considered or included suicide prevention among them. As some risk factors place youth at risk for more than one problem at the same time, utilizing an intervention that impacts one or more risk or protective factors provides an opportunity for change in more than one identified problem. When

a program consciously integrates suicide prevention components (for example, encouraging help-seeking for emotional distress), the program is likely to be even more effective overall in reducing occurrences of multiple health or social problems.[16]

Lead Department:

All Children's Cabinet agencies:

- DHHS:
  - Maine CDC
  - CBHS
- Department of Labor (DOL)
- Department of Corrections (DOC)
- Department of Public Safety (DPS)
- Department of Education (DOE)

Potential Partners:

- MYSPP Steering Committee
- Employers
- Professional Associations
- Volunteer Organizations
- NAMI Maine
- Local mental health organizations
- Local Communities for Children and Youth
- Keeping Maine's Children Connected
- MYAN and other organizations serving Maine youth
- Other organizations to be identified statewide

[16] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 53.

Maine Youth Suicide Prevention Program (MYSPP) Goal 2

Increase public awareness that suicide is a preventable public health problem.

Background:

The stronger and broader the support for a public health initiative, the greater the opportunity for success. As youth suicide is a relatively rare event, many people are unaware of suicide warning signs or how to respond to them; yet suicidal behavior is reported by 13 percent of high school and 20 percent of middle school students in Maine.[17] [18] Because the risk and protective factors for suicide are well known and most suicidal individuals give warning signs of their suicidal intention, it is important that everyone in direct contact with youth have a basic understanding of the risks and warning signs and how to respond effectively.

Greater awareness that suicide is a serious public health problem results in knowledge change, which, in turn, can influence beliefs and behaviors.[19] Better awareness coupled with dispelling myths about suicide and suicide prevention can result in a decrease in the stigma associated with suicidal behaviors and an increase in the early identification of individuals at risk.

Description:

A large-scale campaign to increase public awareness and understanding of suicide prevention was strongly recommended by the committee developing this goal. Such a campaign is not feasible given resource limitations. Thus, public awareness activities are focused on improvement of the program website and prevention materials, dissemination of the statewide crisis hotline number and other available helping resources. An annual awareness event is held during National Suicide Prevention Awareness Week, the Week of World Suicide Prevention Day, September 10, to highlight suicide prevention activities and accomplishments and to acknowledge the contributions of those involved.

Objective 2.1: Increase public awareness that suicide is a public health problem, suicide is preventable, and help is available.

Population Focus:

General public

Rationale:

The factors that contribute to the development, maintenance, and exacerbation of suicidal behaviors are better understood from a public health perspective.[20] Utilizing a public health approach, suicide may be seen as a preventable problem, with pathways to self-injury that may lend themselves to intervention. A public health approach takes into account the psychological,

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[17] American Association of Suicidology. Understanding and Helping the Suicidal Individual. www.suicidology.org.
[18] 2005 Maine Youth Risk Behavioral Survey
[19] Bringing the Public Health Approach to the Problem of Suicide. *Suicide and Life-Threatening Behavior, 2*8. p 325-327.
[20] Silverman, M. M., Maris, R. W. The Prevention of Suicidal Behaviors: An Overview. Suicide and Life-Threatening Behavior, Volume 25, Number 1, Spring. 1995; p 10-21.

emotional, cognitive, and social factors that have been shown to contribute to suicidal behaviors.[21] Social and political forces will be mobilized when the belief that suicidal behaviors are preventable is widespread. If the general public understands that suicide can be prevented, and people are made aware of the roles that individuals and groups can play in prevention, they may be more inclined to take action. All suicides cannot be prevented, but suicide prevention is ALWAYS worth trying.

Lead Department:

- DHHS:
  - Maine CDC
  - OSA
  - CBHS

Potential Partners:

- All Children's Cabinet agencies
- NAMI Maine
- Media

Objective 2.2: Annually increase knowledge of MYSPP resources for youth suicide prevention in Maine among key state and local stakeholders.

Population Focus:

State agency staff, program partners, legislators and other policymakers, and other state and local stakeholders

Rationale:

To enable key state and local stakeholders to support and participate in suicide prevention, they must be aware of resources available. These resources include suicide prevention programs and trainings, current data, and informational materials. Publicizing these resources to a large, diverse group of key stakeholders ensures they have the information needed to make informed decisions and to advocate for suicide prevention activities statewide.

Lead Department:

- DHHS:
  - Maine CDC
  - OSA

Potential Partners:

- Training contractors
- MYSPP training program participants
- Children's Cabinet members

[21] Potter, L. B., Rosenberg, M. L., Hammond, W. R.. Suicide in Youth: A Public Health Framework. Journal of the American Academy of Child and Adolescent Psychiatry. Volume 37, Number 5, May. 1998; p 484–487.

Maine Youth Suicide Prevention Program (MYSPP) Goal 3

Develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and to increase help-seeking behaviors.

Help-seeking behaviors are defined as actions taken by a person who utilizes different sources of informal (parents and peers) and formal (counselors, teachers, or mental health professionals) support.

Background:

There is a strong stigma related to seeking and utilizing behavioral health services in our society. Stigma has been identified as the most formidable obstacle to progress in the arena of mental health.[22] It frequently causes many people to hide their symptoms and avoid treatment. Sadly, only one out of two people with a serious form of mental illness seeks treatment for their disorder.[23] Due to the historic bias and prejudice against those with mental illnesses, health care, mental health care, and substance abuse treatment have traditionally been viewed as separate types of treatment. Persons who need mental health care or substance abuse treatment avoid seeking it, and insurance companies often do not pay for it at the same level of other medical care. Increasing public understanding about mental health and mental illnesses requires action at every level in both the public and private sectors.

[22] U.S. Department of Health and Human Services, Rockville, MD. Mental Health: A Report of the Surgeon General: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.

[23] Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (2002). National Household Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J. et al. (2001). The prevalence and correlates of untreated serious mental illness. Health Services Research, 36, 987-1007.

Farmer, E. M. Z., Mustillo, S., Burns, B. J., & Costello, E. J. (2003). The epidemiology of mental health programs and service use in youth: Results from the Great Smoky Mountains Study. In M.H. Epstein, K. Kutash, & A. Duchnowsk (Eds.), Outcomes for Children and Youth with Behavioral and Emotional Disorders and Their Families: Programs and Evaluation Best Practices 2nd ed., [in press]

The first step to reducing the stigma surrounding mental health and substance abuse problems is to employ public education activities designed to provide factual information about these conditions and to suggest ways to enhance mental health. A successful model exists with the anti-smoking campaigns that promote physical health. Increasing public knowledge that mental health and substance abuse problems are treatable and that obtaining behavioral health services is a normal part of overall healthcare will help to "create conditions that enable persons in need of mental health and substance abuse services to receive them."[24] Eliminating stigma will also help reduce the isolation of these individuals from society.[25]

Description:

Maine's objectives under this goal are built upon several key themes. Increasing widespread public awareness that mental health and substance abuse problems are treatable conditions and an important part of overall healthcare is a major focus. The second theme is based on developing new partnerships to integrate anti-stigma messages into existing public awareness campaigns to increase access to behavioral health services, including substance abuse treatment and suicide prevention services. Finally, building sensitivity to the needs of youth and families at-risk and increasing appropriate help seeking are recommended.

Objective 3.1: Increase the proportion of the general public in Maine who are aware that mental health problems frequently are treatable, and that obtaining mental health and substance abuse services is a part of overall healthcare.

Population Focus:

General public

Rationale:

Research clearly shows that mental health and substance abuse problems are risk factors for suicide.[26] The National Strategy for Suicide Prevention points out research showing that 60 to 90 percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder. It also cites a study that found over 90 percent of adolescent suicide victims or suicide attempters had a psychiatric illness (most commonly mood, disruptive and substance/alcohol abuse disorders).[27] The National Strategy further states: "Despite the fact that effective treatments exist for these disorders and conditions, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination."

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[24] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.

[25] President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care In America. July 2003.

[26] Harris, E. D., & Barraclough, B. Suicide as an Outcome for Mental Disorders. *British Journal of Psychiatry, 170.* 1997; p 205-228.

[27] Shaffer, D., et al. Psychiatric Diagnosis in Child and Adolescent Suicide. *Archives of General Psychiatry,* Volume 53, Number 4. 1996; p 339-348.

Male youth have been shown to be particularly unlikely to seek help.[28] Youth who are unwilling or unable to ask for help or to connect with potential helpers are at an increased risk for suicide. It is therefore important that young people are able to identify and access helping professionals.[29] [30]

The perception that mental health problems are a result of a character flaw or limited will-power is widespread. Consequently, conditions that are treatable remain untreated. When people understand that mental disorders are real illnesses that are responsive to specific treatments, more persons will seek treatment and the suicide rate will be reduced. Normalization of help-seeking behaviors for substance abuse, mental health and suicide prevention services will increase the number of persons at risk for suicide who seek and receive help.[31]

Lead Department:

- DHHS:
  - Maine CDC
  - CBHS
  - OSA
- DOE

Potential Partners:

- NAMI Maine
- Task Force on Early Childhood
- Maine Youth representing diverse backgrounds
- University Residential Directors
- Media

Objective 3.2: Identify ways to decrease stigma and public misperceptions surrounding mental health and substance abuse health issues/conditions.

Population Focus:
General public

Rationale:
The stigma attached to mental illness and substance abuse prevents persons who may be at risk of suicide from seeking help for treatable problems. The stigma of suicide itself can reduce the number of people who seek help, while adding to emotional burdens. Reducing stigma related to mental health conditions and substance abuse will increase the number of persons from all groups who receive appropriate treatment for disorders associated with suicide.[32]

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[28] Canetto, S. S. Meanings of Gender and Suicidal Behavior during Adolescence. Suicide and Life-Threatening Behavior. Volume 27, Number 4, Winter. 1997.
[29] McWhirter, J., McWirter, B., McWhirter, E., & McWhirter, R. At Risk Youth: A Comprehensive Response. Brooks/Cole, Belmont, CA. 2004.
[30] Holt, M. K., Winzeler, A. A Primer on Bullying. UNH Center on Adolescence
[31] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 59.
[32] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 61.

Maine is a rural state with many small towns. Stigma associated with mental health conditions appear to be particularly pronounced among older adults, ethnic and racial minorities, and residents of rural areas.[33] In order for people to receive the services they need, it is important that they not conceal their symptoms and are not embarrassed or ashamed about seeking treatment.

Lead Department:

- DHHS:
  - Commissioner's Office
  - OSA
  - CBHS

Potential Partners:

- NAMI Maine
- Advocacy groups
- American Foundation for Suicide Prevention (AFSP – Survivor Speakers' Bureau)
- Maine media outlets
- Maine youth
- Parent/Family Organizations
- ME Assoc. of Substance Abuse Programs
- ME Assoc. of Prevention Programs
- ME Assoc. of Mental Health Providers
- Governor's Office of Health Policy and Finance
- Keeping Maine's Children's Connected
- Healthy Maine Partnerships
- Contracted trainers

Objective 3.3: Provide opportunities for school-aged youth to understand the importance of seeking help for mental health or substance abuse conditions.

Population Focus:

Youth ages 10-18

Rationale:

Intolerable stress, inadequate problem-solving abilities, and lack of supportive connections are all risk factors for suicide. Among teens, at least one in five suicide victims appears to have been suffering from clinical depression at the time of their suicide.[34] Yet, according to the 2000 NSDUH (National Household Survey on Drug Abuse) survey, only 36 percent of youths at risk for suicide during the previous year received mental health treatment.[35] As the total number of survey respondents for Maine was small, caution must be used with this finding.

[33] President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care In America. July 2003.
[34] Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. Preventing Teenage Suicide: A Critical Review. Journal of the American Academy of Child and Adolescent Psychiatry. Volume 27, Number 6. 1998; p 675-687.
[35] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Substance Use and the Risk of Suicide Among Youth. National Household Survey on Drug Abuse, The NHSDA Report. July 12, 2002.

The extent to which the stigma around seeking mental health or substance abuse services impacts youth help-seeking attitudes is unknown. Unwillingness to seek care may also be attributable to lack of knowledge about these services or other barriers such as access issues. Teens and young adults are also guided in their willingness to seek care by parental attitudes, and by the availability of systems and providers who are culturally competent.

Most suicidal youths confide their concerns to their peers far more often than to adults.[36] However, youth usually do not have the skills to help a friend through a crisis alone. Having awareness and skills to seek help for themselves and for friends is critical in ensuring that youth in crisis receive the level of support needed. The Lifelines Program increases the likelihood that school gatekeepers (administrators, faculty, and staff) and peers who come into contact with youth at-risk can more readily identify suicidal behavior, provide an appropriate response, know how to obtain help, and be consistently inclined to take action.[37] Research shows that when a suicide prevention awareness curriculum focuses on suicide as it relates to mental health problems, more students will seek help, leading to an increased awareness about mental illness and a reduction in suicide rates.[38] [39] [40] In Maine's implementation and evaluation of the Lifelines student lessons, an increase in help-seeking among youth was demonstrated.[41]

Lead Department:

- Department of Education (DOE)
- DHHS:
    - Maine CDC
    - CBHS

Potential Partners:

- DHHS Contracted trainers
- Maine school staff members and the Coordinating School Health Program
- NAMI of Maine
- Maine Medical Center, Portland Identification & Early Referral Program (MMC, PIER)
- Odyssey Program
- Center for Grieving Children
- MYAN and other youth advocacy support organizations

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[34] Kalafat, J., Underwood, M., O'Halloran, S. Lifelines, A School-Based Response to Youth Suicide. Maine Youth Suicide Prevention Program. October 2003.
[35] Kalafat, J., Underwood, M., O'Halloran, S. Lifelines, A School-Based Response to Youth Suicide. Maine Youth Suicide Prevention Program. October 2003.
[38] Ciffone, J. Suicide Prevention: A Classroom Presentation to Adolescents. Social Work, 38. 1993: p 197–203.
[39] Kalafat, J. Prevention of Youth Suicide; Weissberg, R. P., Gullotta, T. P., Hampton, R. L., Ryan, B. A., & Adams, G. R. Enhancing Children's Wellness, Thousand Oaks: CA: Sage. Volume 8; p 175–213.
[40] Ryerson, D. Suicide Awareness Education in Schools: The Development of a Core Program and Subsequent Modifications for Special Populations or Institutions. Death Studies, 14. 1990; p 371–390.
[41] Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. An Evaluation of Maine's Comprehensive School-based Youth Suicide Prevention Program. 2007.

Maine Youth Suicide Prevention Program (MYSPP) Goal 4

Increase the number of Maine schools and communities statewide that implement effective youth suicide prevention activities.

Background:

Comprehensive approaches in school and community settings have proven effective in suicide prevention[42]. Through a grant from the Centers for Disease Control and Prevention (2002-2006), the MYSPP worked with 12 high schools to implement and evaluate the comprehensive school-based Lifelines Program. Evaluation results have demonstrated the desired outcomes. The program is ongoing in the project schools, and youth in need of intervention continue to be identified and referred by school staff members and peers. Youth seek help from trusted adults at higher than previous rates. Planning for the aftermath of a death by suicide (postvention) has helped school staff in two of the project schools to meet the significant challenges of managing the school environment after a suicide and to more effectively handle other crises.

During the time that I have been working with Maine's Statewide Youth Suicide Prevention Program, I have been impressed with their community-based systems approach, which I consider necessary for effective prevention. They have developed an overall project logic model as well as logic models and goals and objectives for each initiative across a spectrum of interrelated programs. Their efforts to evaluate both the implementation and outcomes of the Lifelines school-based youth suicide response program will likely result in it moving from a Promising Program designation to an Evidence-Based program. Their current plan for expanding the involvement of other schools and agencies is a critical next stage in their statewide project.

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Past President, American Association of Suicidology

Description:

Several of the objectives in this goal incorporate what has been learned from implementation and evaluation of the comprehensive Lifelines Program into MYSPP training programs, school protocol guidelines and associated resources. The MYSPP protocol guidelines contain a component to help school personnel assist at-risk students and maintain control of the school environment in a crisis. Administrative protocols, along with agreements between schools and local crisis agencies, aid in building links to services needed by at-risk teens. MYSPP provides all components of the Lifelines training, and, with SAMHSA funding (2005-2008), will provide technical assistance to six additional high schools to implement the comprehensive Lifelines Program. Also included is an objective to integrate mental health key concepts into comprehensive school health education curricula at the middle school level. To prevent suicide among college students and out-of-school youth and young adults, expansion of suicide prevention efforts to universities, colleges, employers and other community agencies serving these populations is recommended.

[42] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.

Another critical component of a comprehensive approach is the continuing need to identify and implement effective approaches to assist high-risk youth to develop the life skills and coping strategies necessary to leading productive lives.

Objective 4.1: Increase the number of Maine high schools with trained staff implementing the Lifelines Program.

Population Focus:
Middle and high school systems statewide

Rationale:
Teen suicide is a real and serious threat and no school is immune from it. With efforts to update school crisis response plans comes the realization that a school-based suicide prevention program is an essential component. Such a program formally recognizes the school's commitment to the prevention of adolescent suicide and increases the likelihood that proactive measures will be taken. The MYSPP has chosen to implement the Lifelines Program as a cornerstone of school-based suicide prevention efforts. The purpose of the Lifelines Program is to "enhance the ability of all members of a school community to recognize troubled students, and to provide them with step-by-step procedures for intervening in a suicidal crisis."[43] Lifelines Program components include: 1) Administrative guidelines/protocols to guide effective responses to suicidal expressions or behavior, including postvention following a suicide attempt or death; 2) Memoranda of Agreement with Crisis Service Providers outlining referral procedures and prevention /intervention services to be provided to the school; 3) Educational programs for all faculty, staff and parents in the school community to include suicide information, indicators of at-risk students and response and referral protocols; 4) Student lessons that teach peers to recognize suicidal behavior, respond appropriately, know how to get help from a trusted adult and be consistently inclined to do so.

Student lessons are instituted only after adults are trained and protocols are in place. Kalafat and Elias (1994) evaluated an early version of the *Lifelines student lessons* [44] and found that students who participated in the classes, showed significant gains in relevant knowledge about suicide and significantly more positive attitudes toward help seeking and intervening with potentially suicidal peers. Maine's project evaluation is demonstrating similar results.[45] Given that the Lifelines Program is a proven, effective suicide prevention strategy, it is important to train teachers to deliver the student lessons across the state.

Lead Department:
- DHHS, Maine CDC
- DOE

[43] Kalafat, J., and Ryerson, D. The Implementation and Institutionalization of a School-Based Youth Suicide Prevention Program. The Journal of Primary Prevention, Volume 19, Number 3. 1999; p 157-175.
[44] Kalafat, J., & Underwood, M. L*ifelines: A Schoo-Based Adolescent Suicide Response Program*. Kendall/Hunt Publishing Co., Dubuque, IA, 1998.
[45] Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. An Evaluation of Maine's Comprehensive School-based Youth Suicide Prevention Program. 2007.

Potential Partners:

- DHHS, CBHS
- DHHS, Coordinating School Health Program
- Lifelines Training Contractor, Medical Care Development (MCD)
- Maine school administrators, pupil services staff and health instructors
- Local crisis service providers

Objective 4.2: Increase the number of middle schools that integrate key concepts related to mental health and help-seeking within comprehensive school health education.

Population Focus:
Maine Middle Schools

Rationale:
In the 2005 Youth Risk Behavior Survey in Maine, the rate among middle school students reporting suicidal thoughts, ideation and behaviors surpassed their high school counterparts.[46] This trend indicates the need for suicide prevention education to begin in middle school. In order to facilitate this process, key stakeholders, health teachers and the Department of Education must be engaged in identifying and integrating mental health key concepts related to suicide into the comprehensive school health education curriculum.

Lead Department:

- Department of Education (DOE)

Potential Partners:

- Contracted trainers
- NAMI Maine

Objective 4.3: Annually, increase the number of community-based organizations, institutions and other groups serving middle and high-school aged youth during non-school hours that have gatekeepers trained to intervene and prevent suicide.

Population Focus:
Staff in community-based organizations such as recreation programs, mentoring programs, church groups, Boy/Girl Scouts, after school arts programs, theater groups and other youth oriented programs

Rationale:
Community-based programs provide a wide variety of opportunities in many different settings, all of which have the potential to provide important support and safety to the youths they serve. No matter what their focus, these programs are very likely to play a key role in preventing a youth suicide as well as in the aftermath of a suicide in the community. It is important that community organizations have trained staff and established protocols for 1) how to appropriately respond to suicidal behavior and 2) how to manage the aftermath of a suicide crisis.

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[46] Centers for Disease Control and Prevention. *2005 Youth Risk Behavior Survey*. www.cdc.gov/yrbss. Accessed July 24, 2006.

Some organizations are structured so that all staff are trained to intervene directly with youth, while other organizations are structured so that all staff have suicide prevention training and very clear guidelines on who will actually coordinate intervention efforts. All staff in these community-based organizations need to be clear about their professional roles/boundaries and personal/organizational liability issues when responding to these types of events. All staff must be educated about the contagion factor as it relates to suicidal behavior and suicides.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Interdepartmental Coordinating Committee
- Communities for Children and Youth

Objective 4.4: Increase the number of post-secondary educational institutions with staff trained to assist students at risk of suicide and to appropriately involve their families.

Population Focus:

Primary care, mental health and substance abuse service providers, residential life faculty in post-secondary educational institutions in Maine.

Rationale:

Graduating from high school and beginning a post-secondary education program is a key transition period in a young person's life. For many, this is the first time living away from home as well as a time to transition from childhood health care providers to new health care providers. However, the need for adult supports still exists. Post-secondary institutions play a critical role in promoting the health of the young adult population.

Common health issues addressed on college campuses include alcohol and drug use, unsafe sexual activity and STDs, and interpersonal violence. Many campuses have innovative programs that address decision-making and communication skills, programs and policies to decrease alcohol abuse, and task forces that organize campus activities surrounding particular health issues.[47]

One-fourth of all individuals in the U.S. ages 18-24 are full- or part-time college students, suggesting that a large proportion of young adults could be reached through college-based suicide prevention efforts.[48] In 2000, the census data showed that one third of persons ages 18-24 years were either full- or part-time undergraduate or graduate students living in Maine.[49] Thus, college-based suicide prevention efforts would serve about a third of the 18-24 population.

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[47]Centers for Disease Control and Prevention. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities.* Atlanta, GA. 2004.

[48] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U S Department of Health and Human Services, Public Health Service. 2001; p 66.

[49] Maine State Planning Office. Complete Census 2000, 2000 Edition, Augusta: SPO. 2000. http://maine.gov/spo/economics/census.

While for many individuals, college serves as a protective factor, there are two groups who might be at higher risk for suicide: 1) those who enter college with a pre-existing mental health condition and 2) those who develop a mental health condition once in college. Just as with the general population, depression plays a large role in suicide. "Ten percent of college students have been diagnosed with depression." The majority of young adults ages 18 and older who are diagnosed with depression do not receive appropriate or even any treatment at all." [50] Primary and mental health care providers who have the skills to assist youth at-risk of suicide increase the likelihood of appropriate interventions when faced with a suicidal individual. It is also important to facilitate appropriate family involvement in the young person's treatment.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Post-secondary institutions in Maine
- Maine College Health Association
- DOL
- DHHS Programs

Objective 4.5: Annually, increase the number of community-based organizations serving youth who are not in secondary or post secondary educational settings with staff who are prepared to intervene to prevent suicide.

Population Focus:

Community agencies serving youth ages 18-24 who are not in high school or post-secondary educational settings

Rationale:

In 2000, Maine census data showed that two-thirds of persons ages 18-24 were not enrolled in any type of post-secondary education.[51] Since this is a large population of young people who are not being reached in educational settings, it is important to reach out to community-based organizations, associations, employers and other entities connecting with youth in that age group.

The suicide rate among the 18-24 year-old age group in Maine is higher than the national and regional suicide rates.[52] Between 2000-2004, Maine's rate was 15.1/100,000, while the national rate in the same period was 11.7/100,000 and the regional rate was 9.0/100,000.

[50] National Mental Health Association and the Jed Foundation: Safeguarding your Students Against Suicide-Expanding the Safety Net: Proceedings from and Expert Panel on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses. 2002.

[51] Maine State Planning Office. Complete Census 2000, 2000 Edition, Augusta: SPO. 2000. http://maine.gov/spo/economics/census.

[52] Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS), http://www.cdc.gov/ncipc/wisqars/

Lead Department:

- DHHS, Maine CDC
- DOE, Adult and Community Education, truancy, dropout and homeless
- DOL, Committee on Transition

Potential Partners:

- MYAN
- OUTRIGHT
- Tribal health leaders and Tribal representatives
- Health Service Providers
- Homeless shelters
- Communities for Children and Youth/Prevention Coalitions
- Maine Medical Center

Objective 4.6: Increase the number of secondary schools with staff members trained to implement best practice and/or promising programs designed to improve outcomes for at-risk students.

Population Focus:
Maine secondary schools including alternative schools

Rationale:
The increased potential for suicide in some youths is indicated by the presence of suicidal thoughts, prior suicide attempts, ongoing depression and/or drug or alcohol involvement. Prevention strategies for these high-risk youths need to focus on building life skills, enhancing social supports, and making mental health and substance abuse treatment services accessible and responsive to these youths at risk and their families.

In response to the serious problem of suicide in the United States, hundreds of suicide prevention programs have been created and employed across the country. However, accessible evidence concerning the effectiveness of these programs with high risk youth is limited. The Suicide Prevention Resource Center (SPRC) has an up-to-date online registry of evidence-based suicide prevention programs. Many of the programs are in the school domain, but few are especially designed for high-risk youths. Among the designated best practice programs is Coping and Support Training (C.A.S.T.), a school-based intervention for students at-risk for suicide who require an intensive intervention.

Lead Department:

- DHHS:
  - OSA
  - Maine CDC

Potential Partners:

- Contracted trainers
- Maine Schools

Maine Youth Suicide Prevention Program (MYSPP) Goal 5

Support initiatives to decrease the risk of youth suicides by reducing access to lethal means.

Note: Lethal Means is defined as any instrument or object utilized to carry out a self-destructive act (i.e., firearm, poison, medication, rope, chemicals and/or other hazardous material).

Background:

As firearms have high lethality, the majority of suicide attempts by firearm are fatal. From 2000-2004, firearms were used in more than half (57 percent) of all youth suicides among Maine residents ages 12-24. In that five year period, there were a total of 79 firearm deaths among 12-24 year olds, 65 of which were suicides. The second leading method of youth suicides in this period was hanging, accounting for 41, or 36 percent of youth suicides.

It has been demonstrated that a large percentage of youth suicides occurred as the result of an impulsive act. One study conducted by the Harvard Injury Control Research Center and the American Association of Suicidology asked individuals ages 15-24 how much time elapsed between the moment they decided to commit suicide and the time they took action. Nearly one quarter stated that less than five minutes passed.[53] Another study showed that 25 percent of 153 survivors of near lethal suicide attempts acted within five minutes of the impulse to do so and 71 percent acted within one hour.[54] Other studies that followed victims of nearly lethal attempts found that 10 to 20 years later, 90 percent or more had not died by suicide.[55]

Imagine a 14-year-old running out of the kitchen after an argument with a parent. The youth reaches into a closet, takes a loaded firearm, and pulls the trigger. A life is suddenly and sadly lost. Now imagine there is no gun, and in the 15-20 minutes it takes to find a rope, gather pills or fill the garage with fumes, the anger felt may have passed and/or a family member may have intervened to help. For some youth, the best form of suicide prevention is putting time and distance between the impulse to die and a lethal weapon.

Restricting access to lethal means has been cited as one of the most effective ways to reduce youth suicide.[56] An analysis of suicide data in Northeast states showed that states with higher ownership rates have higher suicide rates.[57] The National Council for Suicide Prevention, a group of 10 national organizations dedicated to reducing suicide, supports education, awareness and policies to reduce the access to firearms by persons determined to be a risk to themselves.

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[53] Harvard Injury Control Research Center and the American Association of Suicidology. A Public Health Approach to Preventing Suicide. June 2003.
[54] Swahn, M. H., Potter, L. B. Factors Associated with the Medical Severity of Suicide Attempts in Youth and Young Adults. 2001.
[55] Barber, C. Fatal Connection; The Link Between Guns and Suicide. Advancing Suicide Prevention, Volume 1, Issue 2, July/August. 2005.
[56] Hemenway, D. Private Guns, Public Health. The University of Michigan Press, Ann Harbor. 2004.
[57] Miller, M., Hemenway, D., Azrael, D. "Firearms and Suicide in the Northeast" *Journal of Trauma, 57.* 2004; p 626-632.

Description:
The four objectives in this goal are designed to reduce access to lethal means for young people at risk of suicide. First, public awareness education efforts must be increased in order to raise awareness among adults about the importance of restricting access to all types of lethal means. Second, is increasing the number of primary and behavioral health care clinicians, public safety officials who routinely assess for the presence of all types of lethal means in the home and educate about the actions to reduce associated risks. Third and fourth are policy solutions to strengthen the Child Access Prevention (CAP) Law in Maine and to require parental permission for the purchase of a long gun by persons up to age 18.

Objective 5.1: Increase awareness among adults in Maine about the importance of restricting access to all types of lethal means for at-risk individuals.

Population Focus:
General public, MYSPP web users and training participants

Rationale:
Public information campaigns have been shown to be effective in changing health behavior and improving public health. Successful public information campaigns have decreased tobacco use, increased seat belt use and decreased the incidence of drunk driving.[58] Evidence from many countries and cultures has shown that limiting access to lethal means is an effective strategy to prevent self-destructive behaviors in at-risk individuals.[59] The success of campaigns described previously indicates that similar efforts to educate the public about restricting access to lethal means in the home could also be successful.

Law enforcement officials are trained to safely remove lethal means from a dangerous situation. However, while law enforcement officials are trained and available to assist with removing lethal means from the environment of a suicidal person, this practice is not widely known by the public and not all law enforcement agencies have procedures about removing lethal means from the environment of a suicidal person.

Lead Department:
- DHHS, Maine CDC
- DPS
- DOE

[58] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 75.
[59] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 71.

Potential Partners:

- Law Enforcement and Emergency Medical Technicians (EMTs)
- Department of Inland Fisheries & Wildlife (DIF/W)
- OSA
- Public Health Nursing
- Schools
- Youth and Parents
- Community agencies, organizations and businesses
- The Office of The Maine Attorney General
- US Attorney's Office
- Sportsman's Alliance of Maine and other Hunting and Rod and Gun Clubs
- Maine Coalition Against Domestic Violence
- Media Outlets
- Legislators

Objective 5.2: Increase the number of primary care providers, behavioral health clinicians and public safety officials who routinely assess the presence of all types of lethal means in the home and educate about the actions to reduce associated risks.[60]

Population Focus:
Primary care providers, behavioral health clinicians, and public safety officials

Rationale:
It has been shown that the presence of a lethal means, particularly a firearm, in the home is associated with increased rates of suicide.[61] One study showed that, among parents whose children visited an emergency department for a mental health assessment or treatment, those who received injury prevention education from hospital staff were significantly more likely to limit access to lethal means of self-harm than are families who did not receive such education.[62] Currently, there are no universally accepted guidelines for the assessment of suicidal risk in primary health care and emergency department settings. Such guidelines would assure that these assessments would become part of the routine protocol for providing clinical care to all individuals seen in these health care settings and would assist in the process of making clinically appropriate referrals for mental health and substance abuse treatment.[63]

Lead Department:
- DHHS, Maine CDC
- The Office of The Maine Attorney General
- DPS: State Police / Emergency Medical Services (EMS)

Potential Partners:
- ME Mental Health Association
- ME Assoc. of Family Physicians
- ME Criminal Justice Academy
- ME Chapter of American Academy of Pediatrics
- Northern New England Poison Center
- Residential Programs
- Local Law Enforcement
- OSA
- Emergency Room Staff
- Medical Care Providers and/or Personnel
- Intimate Partner Violence Prevention Organizations

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[60] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 74.
[61] Center to Prevent Handgun Violence Brochure.
[62] Grossman, K. M. Suicide and Violence Prevention: Parent Education in the Emergency Department. 1999.
[63] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 91.

Objective 5.3: Provide data and research to demonstrate the benefits of strengthening the Child Access Prevention (CAP) Law in Maine.

Population Focus:
Safety advocates and Maine citizens

Rationale:
CAP laws hold adult owners of firearms criminally responsible if a child under age 18 gains access to a gun that is not made reasonably inaccessible or does not have a device to lock the gun in place. Multiple studies have shown that strengthening Child Access Prevention (CAP) laws can increase child safety. A study conducted by researchers at the Johns Hopkins Bloomberg School of Public Health provides evidence that the CAP laws for firearms enacted by 18 states significantly reduced suicide rates among young people ages 14-17.[64] Evidence from a study in Houston, Texas suggests that CAP Laws have been successful in reducing deaths due to unintentional and suicide firearm injuries among children under age 16.[65] Holding adult owners of firearms criminally responsible for improper storage combined with widespread public awareness education would provide a strong message about the obligation of adults to keep youth safe from intentional and unintentional firearm injuries. Maine's CAP law currently states that "gun owners may be held responsible if they leave a gun easily accessible to a child under 16 years old," but there are broad exemptions under this law. While Maine has a low rate of unintentional deaths by firearms,[66] the incidence of suicide deaths by firearms is high.

Lead Department:
- DHHS:
  - Maine CDC
  - CBHS
- DPS: State Police / EMS

Potential Partners:
- Maine Citizen's Against Handgun Violence
- Maine representatives of the Million Mom March
- Sportsman's Alliance of Maine
- Medical Community
- Legislators
- Law Enforcement
- Local EMTs
- Parents and Youth

[64] Johns Hopkins Bloomberg School of Public Health. *Gun Laws Requiring Safe Storage Prevent Some Youth Suicides.* Journal of American Medical Association. 2004.
[65] www.bradycampaign.org/facts/faqs/?page=cap
[66] Scruggs, R. Why Kids Just Can't Say No (presented by The Sportsman's Alliance of Maine). 2003; p 10.

Objective 5.4: Provide data and research that demonstrates the benefits of strengthening the law requiring parental permission for the purchase of a long gun by persons up to age 18.

Population Focus:
Legislature and Maine Citizens

Rationale:
A literature review of the effectiveness of firearm legislation indicates that restricting access to firearms through legislation and enforcement reduces youth suicide. Substitution of other means does not appear to offset the benefits of restriction.[67] Current Maine law restricts selling or giving handguns to juveniles under age 18, and restricts selling or giving rifles or shotguns to juveniles under 16, except for supervised loans of firearms or for limited lawful activities such as hunting. There is no limit on youth possessing firearms, nor parental permission required to possess a firearm.

Lead Department:
- DHHS:
  - Maine CDC
  - CBHS
- DPS: State Police / EMS

Potential Partners:
- Maine Citizen's Against Handgun Violence
- Maine representatives of the Million Mom March
- Sportsman's Alliance of Maine
- Medical Community
- Maine Legislators
- Law Enforcement
- Local EMTs
- Parents and Youth

[67] Hemenway, D. *Private Guns Public Health*. University of Michigan Press. 2004.

Maine Youth Suicide Prevention Program (MYSPP) Goal 6

Implement training for recognition of at-risk behavior and appropriate response to a variety of audiences statewide.

Background:
Training and education programs offer a face-to-face opportunity to dispel myths, address misconceptions, increase knowledge and improve attitudes about suicide prevention. As pre-service (college) education in effective suicide prevention and intervention strategies for professionals entering the fields of education, health care, public safety and other fields is not universally available, continuing education in effective suicide prevention strategies is essential for those working directly with youth. Training for the individuals in close contact with youth facilitates the early identification and referral of persons at risk. Suicide prevention education must be integrated into programs and activities that already exist and included in the agendas of communities and state groups.[68]

Description:
Objectives under this goal are focused on increasing knowledge, skills and confidence levels among key personnel in schools, colleges and communities in Maine. Basic suicide prevention awareness and skills trainings will be delivered to general and selected audiences. Adults attending the sessions will be trained to identify and assist youth at risk of suicide.

Objective 6.1: Increase knowledge, confidence, and skills among a wide variety of individuals trained to identify and respond appropriately to youth at-risk of suicide.

Population Focus:
Individuals routinely interacting with youth, ages 10-24 and those working with, providing services to, or having consistent contact with youth

Rationale:
Creating a network of individuals trained to identify and respond appropriately to youth at-risk of suicide accomplishes three things. First, it ensures that individuals are trained to intervene appropriately with suicidal youth; second, these individuals know how to connect youth to the appropriate services, and third, it ensures that individuals are supportive to the youth during the process, thus providing a safe and trusting environment for them. More adults in Maine trained to handle suicidal situations will result in an increase in successful interventions that save more young people's lives.

It is vital to increase the confidence of adults who are trained to respond to youth when intervening in a suicidal situation. Continued in-service trainings reinforce current skills,

[68] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 53.

refresh awareness and commitment to suicide prevention, and provide support to those who have dealt with difficult situations.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Training contractors
- DHHS, Behavioral Health Offices
- Children's Cabinet agency training staff and contractors
- Communities for Children and Youth
- Representatives from Gatekeeper Training audiences

Objective 6.2: Annually, increase the number of staff in youth-serving organizations and individuals working with youth who have received youth suicide prevention awareness education.

Population Focus:

Individuals routinely interacting with youth, ages 10-24, and those working with, providing services to, or having consistent contact with youth

Rationale:

Anyone working closely with youth can learn to conduct a basic three-step suicide intervention once they have received a basic suicide prevention awareness education program (60-90 minutes) offered by a trained gatekeeper. Not all adults who are part of a young person's support network see themselves as "gatekeepers," but they may be in a better position, through regular contact with a young person, to identify a need for help. These adults may be in the role of teacher, employer, relative, coach, or neighbor. Enlarging the pool of people who know the risk factors and warnings signs, how to ask the questions about suicidal intent, and what resources are available, broadens the safety net for all youth.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Training contractors
- Children's Cabinet agency training staff
- Communities for Children and Youth
- DOL
- NAMI Maine
- AFSP, Maine Chapter
- CBHS
- DOE
- DPS

- DOC
- Sub-contractors of all Children's Cabinet agencies
- Healthy Maine Partnerships

Objective 6.3: Increase the number of secondary schools with school-based primary and mental health care providers trained to assist youth and families at risk of suicide.

Population Focus:
School-based primary and mental health care providers

Rationale: The 2000 National Household Survey on Drug Abuse found that, while most youth who reported some risk for suicide had not received any type of treatment (65 percent), 15.1 percent reported seeing a school counselor, school psychologist or teacher.[69] Teens spend a great deal of time in school. School personnel, including primary and mental health care providers, can play an important role in suicide prevention and intervention. Training in effective suicide prevention and intervention will provide them with increased knowledge and confidence to directly address their concerns with a student. With support from the MYSPP, linkages between schools and local mental health providers will be strengthened as well in order to facilitate referrals and case management.

Lead Department:
- DHHS, Maine CDC

Potential Partners:
- DHHS:
  - CBHS
  - OSA
  - Maine CDC
- DOE, Student Assistance Team Unit (SAT)

Objective 6.4: Annually, increase the number of community based primary health care providers who are trained to identify and assist youth, young adults and families at-risk of suicide.

Population Focus:
Community based physicians, nurses, physician assistants, nurse practitioners, crisis response providers, psychologists, social workers and substance abuse treatment providers

[69] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Substance Use and the Risk of Suicide Among Youth. National Household Survey on Drug Abuse, The NHSDA Report, July 12, 2002.

Rationale:

Community based primary health care professionals, crisis workers and substance abuse treatment providers are in key positions to identify, intervene, and refer youth and young adults at-risk of suicidal behavior. Many suicidal individuals make contact with their primary care physicians within a few weeks prior to their death.[70] A number of studies indicate that many professionals are inadequately prepared in these areas.[71] Training of community-based professionals can effectively expand the identification and treatment of individuals at risk of suicide, and ensure an efficient use of limited resources.

Lead Department:

- DHHS:
  - Maine CDC
  - CBHS
  - OSA

Potential Partners:

- University of New England
- Muskie School for Public Service
- Department of Professional and Financial Regulation
- NAMI Maine
- Maine Family Practice Association
- Managed Care Consumer Assistance Program
- ME Chapter American Academy of Pediatrics
- National Association of Social Workers, Maine Chapter
- University of Maine System

[68] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 82.

[71] Key, J., Marsh, L., Darden, P. Adolescent Medicine in Pediatric Practice: A Survey of Practice and Training. American Journal of Medical Sciemce, Geb; 309(2). 1995: p 83-87.

Maine Youth Suicide Prevention Program (MYSPP) Goal 7

Develop and promote effective clinical and professional practices.

Background:

Clinical practices that have been identified to prevent suicide in youth include:

- Early identification
- Early intervention
- Treatment of co-morbid problems (e.g. depressed mood, hopelessness, helplessness, agitation, severe anxiety, pervasive insomnia, alcohol and drug abuse, and conduct problems);
- Follow through with natural and community supports as well as professional services;
- Effective clinical treatments and interventions.

Additional strategies that are more universal, such as promoting and supporting the presence of protective factors including a safe and supportive environment, skills in problem solving, conflict resolution and nonviolent handling of disputes are also appropriate for at-risk individuals. A cognitive behavioral approach to treatment strengthens these protective factors of problem solving and coping skills. Recently, it has been documented that cognitive therapy could reduce repeat suicide attempts by as much as 50 percent.[72]

Description:

Objectives under this goal are designed to ensure appropriate and effective identification and intervention for at risk individuals including the implementation of aftercare treatment programs for individuals who have exhibited suicidal behavior and the expansion of training and use of evidence based treatment models for persons with mood and other associated disorders.

Objective 7.1: Engage at least one survivor organization, two family member organizations and at least two provider organizations in the development and/or adaptation of suicide prevention educational materials about the identification, assessment and treatment of mental health and substance abuse and associated risk of suicide.

Population Focus:

Families, community members, psychiatric and substance abuse treatment facility personnel

[72] Journal of the American Medical Association (JAMA); study by Beck, Brown, University of Penn and colleagues. August 3, 2005.

Rationale:
Family and community members are key stakeholders and should be engaged in the effort to develop guidelines for materials that identify individuals at risk for suicide through stigma reduction, monitoring and intervening with persons at risk for suicide for dissemination to families. It has been shown that educating family members about how to understand, monitor, and intervene with family members at risk for suicide results in better management and treatment of those identified individuals[73] Organizations such as NAMI Maine have conclusively demonstrated the value of family education and support network education to improve the care of individuals who are at risk. Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network are knowledgeable about potential risks for suicide and about how to protect an individual from harm.[74]

Lead Department:
- DHHS, CBHS

Potential Partners:
- NAMI Maine
- Gaining Empowerment Achieves Results (Gear)
- MMC, Division of Child and Adolescent Psychiatry
- AFSP, Maine Chapter
- MMC, PIER
- Center for Grieving Children
- ME Assoc. of Mental Health Service Providers
- ME Assoc. of Substance Abuse Programs

Objective 7.2: Develop and implement suicide prevention discharge guidelines in 80 percent of inpatient, residential treatment, and youth detention facilities.

Population Focus:
Facility providers, outpatient providers, youth, family members, and school personnel serving youth up to age 21

Rationale:
At the time of transition from intensive out–of-home facilities back to the community, children and youth experience a significant decrease in structure, support, treatment intensity and pro-social supports. This leads to increased stress and increased use of dysfunctional coping mechanisms. Children, teens and young adults recently discharged from out-of-home facilities are at an increased risk of suicide attempts. Studies indicate that there is a very high association between youth involved with the corrections system and increased risk for suicide.[75] This risk remains after the young person is released from

[73] Richman, J. Family Therapy for Suicidal People. NY: Springer Sylvania. 1980.
[74] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 85.
[75] Harris & Barraclough, 1997; Inskip, Harris & Barraclough, 1998; Tanney, 2000.

the correctional system. Youth re-entering homes and schools have less structure and may have fewer supports to help them cope with suicidal thoughts.[76]

Incarcerated mentally ill youth are routinely transferred from state rehabilitative facilities to the community upon the termination of their sentences. Upon release, these youth, like other juvenile offenders requiring specialized forms of treatment, have a poor prognosis for successful community reintegration and adjustment.[77] Wood's study on the transition of incarcerated youth indicates that higher levels of intersystem discharge planning and community treatment services are needed for incarcerated mentally ill youth upon community release.[78]

Lead Department:

- DOC
- DHHS:
    - CBHS
    - Child Welfare Services (CWS)

Potential Partners:

- DOE
- Keeping Maine's Children Connected
- AFSP Maine Chapter
- Correctional Facilities
- NAMI Maine
- Psychiatric Hospitals
- School Districts
- Residential Treatment Facilities
- Community service providers
- Family members

Objective 7.3: Increase the proportion of primary and mental health care and emergency department settings that have adopted standardized assessment, intervention and follow-up guidelines for youth suicide prevention.

Population Focus:

Primary care providers, emergency room staff, school based health center personnel, educational personnel, post-secondary health centers and mental health and substance abuse treatment providers

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[76] Wood, P., Trupin, E., Turner, A., Vander Stoep, A., Stewart, D. (NCMHJJ website: *The Community Transition of Incarcerated Mentally Ill Youth: An Outcome Study*. Washington State Department of Social and Health Services, Seattle, WA. 1999.

[77] Altzchul and Armstrong, Intensive Aftercare for High-Risk Juveniles: A Community Care Model. Program Summary, Office of Juvenile Justice and Delinquency Prevention. 1994.
Stewart, Boeky, Truptn, Mental Health Screening of Youth in IRA with Significant Emotional and Behavioral Problems. 1999.

[78] Wood, P., Trupin, E., Turner, A., Vander Stoep, A., Stewart, D. (NCMHJJ website: *The Community Transition of Incarcerated Mentally Ill Youth: An Outcome Study*. Washington State Department of Social and Health Services, Seattle, WA. 1999; p 7.

Rationale:
Persons at risk for suicide first present in emergency departments, primary health care settings, and in school-based health centers with a variety of concerns, including mental illness and substance use disorders, physical abuse, recent losses, and painful physical illnesses that can place them at increased risk for suicide.[79] These settings are identified as increasingly important for access to behavioral health services. In addition to assessing these individuals for suicide and associated problems, it is essential that they get connected to and follow through with the appropriate resources. Only then can they receive the treatment they need to decrease the risk of suicide. Development and dissemination of assessment, referral, and follow up guidelines would assure that these assessments become part of the routine protocol for individuals at risk for suicide, who are seen in health care settings.[80]

Lead Department:
- DHHS:
  - Office of MaineCare Services (OMS)
  - Maine CDC, Teen & Young Adult Health Program (TYAHP)
  - CBHS

Potential Partners:
- Maine Hospital Association
- Mental Health Council
- Mental Health Provider Organization
- American College of Emergency Physicians, Maine Chapter
- Maine Primary Care Association
- ME Assoc. of Substance Abuse Programs
- School-based Health Center and educational personnel

Objective 7.4: Increase to 100 percent the young adult, teen and child serving state departments in Maine that have adopted best practice guidelines for suicide prevention and intervention.

Population Focus:
State departments serving children, teens and young adults and contracted providers of clinical services

Rationale:
Child-serving state agencies often receive inquiries from the public seeking help. These agencies are often working with people who face multiple life challenges and are therefore at higher risk for suicide. In addition, state agencies should set standards for their own operations that model the best practices desired in community-based partners organizations. Following a "no wrong door" policy, all agency personnel should be prepared to assist those who are seeking help for themselves or a loved one who may be

[79] Harris & Barraclough, 1997; WHO, 2000a, 2000c
[80] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 91.

suicidal. Policies, procedures and training can prepare personnel to respond effectively, as well as to support these personnel in dealing with difficult cases. Such policies should not replace the hot and warm lines supported by DHHS, but make personnel aware of these resources, and appropriate referral sources.

Lead Department:

- DHHS:
    - CBHS with all child, teen and young adult serving state departments including the Quality Improvement Division

Potential Partners:

- Clinical service providers

Objective 7.5: Increase by 20 percent the number of primary care offices and school based health centers that use the Care Model for patients with depression.

Population Focus:

Primary care providers including school based health centers

Rationale:

The "Chronic Care Model" (Care Model) incorporates the following: 1) Development of a Diagnosis Specific Registry to help a practice with a population-based approach to depression; 2) Use of an assessment tool (a patient self report measure for depression) to facilitate the initial diagnosis and monitor recovery over time; 3) Patient Self Management (patients taking an active role in their treatment); 4) Contact with a care manager (who follow the patient's progress, lack of progress, side effects, and self management) during the active phase of illness.

Use of the Care Model as applied to the treatment of depression improves care in a number of ways: 1) it provides the basis for increased training for primary care physicians and nurses, increasing their comfort with the diagnosis of depression and their effectiveness in treating chronic depression; 2) it allows for the monitoring of improvement in care; 3) it encourages engaging the patient in responsibility for their care, thereby increasing follow-up and treatment management success; and 4) it allows identification of missed appointments. This treatment is an investment in maintaining health, with associated improved functioning and savings in resources.[81]

Lead Department:

- DHHS:
    - CBHS
    - OMS

[81] Accelerating Change Today (A.C.T.) for America's Health, May 2002, The National Coalition on Health Care and the Institute for Health Care Improvement, Article "Connecting the Dots: Health Plans Pivotal Role in Chronic Illness Improvement".

Potential Partners:

- School based health centers
- MMC
- NAMI Maine
- Community Providers
- Primary care providers
- Maine Care Model Pilot Programs
- Learning Collaborative on Depression

Objective 7.6: Increase by 25 percent the number of patients at risk for suicide with a follow up plan from the crisis service provider, that pursue the proposed mental health follow-up plan.

Population Focus:
Crisis service providers

Rationale:
All youth in Maine hospital emergency departments, or in community settings who present with evidence of suicidal ideation or behavior, are seen by a mobile crisis team worker with few exceptions. However, crisis workers may not routinely contact these individuals to learn if the follow-up plan is being implemented. Efforts to focus on improved follow-up care for suicidal youth, therefore, should focus on mobile crisis team workers and improving the timely availability of evidence based community treatment services (psychiatric assessment and treatment, evidence based psychotherapies, and intensive in home treatment services where necessary).

Clinical studies have shown the importance of training personnel to address suicide attempts and treat the underlying cause(s) intensively. Family members of adolescents should be educated about the dangers of ignoring suicide attempts and the benefits of follow-up treatment to reduce the reoccurrence of attempted suicide. Family members should be actively included in the treatment planning and implementation. Youth also should be integrally involved in treatment planning. Without follow-up treatment, significant improvement in clinical status is extremely unlikely. Both the patient and the health care delivery system benefit from better linkages between emergency and appropriate follow-up care. Adolescents experiencing multiple evaluations, lengthy waiting periods and poor communication during the process are significantly less likely to become involved in the aftercare.

Lead Department:

- DHHS
    - CBHS
    - Adult Behavioral Health Services (ABHS)

Potential Partners:

- Community crisis service providers
- Family members
- NAMI Maine
- ME Assoc. of Mental Health Service Providers
- ME Assoc. of Substance Abuse Programs

Objective 7.7: Increase the number of mental health and substance abuse providers assessing trauma survivors for suicide risk, including in correctional settings.

Population Focus:
Emergency Department personnel, mental health professionals, substance abuse treatment professionals, Department of Corrections Staff, local correctional facilities and community based justice programs

Rationale:
Risk factors of adolescent suicide include the following: the use of illegal drugs; history of abuse by a significant other; issues resulting from gay, lesbian, transgender and questioning youth status (LGBT); minority cultural status and co-occurring mental illnesses. In addition, post traumatic stress disorder is significantly associated with other risk factors for suicidal behavior: anxiety, depression, mood instability, substance abuse, trouble concentrating and disruptive behaviors. Therefore, preventing and treating trauma-based disorders are very likely to significantly decrease the factors associated with suicidal behavior.

Lead Department:

- DHHS, CBHS

Potential Partners:

- Maine Trauma Network
- National Trauma Network
- Victims Advocates
- Sexual Assault Nurses Examiner Program
- Sexual Assault Crisis Centers
- Coalition to End Domestic Violence
- Community Providers

Objective 7.8: Increase the number of first responders and health professionals who receive best practice training and support that addresses their own exposure to suicide.

Population Focus:
First responders, funeral directors, clergy, primary care physicians, mental health and substance abuse therapists

Rationale:
Suicide survivors, whether professional or personally connected to the victim, are at increased risk of repeated trauma when exposed to further suicide. First responders who are routinely exposed to suicide are likely to be in this position and yet are often conditioned to ignore their own needs in responding to others. By supporting first responders with training that acknowledges the increased stress they may experience and encouraging help-seeking for these individuals, their effectiveness can be increased and burn-out can be reduced.

Lead Department:
- DHHS, CBHS
- DPS: State Police / EMS

Potential Partners:
- EMS Providers
- Law Enforcement
- American Red Cross
- Maine Emergency Management Agency
- NAMI Maine
- AFSP, Maine Chapter
- Clergy Association(s)
- American Social Work Association, Maine Chapter
- American Psychiatric Association, Maine Chapter
- American Psychological Association, Maine Chapter

Maine Youth Suicide Prevention Program (MYSPP) Goal 8

Improve access to and community linkages with mental health, substance abuse, and suicide prevention services.

Background:
Increasing access to mental health services and substance abuse services can help individuals experiencing suicidal behaviors as well as those with conditions that increase the risk of suicide. Through public insurance programs and mental health parity laws for private insurance, some barriers to care have been reduced in Maine. However, lack of insurance, underinsurance and other factors continue to create access barriers, which need to be eliminated. Linkages between schools, community agencies and mental health and substance abuse treatment programs need to be established. The use of a multi-systemic collaborative approach is crucial to early identification and successful treatment of at-risk youth.

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals for Healthy People 2010.[82] Some of these health disparities are associated with differences of gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors, as well as increasing barriers to early identification and specialty services such as child and adolescent psychiatric treatment.

Description:
This goal is designed to prevent suicide by ensuring that individuals who are at high risk due to mental health and/or substance use problems have access to prevention and treatment services.

Objective 8.1: Increase the proportion of health and/or social service outreach programs that integrate suicide screening, assessment, support and referral.

Population Focus:
Agencies that serve at-risk children, teens and young adults ages 18-24 who are not regularly involved in school or work and their families

Rationale:
Disconnected youth experience disproportionate difficulty with accessing appropriate mental health services. Integrating suicide prevention into outreach programs for these youth will increase early identification and connect them to appropriate services. In addition, transition periods have been increasingly recognized as times of greater risk. Resiliency factors have been identified that support coping skills for symptoms of mental

[82] U.S. Department of Health and Human Services. (2000). Healthy People 2010 (2nd ed.). Washington, DC: U.S. Government Printing Office. U.S. Public Health Service. (1999). The Surgeon General's Call to Action to Prevent Suicide. Washington, DC: Author.

illness and suicide ideation. Young adults who are alienated from family, social, and community supports are at higher risk for disconnection from other systems of supports. Engagement of these at-risk teens and young adults will serve to mitigate suicide risk.

Lead Department:

- DOE
- DHHS, CBHS
- DOL

Potential Partners:

- DHHS:
    - Maine CDC: TYAHP and Public Health Nursing Program
    - Foster Care
    - OSA
- DOC
- School Based Health Center staff
- Keeping Maine's Children Connected
- Realize ME

Objective 8.2: Increase the number of correctional facilities and community-based justice programs that have screening assessments and treatment protocols in place for mental illness and suicide risk.

Population Focus:

18-24 year old prison population and juveniles involved in justice system community settings

Rationale:

After leaving the public school setting, there exist few opportunities for screening to identify and intervene with individuals at risk. The public safety and correctional systems have become one place where young people struggling with mental illness and substance abuse issues can access screening, assessment and treatment for suicidal behaviors. The Maine Juvenile Justice system, in collaboration with Children's Behavioral Health Services, has instituted mental health screening for all incarcerated juveniles and young adults. A similar screening program, the Massachusetts Assessment Youth Screening Inventory (MAYSI), is being piloted in three counties by the DOC.

Lead Department:

- DOC
- DHHS, ABHS

Potential Partners:

- Juvenile Community Corrections Officers (JCCOs)
- DHHS, CBHS
- Community-based Crisis Service Providers

Objective 8.3: Increase by 10 percent the number of Maine secondary schools and post-secondary institutions that adopt best practice guidelines for mental health and substance abuse screening and referral of at-risk students.

Population Focus:
Secondary schools and post-secondary institutions in Maine

Rationale:
Suicide is the second leading cause of death among Maine youth aged 15-24. Screening efforts have demonstrated success in identifying youth at risk for mental illness or substance abuse in some school-based programs, however, limited resources for such programs require that they be chosen carefully and implemented based on available research. Mental health screening tools need to be reviewed and evaluated to see if they are effective at decreasing suicide in youth. Less evidence has been established for screening programs for the college-aged, but since rates for suicide are higher for the age group, outreach to colleges is critical to address the older population.

Lead Department:
- DOE, SAT
- DHHS:
    - CBHS
    - TYAHP
- DOC

Potential Partners:
- Maine public schools, colleges, and universities
- Mental health providers

Objective 8.4: Develop program resources for support of suicide survivors with stakeholder buy-in.

Population Focus:
Suicide survivors

Rationale:
Suicide survivors are at increased risk for suicide themselves. Support of the families, friends and relations of suicide victims is an important suicide prevention strategy. Survivors can also serve as resources in developing suicide prevention, assessment and follow-up supports.

Lead Department:
- DHHS:
    - Maine CDC
    - CBHS
    - OSA Information Resource Center

Potential Partners:

- Training contractors
- AFSP, Maine Chapter
- NAMI Maine
- Hospice Centers conducting suicide survivor support groups
- Center for Grieving Children

Objective 8.5: Develop and implement in at least two of Maine's managed care and/or health insurance plans (including MaineCare) quality care/utilization management guidelines for effective response to suicidal risk or behavior.

Population Focus:
Families and individuals at risk of suicide

Rationale:
Providing guidelines for effective response to suicide risks will allow the State to determine whether this significant problem is being identified and addressed according to national standards and best practices responses. Distribution and adoption of such guidelines helps to create a comprehensive approach across systems. Only with this information can a system-wide planful response be developed and implemented.

Lead Department:

- DHHS, CBHS

Potential Partners:

- OMS
- ME Assoc. of Health Plans
- NAMI Maine
- Managed Care Association

Objective 8.6: Increase by 10 percent the number of school districts in which school-based mental health, substance abuse and suicide prevention services are available to all students in need.

Population Focus:
Maine School Districts, local mental health and substance abuse treatment service providers

Rationale:
Increased early identification, recognition and treatment of risk factors for youth suicide will decrease the youth suicide rate. Mental illness and substance abuse are identified risk factors for suicidal behavior. Approximately 20 percent of youth suffer from mental illness (7 to 12 million).[83] Recent studies reveal that the earlier in life a mental disorder begins, the slower a person or their family is to seek treatment and the more persistent the

[83] National Institute for Mental Health website

illness becomes. Untreated mental illness can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses and substance abuse. In addition, despite the fact that there are presently effective treatments for dealing with mental illness, there are long delays, sometimes decades, between the first onset of symptoms and individuals seeking and receiving treatment.[84] Some studies claim that as many as 90 percent of youth who die by suicide suffer from a diagnosable mental illness at their time of death.[85] Schools are an easier and appropriate point of access for youth to identify the need for services, and to receive information on treatment resources.[86]

Lead Department:

- DOE
- DHHS:
    - Maine CDC, TYAHP
    - CBHS
    - OSA

Potential Partners:

- Substance abuse and mental health providers
- School districts

Objective 8.7: Respond to requests from local schools and communities to provide resource information in situations where contagion appears to be a factor.

Population Focus:

Maine schools and communities with multiple youth suicides in a short time period

Rationale:

Suicide contagion**,** as defined by the National Strategy for Suicide Prevention: Goals and Objectives for Action, is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts. Contagion assumes either direct or indirect awareness of the prior suicide. Various suicide contagion pathways may exist: direct contact or friendship with a victim, word-of-mouth knowledge, and indirect transmission through the media.[87] There is ample evidence from the literature on suicide clusters to support the contention that suicide is "contagious".[88]

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[84] National Co-morbidity Survey Replication (NCS-R) in the Archives of General Psychiatry.
[85] Shaffer, D., Gould, M. et al. Psychiatric Diagnosis in Child and Adolescent Suicide. Archives of General Psychiatry, Volume 53, Number 4, April. 1996; p 339-348.
[84] Mental Health: A Report Surgeon General. 1999
[86] Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.
[86] Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.
[86] Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.
[86] Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.
[87] Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.
[88] Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.

One such study determined that the incidence of suicide and suicidal behavior in an area under observation was markedly elevated compared to national and local normative data when the area had a recent number of suicides occur.[89] Because contagion is a dangerous process by which one suicide may facilitate another,[90] it is important that the MYSPP respond appropriately to requests for assistance from local schools and community organizations in the aftermath of a suicide. Such assistance includes guidance about utilizing crisis services appropriately, resource information, guidelines for speaking to the media in ways that do not add to the threat of contagion and information on children's grief.

Lead Department:

- DHHS
  - Maine CDC
  - CBHS
- DOE, SAT

Potential Partners:

- Contracted trainers
- School and community leaders and organizations
- Medical Examiner's Office
- DHHS, Maine CDC, Epidemiology Team
- DOC

[89] Brent, D. A., Kerr, M. M., Goldstein, C., Bozigar, J., Wartella, M., Allan, M. J. An Outbreak of Suicide and Suicidal Behavior in a High School. Journal of American Academy of Child Adolescence. Volume 28, Number 6. 1989.
[90] Hazell, P. Adolescent Suicide Clusters: Evidence, Mechanisms, and Prevention. Australian and New Zealand Journal of Psychiatry, 27. 1993; p 653-665.

Maine Youth Suicide Prevention Program (MYSPP) Goal 9

Improve reporting practices to reduce the potential of suicide contagion.

Background:

Working with media and program partners statewide to promote safe reporting practices can save lives. Emphasis is on the importance of following the national consensus reporting recommendations to avoid contagion among vulnerable Maine youth. Contagion is defined as a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.[91]

Description:

Maine's objectives take a multi-pronged approach with a focus on providing education, training, guidelines, and information to representatives of the media, gatekeepers, school administrators, clinicians, helping professionals and suicide survivors in order to improve reporting practices. Part of the approach is to involve media in a positive role of partnering with the MYSPP and interested parties to educate the public in safe and responsible ways through feature stories, editorials and other venues where media can help to promote suicide prevention and help-seeking behaviors.

Objective 9.1: Increase the number of media representatives in Maine who are knowledgeable about safe reporting practices regarding suicide and media contagion.

Population Focus:

Members of all types of media and program partners statewide

Rationale:

There is considerable evidence that some suicide reporting practices in the mass media, including newspaper articles, may contribute to an increase in the number of suicides.[92] Publicizing graphic and repetitive representations of suicides (including the method used and how obtained), and glorifying the suicide victim appear to increase the actual number of suicides by the "copycat effect",[93] a well-researched form of behavior contagion. Research consistently finds a strong relationship between reports of suicide in the media and subsequent increases in suicide rates. Since 1990, the effect of media coverage on suicide rates has been documented in many countries, including the United States. These effects show that the risk of suicide following exposure to another person's suicide was 2 to 4 times higher among 15 to 19 year-olds than among other age groups.[94]

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[91] National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.
[92] Gould, M., Jamieson, P., Romer, D. Media Contagion and Suicide Among the Young. American Behavioral Scientists, Volume 46, Number 9, May. 2003.
[93] Coleman, L. The Copycat Effect: How the Media and Popular Culture Trigger the Mayhem in Tomorrow's Headlines. 2004.
[94] Gould, M., Jamieson, P., Romer, D. Media Contagion and Suicide Among the Young. American Behavioral Scientists, Volume 46, Number 9, May. 2003.

Since the media strongly influences community attitudes, beliefs and behaviors, and plays a vital role in politics, economics and social practice, it is important to understand the impact that reporting on suicide can have. Research shows that use of phrases like "successful suicides" and "failed attempts" can have detrimental effects.[95] This use of language gives the message that to kill oneself is a "success" and that a non-fatal attempt is a "failure." The verb "committed" is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context.[96] If the media were to consistently follow the guidelines set by the American Foundation for Suicide Prevention, it is thought that not only would suicide contagion decrease, but the amount of negative stigma around suicide and mental illness would decrease as well.

Mass media play a significant role in today's society by providing a wide range of information in a variety of ways. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances.[97] They can also highlight opportunities to prevent suicide by promoting the use of behavioral health services as a part of overall healthcare and providing information on where to get help. The more people are aware that suicide is a public health problem and that help is available, the more effective suicide prevention in Maine will be.

Lead Department:

- DHHS:
  - Commissioner's Office
  - Maine CDC
  - OSA

Potential Partners:

- Representatives of print, television and radio media
- Local suicide prevention partners
- AFSP, Maine Chapter
- Suicide survivors
- Behavioral health and suicide prevention experts
- Schools of journalism and broadcasting

Objective 9.2: Increase the number of stories in print and electronic media about suicidal behavior, mental illness and related issues that use accurate and responsible depictions and promote help-seeking behavior.

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[95] Suicide and the Media: A study of the media response to *Suicide and the Media: The Reporting and Portrayal of Suicide in the Media, A Resource.* Jim Tully and Nadia Elsaka School of Political Science and Communication University of Canterbury 2004.

[96] At-a-Glance: Safe Reporting on Suicide. Suicide Prevention Resource Center. http://www.sprc.org/library/at_a_glance.pdf August 9, 2005.

[97] Reporting on Suicide: Recommendations for the Media. Centers for Disease Control and Prevention National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. <http://www.afsp.org/education/recommendations/5/index.html>

Population Focus:
Members of all types of media and program partners statewide

Rationale:
Working with media representatives to utilize safe reporting practices creates opportunities for media representatives to develop interesting stories, meet their needs and prevent unintended consequences of unsafe reporting.

Increased knowledge about mental health and substance abuse issues among media representatives allows for the dissemination of accurate reports. Accurate print and electronic media leads to an increased public knowledge and understanding of the issues surrounding suicide.

Not only are knowledge and understanding key factors in suicide prevention, but promoting help-seeking behaviors is also critically important. The media has tremendous potential to take on this role as it reaches a large portion of the public. When print and electronic media promote the message that behavioral health services are a part of overall healthcare and disseminate information on available resources to the public, the general awareness of suicide prevention strategies and available helping resources is heightened.

Lead Department:
- DHHS:
    - Commissioner's Office
    - Maine CDC
    - OSA

Potential Partners:
- Suicide survivors
- Suicide prevention experts
- MYSPP Steering Committee
- NAMI Maine
- AFSP, Maine Chapter
- Media personnel
- Partner communities

Objective 9.3: Increase understanding of the key issues surrounding media contagion through education and technical assistance to participants of MYSPP training and education programs.

Population Focus:
Training/education program participants statewide

Rationale:
When a youth suicide occurs, news reporters often seek comments from those closest to the victim. It is important that school staff and other community based gatekeepers are prepared to respond in ways that are respectful of surviving family, friends and

community members by using sensitive language and promoting the available helping resources.

In order for people to respond appropriately, it is essential that they are not only given guidelines to help ensure accuracy and sensitivity after a youth suicide occurs, but receive education on how and why to utilize them.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Contracted Trainers
- NAMI Maine
- AFSP, Maine Chapter
- Maine and national experts in suicide prevention
- Partner organizations and communities statewide
- Media
- Local community-based organizations

Maine Youth Suicide Prevention Program (MYSPP) Goal 10

Improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.

Background:

Availability of quality data is critical for monitoring trends, establishing risk factors and evaluating the impact of program interventions. However, suicide and self-inflicted injury reporting is not always consistent, may not be accurate, and complete information on suicide death or attempts is not consistently available in current data collection systems.

MYSPP currently monitors suicide using the death certificate database maintained by Maine's Office of Data, Research and Vital Statistics (ODRVS). This information is supplemented by information from Maine's Office of the Chief Medical Examiner (OCME). Information on self-inflicted injuries comes from inpatient and outpatient hospitalization data. Data on self-reported suicidal ideation and behavior are obtained from the Maine Youth Risk Behavior Survey (YRBS) and the Behavioral Risk Factor Surveillance System (BRFSS).

It is important to strengthen and improve suicide surveillance practices so that suicide mortality (death certificates), morbidity (hospital discharge) and risk factor (YRBS and BRFSS) data for Maine residents are routinely collected, analyzed, interpreted, disseminated and utilized in prevention programming to reduce the occurrence of suicide and suicide attempts in Maine. For example, the hospital discharge database records all discharges in Maine's 39 non-federal hospitals. Suicide attempts are included in the E-codes for intentional self-harm. However, E-coding is optional and rates of E-coding vary by hospital. This variability makes it difficult to draw conclusions about geographic differences in the rates of intentional self-injury.

In addition, demographic data including education, income, and race/ethnicity are not available in the hospital discharge database, making it difficult to use these data to identify those at highest risk. By seeking to improve e-coding rates, our understanding of intentional self-injury will be enhanced.

Description:

Objectives under this goal are designed to enhance the quality, collection, analysis and use of data describing suicide and suicidal behaviors utilizing multiple datasets. To develop these objectives, a Data Committee met and worked together using Goal 11 of the National Strategy for Suicide Prevention which calls for improved collection and tracking of suicidal behaviors. Other proposed enhancements to the current system include: maintaining ongoing self-report information on suicide ideation and related risk factors among youth and young adults; helping schools develop data systems for the early identification of high-risk youth; improving the quality of medical examiner data in suicide deaths; and developing linked data and systems and conducting in-depth analyses

to help increase our collective understanding of the factors that precipitate a suicide death.

Objective 10.1: Utilizing the MYSPP Suicidal Behavior Surveillance Plan, continue to improve and maintain the collection, analysis and dissemination of suicide and self-injury data to guide the focus and direction of suicide prevention efforts.

Population Focus:
Data sources, Epidemiology support and program stakeholders

Rationale:
Access to accurate information about the circumstances contributing to suicides is needed to improve understanding of fatal and non-fatal suicidal behaviors among Maine youth. By increasing the quality and accessibility of data through more timely collection, in-depth analysis and interpretation, more effective prevention and intervention activities can be designed. Routine dissemination of data to policymakers and the public can raise awareness of the nature of youth suicide in our state. With funding from the Centers for Disease Control and Prevention (CDC), Division of Disability Outcomes and Programs, from 2002-2006, the MYSPP reviewed suicide surveillance databases and analyzed suicide and self-inflicted injury data. In 2005, a surveillance system was developed for the ongoing systematic collection of data on suicidal behavior to monitor trends and guide policy and program decisions. A suicide surveillance report was issued and disseminated in 2006. Ongoing utilization of and improvements to the MYSPP Suicidal Behavior Surveillance System are necessary to monitor trends and the impact of program activities.

Lead Department:
- DHHS, Maine CDC

Potential Partners:
- DHHS:
  - Maine CDC
  - Epidemiology Support
  - Office of Data, Research & Vital Statistics (ODRVS)
- Office of the Chief Medical Examiner
- Maine Health Data Organization
- Maine Hospital Association
- Association of Health Records Coders

Objective 10.2: **(a)** Maintain on-going collection of survey data on suicide risk and related factors among youth in school systems and young adults **(b)** Develop and implement procedures to use the data collected from these systems to guide program and policy decisions.

Population Focus:
Children's Cabinet agency staff, policymakers, agencies and schools with an interest in gathering or utilizing these data

Rationale:
Survey data are used to assess the prevalence of suicide ideation and self-reported suicide attempts. Despite many of the limitations inherent in self-report surveys, they are one of the few sources of data on adolescent mental health, suicide ideation, and related risk factors. In addition, many suicide attempts that do not require medical attention may only be captured through a survey. Therefore, it is critical that MYSPP continue to play an active role in the development and implementation of Maine youth and adult health surveys.

Lead Department:
- DHHS, Maine CDC

Potential Partners:
- Maine CDC Epidemiology Support
- Children's Cabinet agency data staff

Objective 10.3: Assist local schools to increase the early detection of students at risk by piloting a systematic method of collecting and analyzing available school data.

Population Focus:
Public and private schools statewide

Rationale:
MYSPP leaders and program partners strongly believe that early identification of at-risk students can facilitate important connections to helping resources in local communities. It is an important way to further reduce youth suicide in our state. Maine school systems face multiple challenges in identifying and referring at-risk youth. Through federal funding, the MYSPP has worked with local high schools to pilot a school-based data system to increase the early identification of at risk students who need referrals for services.

Lead Department:
- DHHS, Maine CDC
- DOE, SAT

Potential Partners:
- Maine schools piloting the data tickler system
- Project Evaluators
- DHHS, CBHS
- Keeping Maine's Children Connected Initiative
- UMO Center for Community Inclusion, Childlink

Objective 10.4: Increase the quality and accessibility of Medical Examiner suicide data to the MYSPP on youth up to age 24.

Population Focus:
Police, funeral directors and local Medical Examiners

Rationale:
While medical examiners, coroners and police officers often collect valuable information about the circumstances surrounding a suicide death, the information typically remains inaccessible in case folders and filing drawers. The public health approach to injury prevention is evidence-based. It pools information about the "who, when, where and how" of all incidents to better understand the "why."[98] Only with the detailed data from a comprehensive set of sources can we better understand the nature of the youth suicide problem in Maine and thus inform prevention activities.

Lead Department:
- Maine Attorney General's Office, Office of the Chief Medical Examiner

Potential Partners:
- DHHS, Maine CDC
- DHHS, Maine CDC Epidemiology Support

Objective 10.5: Expand and enhance the Maine Child Death and Serious Injury Review Panel process to increase understanding of the risk factors associated with violent child deaths and serious injuries.

Population Focus:
Maine Child Death and Serious Injury Review Panel members

Rationale:
The Maine Child Death and Serious Injury Review Panel reviews selected violent child death and serious injury cases on a monthly basis. The mission of the panel is to provide a multidisciplinary, comprehensive case review of child fatalities and serious injuries in children. The purpose is promoting prevention, increasing the responsiveness of the child protective system, and fostering education of both professionals and the public. Currently, the Panel reviews selected child deaths up to age 18 that appear to be related to child abuse and/or neglect. These reviews may be initiated by the Commissioner of the DHHS, the Office of Child and Family Services, or by any Panel member. The Panel serves as a citizen review panel for the DHHS as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247. The state statute permits confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. The Panel is therefore able to conduct in-depth retrospective reviews of all

[98] A Public Health Approach to Preventing Suicide. Harvard Injury Control Research Center and the American Association of Suicidology. June 2003.

relevant records, which is supplemented by oral presentations by involved service providers.

While the Panel has investigated some child and teen suicides, 75 percent of the cases reviewed are children under the age of five. Even when suicides are investigated, this information is not made available to inform prevention activities. During the past year, the Child Death Review Panel has enhanced its' reviews and reports to become more systematic and uniform. Also, the new Maternal and Infant Mortality and Resiliency Review Panel, which had its first meeting in July 2007, has representation from the Child Death Review Panel. *These developments substantially enrich the potential for policy and system change.* In addition to strengthening the review process, expanding and enhancing the Maine Child Death and Serious Injury Review Panel could enable the panel to include all violent deaths to children to age 18. As a result, valuable new information about child deaths from suicides, homicides, and firearms that are not related to child abuse would be gained. This information is of vital importance in the design and implementation of best practices to prevent violent child deaths.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Child Death Review Panel
- Maine CDC
- Maine CDC Epidemiology Support

Objective 10.6: Conduct specialized studies to examine in depth, specific issues in youth suicide when resources permit.

Population Focus:
Epidemiology staff and program stakeholders

Rationale:
Surveillance does not provide in-depth analysis addressing specific questions. For that reason, it can never replace well-conducted, specialized studies to examine more complicated dynamics of a specific issue in a population.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Maine CDC
- Maine CDC Epidemiology Support

Maine Youth Suicide Prevention Program Plan Appendices

Governor Baldacci Executive Order

Glossary of Terms

Public Health Approach to Suicide Prevention

33 FY 04/05

February 18, 2005

AN ORDER TO STRENGTHEN MAINE'S YOUTH SUICIDE PREVENTION EFFORTS

WHEREAS, the health and safety of Maine's young people is of utmost importance to the health of our state; and

WHEREAS, suicide is the second leading cause of death for Maine's young people aged 15-24, taking a total of 115 young lives from 1998-2002, an average of 23 each year; and

WHEREAS, the suicide rate among Maine youth is 50percent above the national average, the eighth highest in the country and the highest in New England; and

WHEREAS, every child's death is a tragedy and suicide claims more young people's lives than homicide, cancer, heart disease, AIDS and birth defects combined; and

WHEREAS, it is estimated that for every young life claimed by suicide there are up to 100 non-fatal suicide attempts by youth; and

WHEREAS, in any given high school classroom, it is likely that there are two female and one male student who are actually contemplating taking their lives; and

WHEREAS, with advanced planning, training and education, school personnel and students can play a significant role in identifying and assisting suicidal students; and

WHEREAS, increasing public awareness of suicide warning signs and how to recognize and respond effectively to suicidal behavior can save lives; and

WHEREAS, the loss of a friend or loved one to suicide is one of the most devastating events that can be suffered by Maine families and communities; and

WHEREAS, it is incumbent upon State government to provide leadership as well as resources to address preventable health problems;

NOW, THEREFORE, I, John E. Baldacci, Governor of the State of Maine, do hereby declare that Maine's youth suicide prevention efforts be strengthened, and by the authority vested in me, do hereby order that:

1. The Commissioners of the agencies appointed to the Governor's Children's Cabinet shall:

    - Assign specific staff persons to participate in a strategic planning process in order to:

        i. Update and revise the statewide Maine Youth Suicide Prevention Program (MYSPP) implementation plan, which shall include roles and responsibilities for each Department represented on the Children's Cabinet;
        ii. Outline strategies to improve the quality and accessibility of data pertaining to suicide and self-injury, within the revised implementation plan;
        iii. Submit the revised MYSPP statewide implementation plan to the Office of the Governor by August 31, 2005; and
        iv. Assess and propose regulatory or legislative actions that are likely to contribute to the reduction of youth suicide and suicide attempts.

    - Identify and seek financial resources to support the activities of the revised statewide MYSPP plan priorities.

2. The Department of Health and Human Services, Bureau of Health shall continue to provide leadership to the MYSPP in collaboration with the agencies that participate in the Governor's Children's Cabinet.

3. These agencies shall form partnerships with members of the private sector including service providers, suicide survivors and youth organizations to strengthen Maine's efforts to prevent youth suicide.

Implementation Costs:

The costs for implementing the tasks included in this Executive Order shall be absorbed by the participating agencies.

Effective Date:

The effective date of this Executive Order if February 18, 2005.

_____

John E. Baldacci, Governor

Glossary of Terms Used in MYSPP Plan

Adolescent: A person between the ages of 14 and 24.

Aftercare treatment programs: Programs that provide treatment and support recovery after an initial episode requiring residential or hospital treatment.

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: Is the optimum functioning and development of a individual in all important spheres of his/her life including family and peer relationships, involvement with school and community, physical health, and play or recreational pursuits.

Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.

Bisexuality: Being attracted to members of both sexes.

Cognitive behavioral approach: Cognitive Behavioral Treatment is a treatment method that focuses on here and now behaviors, thoughts and responses and uses a 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.

Coroner: A public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes.

Crisis response plan: A document that spells out the procedures to be followed in the event of threatening situations.

Crisis team: A group of individuals trained and assembled for the purpose of responding to the needs of other 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 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 somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Disconnected youth: Youth, through age 24, who are out of school, out of work, often homeless, and/or have aged-out of child welfare and state benefits, including the foster care system, and generally not consistently connected to healthcare and/or treatment services.

E-codes: External cause of injury codes are diagnostic categories, using the 9th revision of the International Classification of Diseases (ICD-9). E-codes provide data on the cause, rather than the type, of injury. Example: a traumatic head injury, coded with an N-code, could result from a car crash or gunshot wound, both coded with different E-codes.

Epidemiology: The study of statistics and trends in health and disease across communities.

Evidence-based: Programs that have undergone scientific evaluation and proven to be effective.

Executive order: A document issued by the Governor requiring certain actions to be taken.

First responder: 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 routinely in direct contact with a specified target audience 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.

LGBTQ: Lesbian, gay, bisexual, transgender, questioning youth.

Governor's Children Cabinet: The Commissioners (or his/her designee) of Departments of State government that provide services to youth and their families. Those Departments are Corrections, Education, Health and Human Services, Labor, and Public Safety. The Children's Cabinet is chaired by the First Lady.

Health disparities: The disproportionate burden of disease, disability and death among a particular population or group when compared to the proportion of the population.

Help-seeking behavior: Actions taken by a person who utilizes different sources of informal (parent and peers) and formal (counselors, teachers, or mental health professionals) support.

Homicide: The killing of one person by another.

Homosexuality: Sexual desire for and/or sexual activity with others of one's own sex.

Incarcerated youth: Refers to young people who are detained and being housed in a prison, jail, detention center, etc.

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.

Intervention: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

Insomnia: Chronic inability to sleep.

Lethal means: Any instrument or object utilized to carry out a self-destructive act (i.e. firearm, poison, medication, rope, chemicals and/or other hazardous material).

Long gun: A gun with a long barrel that is fired from the shoulder - (rifle or shotgun)

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 a government unit to ascertain causes of deaths, especially those 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% coverage for physical illness then they would have to provide the same percentage 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 cognitive, emotional or socials abilities.

Mobile crisis team: Mental health clinicians trained to perform suicide assessments/evaluations in multiple places such as an emergency room department, client's home, school, etc.

Morbidity: The relative frequency of illness or injury, or the illness for injury rate, in a community or population.

Mortality: The relative frequency of death, or the death rate, in a community or population.

National Strategy for Suicide Prevention: A comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. This document was issued in 2001 and contains 11 goals and 68 objectives designed to be a catalyst for social change.

Non-fatal suicidal behavior: Another term for suicide attempt.

Post traumatic stress disorder: When a person has experienced a traumatic event in which he/she were both threatened and experienced intense fear or helplessness and: a) re-experienced symptoms of the trauma; b) persistently avoid reminders of the trauma; and c) experience increased arousal or tension.

Postvention: A coordinated and comprehensive set of specific interventions to be implemented after a crisis or traumatic event 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 health condition divided by the total number of people in the population. (For less common conditions, prevalence is often expressed per 100,000 people, for example, rather than as a percentage.)

Prognosis: A prediction of the probable course and outcome of a disease.

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: Guideline for actions to take. MYSPP developed a Protocol document that helps schools be better prepared to address suicide prevention, intervention, and postvention.

Public health: Regulatory and voluntary focus on effective and feasible risk management actions at the national 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. See Appendix C for additional information.

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 health outcomes.

Risk factor: Long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death.

School-based: Services provided on school grounds by either school personnel or by community organizations that have arrangements with schools.

Self harm or self-injury: The various methods by which individuals injure themselves, such as cutting, self-battering, taking overdoses or deliberate recklessness.

Sexual minority: Refers to gay men, lesbian women and bisexual and transgendered persons. These groups are considered to be “minority” because of several commonalities with other minority groups—including separate cultural norms, idiosyncratic use of language and terminology, and the reality of being discriminated against of their social minority status.

Sexual orientation: Refers to a complex web of emotions, behaviors, fantasies, attitudes and attractions. There are three possible sexual orientations: heterosexual, homosexual and bisexual (attracted to both males and females).

Stakeholder: Entities, including organizations, groups and individuals, who are affected by and contribute to decisions, consultations and policies.

Stigma: Stigma is 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. Stigma leads the public to avoid people with mental disorders. It reduces access to resources and leads 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 substance abuse.

Suicide: Self-inflicted death with evidence (implicit or explicit) of the intent to die.

Suicide attempt: A 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: Thoughts about dying by suicide are clinically referred to as "suicidal ideation".

Suicide survivor: Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Teens: Persons aged 13-19.

Trauma survivor: Refers to a person who has experienced trauma.

Warning sign: The earliest, observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours, or days).

Years of potential life lost (YPLL): A measure of premature mortality (early death). YPLL provides insight into the impact of injury-related death on society compared to other leading causes of death.

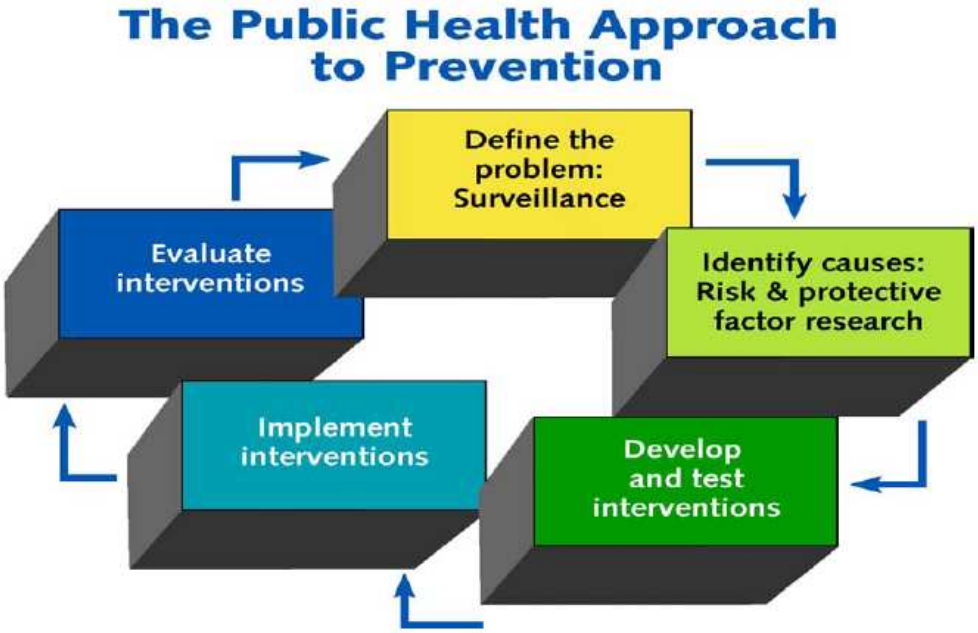
Young adults: Persons aged 20-24

Youth Risk Behavior Survey: A biennial survey of middle and high school students conducted as part of a national effort by the U.S. Centers for Disease Control and Prevention to monitor health-risk behaviors of the nation's students.

Suicide Prevention: The Public Health Approach

The National Strategy for Suicide Prevention advocates a public health approach to suicide prevention. Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.

The public health approach is widely regarded as the approach that is mostly likely to produce significant and sustained reductions in suicide. It uses five basic evidence-based[1] steps in a systematic way. These steps are applicable to any health problem that threatens substantial portions of a group or population.



The steps may be sequential, or overlap. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. Evaluating interventions must be built into implementation, and information gained from evaluations should guide the development of new interventions.

This document has been published by the Suicide Prevention Resource Center at EDC as a collection of resources, promising initiatives and other helpful information on the subject of suicide prevention. It is the reader's sole responsibility to determine whether any of the information contained in these materials is useful to them. This material is based upon work supported by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under grant No. 1 U79 SM55029-01. Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[1] Evidence-based: Programs that have undergone scientific evaluation and have proven to be effective.

Suicide Prevention: The Public Health Approach

Applying the Public Health Approach to Suicide Prevention

1. Define the problem: Surveillance[2]

Suicide Surveillance – Collecting information about the rates of suicidal behaviors[3]. This can include the collection of information about individuals who attempt or die by suicide, their circumstances, and the effects on others. Data on suicidal behavior is available from the Centers for Disease Control and Prevention at http://www.cdc.gov/nchs/fastats/suicide.htm. (See the SPRC fact sheet, "Sources of Data on Suicidal Behavior," for sources of data on your state, territory or community.)

2. Identify causes

Suicide is best understood as a very complex human behavior, with no single determining cause. The factors that affect the likelihood of a person attempting or completing suicide are known as *risk*[4] or *protective*[5] *factors,* depending on whether they raise or lower the likelihood of suicidal behavior. Risk factors include mental illness and loss of a loved one. Protective factors include support networks and access to mental health care.

While people who attempt or complete suicide typically experience a combination of risk factors, there is often one precipitating factor that leads the person to attempt suicide. However, a person with many risk factors may not attempt to commit suicide if his or her risk factors are balanced by protective factors.

3. Develop and test interventions

Interventions might attempt to influence some combination of psychological state, physical environment, and cultural conditions. It is important to test intervention methods to ensure that they are safe, ethical, and feasible. Interventions that are successful in one setting may not be universally applicable. Comprehensive suicide prevention programs are believed to have a greater likelihood of reducing the suicide rate than are interventions that address only one risk or protective factor. Collaboration between community leaders and coalitions that cut across traditionally separate sectors can increase effectiveness.

Formative evaluation, including pre-testing, permits necessary revisions before the full effort goes forward. Its purpose is to maximize success of the program prior to implementation. Thorough consideration needs to be given to the possibility of increase in demand for services that do not exist in the community.

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[2] Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.
[3] Suicidal behaviors: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.
[4] Risk factors make it *more* likely that individuals will develop a disorder; they may include biological, psychological, or social factors in the individual, family, and environment.
[5] Protective factors that make it *less* likely that individuals will develop a disorder; they may include biological, psychological, or social factors in the individual, family, and environment.

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

DHHS - Non-Discrimination Notice

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), 1-800-606-0215 (TTY). 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.

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Memorandum of Understanding Between
Maine Department of Corrections, Division of Juvenile Services and
Department of Health and Human Services, Children's Behavioral Health Services
Regarding Respective Roles and Responsibilities

I. Background

This memorandum of agreement serves to delineate the roles and responsibilities of the Maine Department of Corrections, Division of Juvenile Services, hereinafter referred to as "DJS" and Children's Behavioral Health Services, and hereinafter referred to as "CBHS" in the implementation and management of behavioral health services for juveniles and their families.

II. Population of Concern

Juveniles involved in the juvenile justice system who are receiving or may be in need of behavioral health services.

III. Authorities

Children's Behavioral Health Services "CBHS" is the lead executive agency responsible for the development and implementation of a system of care for children, adolescents, and their families in need of behavioral health services. This responsibility includes: collaborating with DJS in system design, implementation and management of the network of local providers that provide a full range of services, establishment of a single point of authorization, establishment of uniform standards policies and procedures, case coordination, monitoring and evaluation.

The Division of Juvenile Services "DJS" is responsible for diverting youth from the juvenile justice system, supervising youth in the community on conditional release, probation, or community reintegration status, and providing care and supervision to youth detained in or committed to the juvenile correctional facilities.

IV. Operating Principles

The Departments jointly recognize that many youth in the juvenile justice system have a combination of behavioral health and correctional needs, and agree to work together to address these needs in a unified system of care, including criminogenic risk reduction and meeting the behavioral health needs of youth.

CBHS and DJS are committed to collaborative system approaches in an effort to individualize treatment/service plans for all youth. For some youth that may mean diverting them entirely from the juvenile justice system, and for other youth it will mean joint planning to target both behavioral health needs and criminogenic risk factors.

Research at the national and state level has identified a large percentage of children in the juvenile justice system with behavioral health issues. Children in this system may not have had access to behavioral health services for a variety of reasons, and, in some cases, may have been confined in juvenile facilities. The goal of this agreement is to assure that all youth under the jurisdiction of DJS will be screened for behavioral health service needs, evaluated appropriately, and provided needed services.

Services will be provided in the least restrictive environment to accomplish the identified goals of the collaborative case plan. Plans will be family driven, youth guided, culturally competent, strengths based, trauma informed and apply the principles of effective intervention for youth in the juvenile justice system. There is an assumption that planning and services will be developed in collaboration with youth and families to the fullest extent possible.

V. Responsibilities of the Parties:

A. Community Mental Health Program Coordinators:

CBHS will provide Community Mental Health Program Coordinators in DJS Regions to ensure continuity of care across settings. Community Mental Health Program Coordinators will work with DJS staff will work to:

1. Coordinate screening and assessment for behavioral health needs for youth
2. Coordinate behavioral health treatment services
3. Facilitate multidisciplinary treatment and multi-departmental case planning.
4. Cultivate and maintain relationships with outside individual and agency behavioral health treatment providers.
5. Coordinate with the contracted behavioral health providers.
6. Develop and implement staff training on behavioral health related topics.
7. Consult with DJS staff in the development of individualized case plans to assure that behavioral health treatment needs are identified and addressed and that the correctional plan responds appropriately by taking into account any behavioral health concerns. This includes the coordination of screening and assessment for behavioral health service needs.
8. Maintain information about providers within their respective geographical regions in order to assist DJS staff in referring to appropriate providers for identified needed services.
9. Manage available flex funds.
10. Consult with providers regarding the needs of youth in the juvenile justice system.

B. Mental Health Program Coordinators at Long Creek and Mountain View Youth Development Centers:

CBHS will provide one Social Service Manager who will act as a Mental Health Program Coordinator at Long Creek Youth Development Center and one Mental Health Program Coordinator at Mountain View Youth Development Center to ensure continuity of care across settings. Mental Health Program Coordinators at the Centers will work to:

1. Coordinate screening and assessment for behavioral health needs for youth
2. Coordinate behavioral health treatment services
3. Facilitate multidisciplinary treatment and multi-departmental case planning.
4. Cultivate and maintain relationships with outside individual and agency behavioral health treatment providers.
5. Coordinate with the contracted behavioral health providers.

6. Develop and implement staff training on behavioral health related topics.

7. Consult with DJS staff in the development of individualized case plans to assure that behavioral health treatment needs are identified and addressed and that the correctional plan responds appropriately by taking into account any behavioral health concerns. This includes the coordination of screening and assessment for behavioral health service needs.
8. Maintain information about providers within their respective geographical regions in order to assist DJS staff in referring to appropriate providers for identified needed services.
9. Manage available flex funds.
10. Consult with providers regarding the needs of youth in the juvenile justice system.

C. Psychiatric Social Workers:

Two clinical Psychiatric Social Workers at Long Creek Youth Development Center and a Psychiatric Social Worker at Mountain View Youth Development Center.

1. Psychiatric Social Workers in each facility will:
   a. Screen and assess juveniles for behavioral health treatment.
   b. Assess youth in crisis and appropriately intervene.
   c. Provide individual, group, and family treatment on an as needed basis.
   d. Provide community service linkage.
   e. Participate as a regular member of multidisciplinary treatment teams.

2. Psychiatric Social Workers at Long Creek Youth Development Center will work specifically with the detained/hold for court population. They will also participate in gender specific treatment of detained and committed girls to help improve the treatment response.

3. The Psychiatric Social Worker at Mountain View Youth Development Center will work with the committed residents throughout the facility who are identified as needing behavioral health services.

D. Other Duties and Change of Assignments of Children's Behavioral Health Staff:

Assignment may change as dictated by the needs of the youth or facility and as agreed to between CBHS and DJS. All Children's Behavioral Health staff will perform duties within respect to their individual certification or licensure capacities.

E. Supervision and Reporting:

1. Community Mental Health Program Coordinators will be supervised by the Regional CBHS Team Leader or Supervisor who in turn will consult with the Regional Correctional Administrators regarding the functions of the Mental Health Program Coordinators.

2. The Social Service Manger at Long Creek Youth Development Center will be supervised by the CBHS Medical Director.

3. The two Psychiatric Social Workers at Long Creek and the Mental Health Program Coordinator at Mountain View will be supervised by the Social Services Manager at Long Creek Youth Development Center.

4. The Psychiatric Social Worker at Mountain View will be supervised by the Mental Health Program Coordinator at Mountain View.

VII. Policies and Procedures:

A. Screening Methods:

DJS and or CBHS staff will administer screening tools or use other procedures to identify behavioral health service needs as specifically agreed to by CBHS and DJS. CBHS and DJS will develop and implement protocols to ensure that juveniles receive the appropriate screening in a timely manner.

B. Treatment Services:

DJS staff will collaborate with the CBHS staff in the development of policy and procedures to assure that behavioral health needs of juveniles are met across all settings.

CBHS and DJS will work jointly to develop appropriate services for youth who, due to severe behavioral health disorders, mental retardation, pervasive developmental disorders, or co-occurring substance abuse issues, would otherwise be inappropriately placed at a juvenile correctional facility pursuant to Title 34-A, Chapter 3 §3805 sub. §2 and Title 34-A MRSA §4104, sub. §2.

C. Collaborative System of Care

DJS and CBHS will work collaboratively to review and enhance systems and resources to identify youth with behavioral health needs, provide appropriate behavioral health services across settings, increase functional status of youth and families, use existing services, reduce risk of recidivism, identify gaps and barriers, and develop services and resources to address them.

D. Outcome Measures:

DJS and CBHS shall collect data and jointly develop a method to evaluate the utility and benefit of this agreement. DJS and CBHS will identify performance measures to monitor progress towards attainment of goals and develop a data collection system to measure the level of progress

Goals to be achieved by this agreement include:

1. Effective implementation of the agreement.
2. Identification of youth with behavioral health needs.
3. Provision of appropriate behavioral health services across settings.
4. Assessment of systemic needs.
5. Increased functional status of youth and families.
6. Maximization of appropriate existing services.
7. Reduction of the risk factors for recidivism.
8. Identification of service gaps.
9. Development of services and resources to address gaps.
10. Appropriate use of funding.

E. Flexible Funding:

The parties agree to maximize existing and available resources to support youth and family needs. Flexible funds will be used according to each agency's respective policies and procedures. At the start of each quarter, CBHS and DJS staff will meet to identify the amount of funding available to youth within each of their respective regions. The parties will document use of funds and exchange the documentation on an annual basis. In the event that funds are not available for a specific situation, the parties shall explore all other financial resources and report the outcome to the other department at the earliest possible date.

F. Training and Education:

1. CBHS and DJS will jointly develop and implement appropriate cross-training curricula for staff of the two Departments in an annual training plan. Cross training will include but not be limited to: procedures, and impact of out of home placement or detention. The parties will communicate about training needs and provide trainings in a timely manner.

2. DJS will provide CBHS staff stationed in the juvenile correctional facilities all American Corrections Association (ACA) trainings required to keep CBHS staff and DJS facilities in compliance with ACA Accreditation.

3. CBHS and DJS will work together to develop and deliver trainings as needed for community partners and others as identified by DJS and CBHS staff.

4. All trainings will be consistent with training requirements of DJS and CBHS.

5. DJS will provide space, telecommunications equipment and support, information technology equipment and support, postage, office supplies for CBHS staff and necessary supplies and

6. DJS will supply limited training and travel reimbursement as agreed on an individual basis.

G. Exchange of Information and Confidentiality:

CBHS and the DJS will develop and implement a plan to share information needed for managing joint cases and for planning and operational purposes. All information exchanges shall be in accordance with all applicable state and federal laws and regulations. The parties shall work together to develop standard forms for release of confidential information.

VII. Memorandum Management Process

Every reasonable effort shall be made by the parties to resolve conflicts at the regional level. In the event that the parties are not able to reach a resolution through regional staff within a reasonable period of time (not to exceed ten (10) business days) of both parties having had the opportunity to address a conflict, the parties have an obligation to present the dispute to the Associate Commissioner for Corrections and the Director of CBHS or their designee(s) for resolution within a reasonable period of time no later than seven (7) business days from the date of presentation of the issue.

VIII. Monitoring and Evaluation

On a quarterly basis, DJS and CBHS regional staff will bring cases to review at a statewide meeting and document the reviews. The purpose of this case review will be to process and learn about the effectiveness of the system and service provision.

This agreement will be carried out under the direction of a Monitoring Committee that will consist of the Associate Commissioner for Juvenile Services of DJS, the Director of CBHS, and others as needed. The Monitoring Committee shall meet on a quarterly basis to ensure that the terms of the agreement are being met. The committee shall also review data collection and cases that have a statewide impact.

IX. Effective Date

This agreement will be n effect as of November 1, 2007 and will continue unless terminated earlier by either party. This agreement may be amended at the request of either party and by mutual agreement of both parties.

Associate Commissioner Department of Corrections Division of Juvenile Services	Director, Children's Behavioral Health Services
Date	Date

11/16/07

Interdepartmental Protocol Concerning Title 15 Referrals to The Department of Health and Human Services

I. Purpose of the Protocol

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

This protocol covers all Title15 referrals, including judicial review of disposition under Title 15 Section 3317. DJS personnel will initiate this interdepartmental protocol when they initially identify youth for whom they believe remaining in their homes, or returning to their homes, is contrary to their welfare and may require custody by DHHS. A recommendation that a youth be placed in DHHS custody may be considered in, but is not limited to, the following situations:

- A youth has a guardian who is unwilling or unable to provide adequate care and protection, and or supervision;
- Reasonable efforts to safely maintain the youth in his her own home have been tried, documented, and substantially failed;
- Parental behavior/environment is a significant risk factor apparently contributing to youth's delinquent behavior;
- When work with the youth and the youth's family has resulted in the youth making progress, but the parent(s) have not adequately progressed so that the youth's care and protection can be assured.

II. Protocol Steps

When considering a recommendation for DHHS custody, the following protocol shall be implemented by DJS personnel. Upon consideration of the individual case characteristics, particularly if there are significant issues — including criminality, abuse/neglect issues, public safety concerns, and or mental health needs — DJS personnel will initiate the following protocol steps:

1. DJS will consult with Children's Behavioral Health Services' (CBHS) Mental Health Program Coordinator assigned to juvenile cases, and other appropriate agencies and individuals as indicated, to assess and review

the youth's unmet mental health and behavioral health treatment needs. The Mental Health Program Coordinator will assist with referrals.

2. Following that consultation, DJS may initiate a referral of the youth for possible DHHS custody, if a youth's situation appears to meet any of the criteria listed in Section I. If the decision is to refer, DJS will notify DHHS by calling the Child Protective Intake office.

3. Within two working days DJS will forward a written referral of the same nature to the appropriate District Office of DHHS. Simultaneously, DJS will notify the youth's parents that a referral to DHHS has been made and that they will be invited to a meeting to review and discuss the referral. When available to DJS, the written referral information to DHHS will include the following:

   - Vital statistics on youth;
   - Primary family members or alternative relative placement;
   - Reasonable efforts that have already been tried to maintain youth in her/his parents' custody;
   - History of any known previous DHHS involvement;
   - Complete criminal history;
   - Current correctional status;
   - Legal guardian/current caretaker;
   - Youth Level of Service/Case Management Inventory (YLS-CMI) findings and any previous assessments and evaluations;
   - Medical history;
   - History with other departments/agencies;
   - School information including special education status and any handicapping condition;
   - Current living circumstances; and
   - Notice of any safety concerns when going into home environment.

4. DJS will schedule an interdepartmental team meeting within three days with DHHS Child Welfare and Children's Behavioral Health Services, and other necessary parties, which should include the juvenile's parents whenever possible. The purpose of this meeting is to assure all pertinent information is available and shared among all participants. The Juvenile Community Corrections Officer (JCCO) of DJS will provide copies of the written referral and results of the Risk/Needs Assessment, YLS/CMI, for this meeting. A date will be set for a Family Team meeting to review the information and findings from the home study.

5. The assigned Child Welfare Caseworker will complete a home study of the family using a standardized format within three weeks of the Interdepartmental Team meeting.

6. The assigned Child Welfare Caseworker will convene a meeting of all stakeholders to review the results of the home study and its findings using the Family Team Meeting planning process. Based on the outcomes of this meeting, one of two plans for the youth/family shall be developed as follows:

   A. If the team is not recommending removal of the youth from the parents' custody, the meeting will focus on developing an alternative plan for the youth and family, which shall include a comprehensive service plan based on the strengths, needs, and challenges as identified in the Home Study and YLS/CMI. The plan will clearly identify services and actions intended to assist the youth/family in reaching goals that provide for the safety and welfare of the youth and his/her community. Goals, objectives, and assignment of responsibilities will be outlined in the plan. The service plan will also contain a contingency or crisis plan to be implemented should the original plan not be implemented for any unforeseen reasons. If all parties agree to the plan, steps will be taken to implement the case plan as soon as possible.

   B. If the team is recommending that the youth be placed in DHHS custody, this meeting will focus on the development of an interim plan of care for the youth pending final disposition. This plan will list the factors that contributed to the recommendation for out-of-home placement, and will identify any responsibilities for parents that will be part of the recommendation to the court and be incorporated into the Family Service Plan.

7. If there is professional disagreement concerning the plan, the assigned Child Welfare Caseworker will forward all documentation and a summary of the meeting within two working days to the District Program Administrator for Child Welfare Services, the Regional Team Leader for Children's Behavioral Health Services, and the Regional Correctional Administrator for the Division of Juvenile Services who will meet and review all of the information and develop a recommendation to be returned to the Youth's Team. Upon agreement this recommendation will be presented at the court hearing.

8. Should the Regional Management, comprised of members listed in number 7, be unable to achieve agreement within two days of receiving the documentation and request for review, the material will be forwarded, along with a summary of issues raised and unresolved by the Regional Management, to the DHHS Director of Children's Behavioral Health Services, the DHHS Director of Child Welfare Services, and the DOC Associate Commissioner for Juvenile Services who will review all materials and develop a recommendation to be returned to the Regional

Management Team and the Youth's Team. This recommendation will be presented at the court hearing.

9. Regardless of specific time frames listed in each section, the process from receipt of referral by the Child Protective Intake until the recommendation to provide to the court is agreed to by all parties, shall not exceed 30 days.

10. DJS in conjunction with the attorney for the state will assure that all parties, including legal and putative parents, shall be notified, and that an income affidavit is distributed.

11. If the youth is placed in DHHS custody all parties of this protocol agree that both departments will stay actively involved and continue to work collaboratively on all significant case management issues that may arise concerning the youth while the juvenile remains under the jurisdiction of both Departments.

12. The lead person in each department responsible for policy implementation, training, and clarifying questions will be:
    DJS — Director, Juvenile Programs
    DHHS — Director, Child Welfare Services
    DHHS – Director, Children's Behavioral Health Services

13. At a minimum, there will be quarterly meetings to review this protocol to determine how it is working, if adjustments need to be made to the protocol, its implementation, or the training around the protocol. DOC's Associate Commissioner of Juvenile Services will convene any necessary meetings.

14. This protocol may be amended by agreement of all parties.

Signatures of agreement for Interdepartmental Protocol Concerning Title 15

January 27, 2007 S/ Brenda Harvey

Date Commissioner, Department of Health &Human Services

January 23, 2007 S/ Marty Magnusson

Date Commissioner, Department of Corrections

Protocol For Assisting Children At Risk

INTRODUCTION/PURPOSE

The Office of Child and Family Services (OCFS) is committed to working collaboratively to best meet the needs of children in Maine. We recognize that there are times when the duties and responsibilities of the various divisions of OCFS will overlap. This protocol is specifically designed to assist the Children's Behavioral Health Service (CBHS) Division and the Child Welfare Service (CWS) Division in planning for such times.

****Please note that this protocol does not negate mandatory reporting of suspected child abuse or neglect by anyone involved with the child and/or family.**

This protocol MUST be used if either of the two following situations is occurring:

1. All of the following must apply:
   - Abuse and/or neglect is suspected or there is an open case with Child Welfare or the child is in state's custody **and**
   - A child is having significant behaviors related to his/her mental health and/or behaviors related to family system challenges **and**
   - Current providers are unable to move forward in addressing the present concerns after documented attempts to engage the family in moving past the barriers.

   Examples – 1.) A child open to Child Welfare who also has significant behaviors that have been unable to be decreased even after planning sessions and attempts to decrease these behaviors with the current providers. 2.) A community case manager involved with a child having significant behaviors and there is concern that family system challenges are so severe that child's behaviors will not resolve unless family system changes are made, and there have already been attempts by current providers to address family concerns without success. 3.) A child's family is refusing/unable to participate in treatment with their child.

2. A child is in Intensive Temporary Residential Treatment (ITRT) **and**:
   - Barriers to discharge exist that stem from safety concerns within the family or there is disagreement around discharge criteria **and**
   - Documented attempts have been made to move past the barriers and have been unsuccessful **and**
   - There is clear documentation that the family has been made aware that if the child can't come home it is their responsibility to find a safe alternative for their child and the family has not done this, or if safety issues exist in the home the caregivers have decided to return the child to **and**

- At least **one** of the following must **also** apply:
    i. History of prior CWS involvement resulting in the removal of a child.
    ii. Caregiver's own need(s) is primary barrier to reunification, including homelessness or inadequate housing, caregiver mental health symptoms, medical illness of caregiver and other identified unmet needs.
    iii. There is documented concern for the safety of the caregiver, other children in the home and/or members of the community should the child return home.
    iv. There is documented concern for the safety of the child should (s)he return home.
    v. The family's progress is not commensurate with the child's progress.
    vi. Caregiver is participating but openly expresses that the child can not return to their home.

Examples- 1.) A child's family is unable/unwilling to participate in treatment with their child. 2.) A child's family is not following treatment recommendations in a manner that is detrimental to the child's progress as determined by the child's treatment team. 3.) A discharge date is set by the facility or by APS Healthcare and the parents are unable/unwilling to take the child home. 4.) Caregiver is openly expressing a desire not to take the child home once treatment is completed.

Guidelines to follow when implementing this protocol:

- Releases of information may need to be signed by the legal guardian(s) if protected information will be shared.
- Meetings should be scheduled when and where it is most convenient to the family, whenever possible.
- We recognize that this process may be very threatening to families. If the decision is made to have a joint meeting with the family, it is suggested that the individual responsible for approaching this with the family bear that in mind. The following wording is suggested: "We have been working together and things are not moving forward as much as we would all hope. Every member of this team wants what is best for this child. Right now, I think we should include another division of OCFS (CWS or CBHS) to see if we can come up with some other ideas and some other resources to help us in this. We hope that you as her/his parents will be involved and help lead this team, but we feel it is important enough that we will meet together regardless."
  **If this is a situation where child welfare is not open, it is important to stress to the family that when child welfare comes to a meeting they will be there as another resource and not as an open case.

- A trauma-informed approach MUST be utilized throughout this process. Key points to this approach that need to be remembered are 1.) Meetings/plans need to be family driven; 2.) Meetings and plans need to be youth guided; 3.) All aspects of the process need to be culturally and linguistically appropriate; 4.)Physical and emotional safety are ensured throughout the process; 5.)Youth and Family Empowerment, Choice and Control are emphasized throughout the process; 6.) All providers involved need to be supported in being trauma competent; 7.) Trustworthiness needs to be maintained throughout the process. **Please contact the Thrive Initiative with any questions pertaining to the trauma-informed approach (207)782-5783.
- A CPS referral may be appropriate during this protocol process and should be made when specified in the outlined steps of this protocol. Maine State Statute states that this would be appropriate at these times most likely related to:

  Title 22, Chapter 1071

  § 4002 Definitions:

  1. Abuse or neglect. "Abuse or neglect. "Abuse or neglect" means a threat to a child' health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these.

  1-A. Abandonment. "Abandonment" means any conduct on the part of the parent showing an intent to forego parental duties or relinquish parental claims. The intent may be evidenced by:

  A. Failure, for a period of at least 6 months, to communicate meaningfully with the child;

  B. Failure, for a period of at least 6 months, to maintain regular visitation with the child:

  C. Failure to participate in any plan or program designed to reunite the parent with the child;

  D. Deserting the child without affording means of identifying the child and his parent or custodian;

  E. Failure to respond to notice of child protective proceedings; or

  F. Any other conduct indicating an intent to forego parental duties or relinquish parental claims.

- If at anytime during this outlined process, there is disagreement between the two divisions (Child Welfare and Children's Behavioral Health) that cannot be resolved, the Program Administrator from Child Welfare, the Team Leader from Children's Behavioral Health Services, and the OCFS Medical Director will be asked to assist. If it can not be resolved at this point, OCFS Central Office will be requested to intervene. This needs to take place in a timely manner so that the needs of the child are met as soon as possible.

- The respective divisions will properly document when this protocol is used (please see further in this document how to do this).
- This protocol will move forward, even if there is disagreement (by APS, caregiver, CBHS, CW, treatment provider) as to whether or not a child meets level of care for treatment, when there appears to be barriers to permanency planning for a child.

PROTOCOL

Criteria I

All of the following must apply:

- Abuse and/or neglect is suspected or there is an open case with Child Welfare or the child is in state's custody **and**
- Significant behaviors occurring related to his/her mental health and/or behaviors related to family system challenges **and**
- Current providers are unable to move forward in addressing the present concerns after documented attempts to engage the family in moving past the barriers.

Examples – 1.) A child open to Child Welfare who also has significant behaviors that have been unable to be decreased even after planning sessions and attempts to decrease with the current providers. 2.) A community case manager involved with a child having significant behaviors and there is concern that family system challenges are so severe that child's behaviors will not resolve unless family system changes are made, and there have already been attempts by current providers to address family concerns without success. 3.) A child's family is refusing to participate in treatment with their child.

Process if child may meet above Criteria I

1.)The CWS caseworker or CBHS community case manager will contact the Mental Health Program Coordinator (MHPC) who will discuss the situation and they will determine together if more intensive collaboration is warranted. The MHPC may decide to have a meeting with the family team prior to initiating a combined process (i.e. meeting/planning with Child Welfare and Children's Behavioral Health Services together).

2.) If the MHPC determines that more intensive collaboration between CWS and CBHS is warranted, a meeting will be convened. CWS will be represented by a supervisor or higher level. CBHS will be represented by the MHPC, Utilization Review (UR) specialist and/or Team Leader.

3.) If it is determined that a meeting with both Child Welfare and Children's Behavioral Health is appropriate:

A. The initiating division will convene a meeting within 2 weeks of determining that this meeting needs to take place. The purpose of this meeting is to explore the strengths and challenges of the child and family with the intent of creating a plan to address the current barriers. At the conclusion of this

meeting a plan will be developed outlining actions steps that will be implemented to best meet the needs of the child. Team members will include the family, representatives from CBHS and CWS, community providers involved with the family, and natural supports the family has identified.

B. Prior to the scheduled meeting, the lead division will contact the other division to have a conversation regarding the current status of the case and identify what information is necessary so that the other division is able to be an active participant in the meeting. Information that may be important to discuss:
   - Identifying Information (name, DOB, address, current provider)
   - History of OCFS involvement (if any)
   - Current strengths and challenges, family history, diagnosis
   - Current and past treatments (psychological, medical and hospital)
   - School information and psychological testing
   - Current Living Situation (legal guardian/caretaker)
   - Past and Present history of violence, risk assessment
   - Documentation of Lack of Family Involvement
   - Documentation of efforts to support parental involvement and efforts to reduce any barriers to involvement.

   The lead division will also request documentation from providers of family participation in treatment as well as attempts to engage the family in treatment prior to the scheduled meeting.

   *** Written information shall be made available to all parties prior to the meeting, whenever possible.

C. The meeting shall be organized in the following manner:
   - The lead division will identify the purpose of the meeting and the agenda (this must include all possible outcomes of this meeting such as "the intention is that a plan will be developed and a follow up meting will occur," "the caregiver finds safe alternatives without the assistance of this team but in a timely manner," or "no plan is created and a CPS report will be made").
   - Introductions will include explanations of each team member's role
   - The family story will be told by the family with input from others at the table as appropriate.
   - Summary of past and present services, highlighting successes, strengths and challenges.
   - Barrier Identification
   - A concrete plan will be created to overcome barriers and will include action steps, who will be the lead in getting each action step completed, and target dates that each step will be completed by.
   - A follow up meeting will be scheduled before the conclusion of the initial meeting and all other subsequent meetings. Follow up meetings will be utilized to monitor progress on the action steps.

- The meeting is clearly documented and all parties receive written notes of the meeting within 1 week of the meeting (it should be documented simply that this process is occurring in the APS Healthcare Care Connection computer system as well).

4.) In the event that no plan can be created at this initial meeting or that the caregiver refuses to have a joint meeting, a Child Protective Services (CPS) report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

5.)If 3 months has passed since the initial meeting and it is determined that progress is not being made a CPS report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is disagreement at this point between the CBHS participant and CW participant about progress made or not made, the District Program Administrator, Team Leader and OCFS Medical Director will be asked to review the case and determine next steps.
If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

6.)If a CPS report is made and Child Welfare opens a case, a CPS assessment will occur as mandated in current practice/law. Once the CPS assessment is completed, all parties involved in this process will be notified of the outcome. If the child goes into state's custody, all parties involved will continue to be involved as needed in future planning for this child until it is agreed otherwise.

If the child does not go into state's custody, the team will continue to meet (including child welfare) for planning purposes and the meeting format decided for use in this protocol should continue to be used. The District Program Administrator, Team Leader and OCFS Medical Director must be made aware of this situation so that they can be part of determining next steps.

Criteria II

A child is in Intensive Temporary Residential Treatment (ITRT) **and**:

- Barriers to discharge exist that stem from parental refusal to take the child home or there are concerns for the parent's ability to meet the needs of the child **and**
- Documented attempts have been made to move past the barriers and have been unsuccessful **and**
- There is clear documentation that the family has been made aware that if the child can't come home it is their responsibility to find a safe alternative for their child and the family has not done this, or if safety issues exist in the home the parents have decided to return the child to **and**
- At least **one** of the following must also apply:
    a. History of prior CWS involvement resulting in the removal of a child.
    b. Caregiver's own need(s) is primary barrier to reunification, including homelessness or inadequate housing, caregiver mental health symptoms, medical illness of caregiver and other identified unmet needs.
    c. There is documented concern for the safety of the caregiver, other children in the home and/or members of the community should the child return home.
    d. There is documented concern for the safety of the child should (s)he return home.
    e. The family's progress is not commensurate with the child's progress.
    f. Caregiver is participating but openly expressed that the child can not return to their home.

Examples- 1.) A child's family is unable/unwilling to participate in treatment with their child. 2.) A child's family is not following treatment recommendations in a manner that is detrimental to the child's progress as determined by the child's treatment team. 3.) A discharge date is set by the facility or by APS Healthcare and the parents are unable/unwilling to take the child home. 4.) Caregiver is openly expressing a desire not to take the child home once treatment is completed.

<u>Process if child may meet above Criteria II</u>

1.)The community case manager, CWS caseworker and/or ITRT provider will contact the CBHS MHPC or UR Specialist to discuss the situation and determine together if more intensive collaboration is warranted. The

MHPC/UR Specialist may decide to have a meeting with the family team prior to initiating a combined process (i.e. meeting/planning with Child Welfare and Children's Behavioral Health Services together).

2.) If the MHPC or Utilization Review Specialist determines that more intensive collaboration between CWS and CBHS is warranted, a meeting will be convened. CWS will be represented by a supervisor or higher level. CBHS will be represented by the MHPC, UR specialist and/or Team Leader.

3.) If it is determined that a meeting with both Child Welfare and Children's Behavioral Health is appropriate:

a. The initiating division will convene a meeting within 2 weeks of determining that this meeting needs to take place. The purpose of this meeting is to explore the strengths and challenges of the child and family with the intent of creating a plan to address the current barriers. At the conclusion of this meeting a plan will be developed outlining actions steps that will be implemented to best meet the needs of the child. Team members will include the family, representatives from CBHS and CWS, community providers involved with the family, and natural supports the family has identified.

b. Prior to the scheduled meeting, the lead division will contact the other division to have a conversation regarding the current status of the case and identify what information is necessary so that the other division is able to be an active participant in the meeting. Information that may be important to discuss:
   - Identifying Information (name, DOB, address, current provider)
   - History of OCFS involvement (if any)
   - Current strengths and challenges, family history, diagnosis
   - Current and past treatments (psychological, medical and hospital)
   - School information and psychological testing
   - Current Living Situation (legal guardian/caretaker)
   - Past and Present history of violence, risk assessment
   - Documentation of Lack of Family Involvement
   - Documentation of efforts to support parental involvement and efforts to reduce any barriers to involvement.

   The lead division will also request documentation from providers of family participation in treatment as well as attempts to engage the family in treatment prior to the scheduled meeting.

   *** Written information shall be made available to all parties prior to the meeting, whenever possible.

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c. The meeting shall be organized in the following manner:
   - The lead division will identify the purpose of the meeting and the agenda (this must include all possible outcomes of this meeting such as "the intention is that a plan will be developed and a follow up meting will occur," "the caregiver finds safe alternatives without the assistance of this team but in a timely manner," or "no plan is created and a CPS report will be made").
   - Introductions will include explanations of each team member's role
   - The family story will be told by the family with input from others at the table as appropriate.
   - Summary of past and present services, highlighting successes, strengths and challenges.
   - Barrier Identification
   - A concrete plan will be created to overcome barriers and will include action steps, who will be the lead in getting each action step completed, and target dates that each step will be completed by.
   - A follow up meeting will be scheduled before the conclusion of the initial meeting and all other subsequent meetings. Follow up meetings will be utilized to monitor progress on the action steps.
   - The meeting is clearly documented and all parties receive written notes of the meeting within 1 week of the meeting (it should be documented simply that this process is occurring in the APS Healthcare Care Connection computer system as well).

4.)In the event that no plan can be created at this initial meeting or that the caregiver refuses to have a joint meeting, a Child Protective Services (CPS) report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

5.)If 3 months has passed since the initial meeting and it is determined that progress is not being made a CPS report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is disagreement at this point between the CBHS participant and CW participant about progress made or not made, the District Program Administrator, Team Leader and OCFS Medical Director will be asked to review the case and determine next steps.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

6.)If a CPS report is made and Child Welfare opens a case, a CPS assessment will occur as mandated in current practice/law. Once the CPS assessment is completed, all parties involved in this process will be notified of the outcome. If the child goes into state's custody, all parties involved will continue to be involved as needed in future planning for this child until it is agreed otherwise.

If the child does not go into state's custody, the team will continue to meet (including child welfare) for planning purposes and the meeting format decided for use in this protocol should continue to be used. The District Program Administrator, Team Leader and OCFS Medical Director must be made aware of this situation so that they can be part of determining next steps.

DOCUMENTATION OF THIS PROCESS

- Each division will keep documentation of their participation in their division's respective formats as required by their individual division.
- Each district will be required to have a district log that keeps track of all OCFS protocols that have taken place. The lead division in each case will be responsible for making sure that the correct information is entered into the district log in a timely manner (See attached documentation format for district logs).

ONGOING MONITORING/EVALAUTION

- The district logs from all 8 districts will be reviewed at a minimum of every 6 months by the OCFS Protocol for Assisting Children at Risk Review Team. It will be determined at these reviews what steps need to be taken to ensure that the protocol is being used appropriately and that it is effective in meeting the needs of children. These reviews may also include talking with key players within the districts to assess the protocols' effectiveness. Further training of staff and/or editing the protocol may or may not need to happen as a result of these reviews.

Maine Alliance of Family Organizations (MAFO) is a statewide alliance that formed to better serve families of children with disabilities and special health care needs, and to strengthen family voice.

Family concerns, needs and voice are foundational to everything we do. We believe families are the primary decision-makers regarding care of their children, and we promote the family role in influencing policies and procedures governing care for all children.

What we hear from parents who have joined a family organization...

"I have learned to speak up without so much anger."

"I had heard this information before, but now I understand it."

"I no longer feel alone. I love the support from parents who have been there. I now know that I am a GOOD mom."

"We have moved beyond past prejudice and fear, and are successfully advocating to achieve the best possible outcomes for our family."

Image by Rhys Strucker

Our organizations help families achieve their goals through education, advocacy, resource cultivation and skilled listening.

Family organizations help families achieve their goals through education, advocacy, resource cultivation and skilled listening.

Community Orientation

We contribute to the health and well-being of our communities' families, collaboratives, organizations and networks. We connect families to vital community resources.

Advocacy

We support individuals and causes through our words and our actions. We value individual opinions and experiences, and we support families' efforts to get their needs met.

Responsive

We listen compassionately and strive to be proactive. We encourage family-serving systems and supports to be readily available, strength-based, trauma-informed and culturally competent, to listen inclusively to expressed needs and concerns, and to meet those needs in a timely manner.

Images by Dan Allard Photography, Co. • Graphic Design by Kip Elliott

Education

We provide a broad spectrum of resources, programs and trainings to families and professionals. We raise public awareness about family and youth issues, as well as highlight their resiliency and contributions to community.

MAFO Member Organizations

Adoptive & Foster Families of Maine
www.affm.net • 1-800-833-9786

Autism Society of Maine
www.asmonline.org • 1-800-273-5200

G.E.A.R. Parent Network
www.gearparentnetwork.com • 1-800-264-9224

Learning Disabilities Association of Maine
www.ldame.org • 1-877-208-4029

Maine Parent Federation
www.mpf.org • 1-800-870-7746

National Alliance on Mental Illness of Maine
www.namimaine.org • 1-800-464-5767

Southern Maine Parent Awareness
www.somepa.org • 1-800-564-9696

Social marketing and technical assistance provided by Thrive System of Care www.thriveinitiative.org

April 25, 2011

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Maine agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Paul R. LePage
Title	Governor
Organization	State of Maine

Signature Paul R. LePage

Date 8-24-11

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	William Boeschenstein
Title	Chief Operating Officer
Organization	Health and Human Services

Signature

Date

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications 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).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

Name	William Boeschenstein
Title	Chief Operating Officer
Organization	Health and Human Services

Signature

Date

Footnotes: