

## I: State Information

### State Information

#### Plan Year

Start Year:

2014

End Year:

2015

#### State DUNS Number

Number

80-904-559

Expiration Date

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

Agency Name

Department of Health and Human Services

Organizational Unit

Office of Substance Abuse and Mental Health Services

Mailing Address

11 SHS, 41 Anthony Ave.

City

Augusta

Zip Code

04333-0011

### II. Contact Person for the Grantee of the Block Grant

First Name

Guy

Last Name

Cousins

Agency Name

Office of Substance Abuse and Mental Health Services

Mailing Address

11 SHS, 41 Anthony Ave.

City

Augusta

Zip Code

04333-0011

Telephone

207-287-2595

Fax

207-287-4334

Email Address

Guy.cousins@maine.gov

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

From

To

### IV. Date Submitted

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

Submission Date

10/1/2013 11:28:02 PM

Revision Date

12/30/2013 10:34:01 AM

#### V. Contact Person Responsible for Application Submission

First Name

Tom

Last Name

Lewis

Telephone

207-287-6342

Fax

207-287-4334

Email Address

tom.lewis@maine.gov

Footnotes:

# I: State Information

## Assurance - Non-Construction Programs

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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.

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

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

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

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Name	<input type="text" value="William J. Boeschstein, Jr."/>
Title	<input type="text" value="Chief Operating Officer"/>
Organization	<input type="text" value="Department of Health and Human Services"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## I: State Information

### Assurance - 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).
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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name	William J. Boeschstein, Jr.
Title	Chief Operating Officer
Organization	Department of Health and Human Services

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Signature:  Date: 3/25/13

**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), (e), 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

### 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.

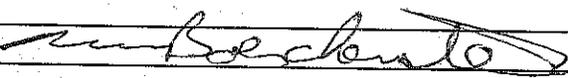
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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.

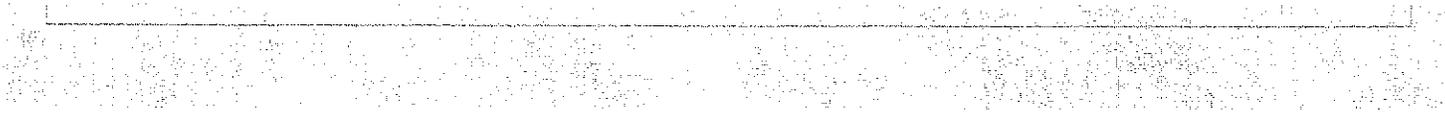
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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 W. Boeschstein, Jr.
Title	Chief Operating Officer
Organization	Department of Health and Human Services

Signature:  Date: 3/25/13

### Footnotes:



## I: State Information

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

#### FY 2014 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

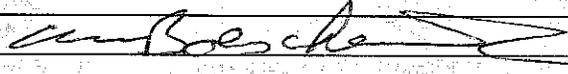
- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

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

Name	William W. Boeschstein, Jr.
Title	Chief Operating Officer
Organization	Department of Health and Human Services

Signature:  Date: 3/25/13

Footnotes:

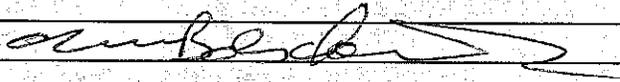
## I: State Information

### Disclosure of Lobbying Activities

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

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

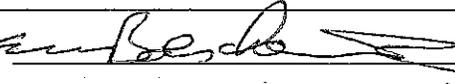
Name	William W. Boeschstein, Jr.
Title	Chief Operating Officer
Organization	Department of Health and Human Services

Signature:  Date: 3/25/13

Footnotes:

### DISCLOSURE OF LOBBYING ACTIVITIES

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

<b>1. Type of Federal Action:</b> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b> <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change <b>For Material Change Only:</b>  Year _____ Quarter _____ date of last report _____
<b>4. Name and Address of Reporting Entity:</b> <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____  Congressional District, if known: _____		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>   Congressional District, if known: _____
<b>6. Federal Department/Agency:</b>	<b>7. Federal Program Name/Description:</b>  CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>	<b>9. Award Amount, if known:</b> \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>	Signature:  Print Name: <u>William W. Boeschenstein, Jr.</u> Title: <u>Chief Operating Officer</u> Telephone No.: <u>(202) 287-1921</u> Date: <u>3/25/13</u>	
<b>Federal Use Only:</b>		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

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**DISCLOSURE OF LOBBYING ACTIVITIES  
CONTINUATION SHEET**

**Reporting Entity:**

**Page**

**of**

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# 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), (c), (d), (e), and (f).

For purposes of paragraph (f) 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

### 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.

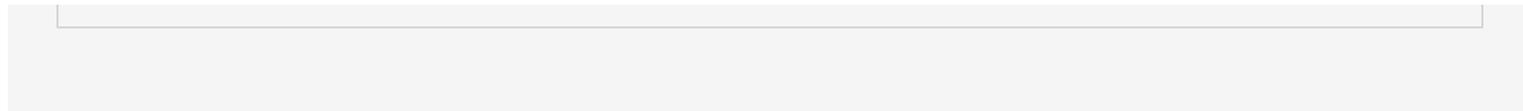
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Name	William W. Boeschstein, Jr.
Title	Chief Operating Officer
Organization	Department of Health and Human Services

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:



## I: State Information

### Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014

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

#### Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant: Approval of State Plan	42 USC § 300x-32

#### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee   
 Title

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

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

Footnotes:

## I: State Information

### Disclosure of Lobbying Activities

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

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

---

Name	<input type="text" value="William W. Boeschstein, Jr."/>
Title	<input type="text" value="Chief Operating Officer"/>
Organization	<input type="text" value="Department of Health and Human Services"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## II: Planning Steps

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

Narrative Question:

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

Footnotes:

In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide a holistic menu of services and support to the people of Maine.

Various public and private organizations in Maine have projects underway that focus on implementing primary and behavioral health care integration. Many FQHC's and some primary care practices are already implementing this model. Maine also has a pilot project focused on Medical Homes. Finally, SAMHS is actively involved on all committees of Value based Purchasing Initiative, which is heavily focused on health care integration in Maine Care (Medicaid) services.

Maine's Medicaid system is working to develop managed care through a value-based purchasing project. At present, the most prevalent model that has come forward is the creation of Health Homes as the preferred model of primary care and behavioral health integration. The first stage of the Medicaid Health Home Initiative is in place; this stage includes individuals with Substance Use Disorders. The Second stage of the Medicaid Health Home Initiative is a work in progress and is anticipated to be in place SFY 14. This stage has a focus on Adults with Serious Mental Illness and Children with Serious Emotional Disturbance with co-occurring substance abuse disorders.

Maine has a team of "content experts" that are working together to address behavioral health integration. Because of the limitations (staff capacity) to have one person delegated to this, we are utilizing the teams' strengths in particular areas and communicating on a regular basis. Additionally, the SSA contributed to the State's Health Plan and is working with stakeholders to implement integration on a larger scale. This task force is comprised of state staff, provider organizations, clients/consumers, and other various stakeholders within behavioral health and primary care.

The Office of Substance Abuse and Mental Health Services (SAMHS) contracts all funding to community providers across the state. SAMHS works with these providers and the provider association to encourage communication with primary care and discussion about the benefits of working in collaboration. With the passing of the Affordable Care Act, SAMHS believes that these conversations will turn into action. [SAMHS worked with the Office of Maine Care Services \(Medicaid\) to activate the CPT codes of 99408 and 99409 for Behavior Change Interventions, Individual \(SBIRT\) and SAMHS Prevention Services are training community coalitions to educate providers about SBIRT to move this initiative throughout the state. The training is conducted through non SAPTBG funds.](http://www.saasnet.org/PDF/Implementing_Healthcare_Reform-First_Steps.pdf)

Maine continues to move toward greater collaboration to integrate substance abuse (SA) and mental health (MH). Efforts include a combined set of standards and regulatory language, the use of a universal screening tool, and greater collaboration between the two areas of expertise to coordinate care. The COSII initiative promoted significant changes and work between the two disciplines at the State level and s worked with over 30 agencies as pilot sites to help them implement integrated care. A Co-occurring Clinical Guideline is available to both SA and MH agencies, and Maine requires co-occurring competency of all providers statewide.

At minimum, address the following populations: Statutory: IVDU, Adolescents, Children and Youth at risk for MH SA etc., Women who are pregnant, parents with SA who have dependent children, Military and families, American Indians/Alaska Natives.

### **Intravenous Drug Use (IVDU):**

The SAMHS Treatment Data System (TDS) reports 5756 all/4087 Treatment only admissions for IVDU by providers who receive State and federal funding for SA treatment. Males were 1.5 times more likely to be treated for IVDU than females. Two public health districts, Cumberland and Downeast had much higher rates of admissions when compared to the percentage of the population living in those districts. (Cumberland has 21.2% of Maine's population, but 22.8% of those treated live in Cumberland; for Downeast it was 6.6% and 8.6% , respectively). Just over 38.4% of all treated IVDUers in Maine live in Cumberland or Western districts. The 2011 MIYHS shows that 4.4% of males and 2.5% of females in high school have used drugs intravenously. 3.6% of 12<sup>th</sup> graders, 3.5% of 11<sup>th</sup> graders, 4.4% of 10<sup>th</sup> graders, and 2.6% of 9<sup>th</sup> graders reported they used drugs intravenously at some point in their life. From the Maine HIV program strategic prevention plan, they reported that 7% of new HIV diagnoses were identified as IVDU. Per the Maine Infectious Disease program, the rate of TB in 2009 was .7 cases per 100,000 population (9 cases for the entire state). Of the 9 TB cases, 1 was an IVDU, 2 used non-injected drugs, and 3 used alcohol excessively.

### **Pregnant Women:**

TDS reports 287 all/255 Treatment only women were pregnant at admission. 91.6 all /91.8% Treatment only were white, 3.1/3.1% Black, 3.1 all/3.5% Treatment only American Indian, and 2.4 all/2.7 Treatment % Hispanic (2010 census shows 95.2% of Maine's population are White; 1.2% are Black; .6% are American Indian; and 1.3% Hispanic). Behavioral Risk Factor Surveillance Survey (BRFSS) reports that between '06-'10 (this was not included in the 2010 or 2011 BRFSS), the percent of pregnant women who drank in the past 30 days (month) ranged from a low of 4.8% to a high of 17.5%. In '09, pregnant women were noticeably less likely to have ever been told by a doctor that they have an anxiety or depressive disorder.

Pregnancy Risk Assessment Monitoring System (PRAMS) data shows a trend of an increase in the percentages of women who drank in the last trimester of pregnancy. In 1998 it was at its lowest level between 1990 and 2011, of 3.5%. Since 2000, the rate has increased by approximately 59.6%, from 5.1% in 2000 to 8.2% in 2011. 2004-2010 Data also indicates that, women who were older (35+) or who made in excess of \$50k had noticeably higher percentages of having used alcohol in the last trimester of pregnancy. Also women who were not on Medicaid/Maine Care or not in WIC were more likely to have used alcohol during their last trimester.

Per TDS, between '08-'12 the percent of pregnant women being treated for a primary substance of synthetic opioids and methadone/buprenorphine has increased sharply from 60.3% in SFY 2008 to 70.9% in SFY 2012 (17.6% increase).

### **Adults in Treatment with Dependent Children:**

5695 admissions to treatment in SFY 2012 were parents with dependent children (3243/57% of which had an opiate (Narcotics, Heroin, Methadone, or Buprenorphine) as their primary drug leading to admission.

Maine State Office of Child and Family Services reports that in 2012 there were 779 notifications/reports of drug affected babies.

Behavioral Risk Factor Surveillance System (BRFSS) reports that in '09, adults who have children were more likely to have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children. From '06-'10, adults with children were more likely to have drunk in the past 30 days (month) than those w/out children. In '09, adults with children were more likely to have drunk in the past 30 days (month) *and* have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children.

### **Children/Youth:**

TDS reports that there were 778 clients under 18 who were admitted to treatment for SA in SFY 2012 (this is an increase of 141 clients from SFY 2011). Just fewer than 40% are from Western district; and 51.9% are from Western and Midcoast districts). Early initiation and use of alcohol drugs has been shown to be a risk factor for future substance abuse disorders. The 2011 Maine Integrated Youth Health Survey (MIYHS) reported 30-day substance use rates in high school youth: 16.9% binge drank; 28.0% drank alcohol; 22.1% smoked marijuana; 15.5% smoked cigarettes; 7.1% used a prescription drug without a prescription. The majority of High School (HS) students who ever drank or smoked marijuana did so between the ages of 13-16.

The Maine Youth Integrated Health Survey (MIYHS) reported that between '09-'11 57.5% of HS students said it's easy to get marijuana. And 2/3rds report alcohol is easy to get. The percentage of HS students who perceive great risk from heavy drinking has remained stable. The percentage of HS students who perceive great risk from heavy drinking has remained stable. The percentage of HS students who perceive binge drinking as risky increased from 73.0% in 2009 to 78.9% in 2011. However, the percentage of HS students who see little to no risk from smoking marijuana regularly increased from 39.1% in 2009 to 43.9% in 2011. HS students report a noticeably higher likelihood of being caught by their parents than by police for drinking alcohol. HS students also report a noticeably higher likelihood that they think parents rather than neighborhood adults feel it would be wrong to drink or smoke marijuana regularly.

The National Survey on Drug Use and Health(NSDUH) reported that between '02-'10 the percent of Mainers ages 12-25 who drank, binge drank, misused prescription drugs, have ever used cocaine (ages 18-25 only), or smoked marijuana in the past 30 days (month) has remained stable. Although, in the 2010-11 NSDUH state report showed Mainers 18-25 years of age at the lowest level in a decade for past month alcohol use, at 62.68% and for past month binge drinking, 42.48%. The percent of Mainers ages 18-25 who perceive great risk from binge drinking has increased from 24.6% to 28.6% between '08/'09 and '10/'11. The percent of 12-25 year-olds who perceive great risk from smoking marijuana once a month has decreased. Between '02-'11, 18-25 year-olds had noticeably higher percentages than 26+

year-olds re: those experiencing serious psychological distress in past year. For all age groups, percentages have been stable regarding those experiencing at least 1 major depressive episode.

Per Department of Public Safety – Uniform Crime Report (DPS-UCR) and the U.S. Census, the rates per 10k of alcohol- and drug-related arrests by juveniles (17 or younger) in Maine have remained stable between '05-'10 (although when broken out by type, OUI's have decreased but alcohol law violation arrests have increased; adult drug violation arrests have increased, juvenile drug law arrests have decreased). Juvenile rates have been less than ½ that of the adult (18+) rates.

Per Maine Department of Transportation (MDOT), alcohol-related motor vehicle crash rate for 16-20 year-olds went up sharply between '08-'09 then decreased dramatically in 2010.

Per National Vital Statistics System (NVSS) between 2006 and 2010, pharmaceutical related overdose deaths per 100k for 12-20 year-olds increased while illicit drug overdose death decreased.

### **Native Americans:**

In the 2011 MIYHS survey of 9<sup>th</sup>-12<sup>th</sup> grade students, those identifying themselves as Native American reported higher rates of use than their peers for the following 4 substances/patterns (30 day):

Binge drinking 24.1%; Alcohol use 34.6%; Marijuana 32.6%; Cigarettes 25.1%; and Prescription drugs 13.8%.

The BRFSS reported that between 2004-2010, average yearly percent of the population that reports to be Native American in Maine is about 1.0 % of the population. Between '04-'10, the percent of Native Americans who drank in the past 30 days decreased from 59.7% to 23.1%, the last 4 years being significantly lower than non- Native Americans.

### **Military/Veterans:**

According to a contact at the Maine Army National Guard station, there are approximately 4,300 reservist (all branches), national guardsmen, and coast guard in Maine. In SFY 2011, approximately 5.6% of admissions to Substance Abuse Treatment in Maine were Veterans. We hope to partner and share information with the Veterans Administration (VA) in Maine around substance abuse treatment. Currently we do not know how many veterans are treated through the VA for substance abuse services. In the past couple of years the VA in Augusta Maine has agreed to allow their prescribers to register and use the States PMP to run reports on patients.

The BRFSS reported from 2003 through 2010, the percent of veterans in Maine has decreased from 17.7% to 14.7%. From 2006 through 2010, the percent of veterans who drank in the past 30 days was similar non-veterans. During that same time period, a vast majority of veterans reported being male (average of 93.1%).

Can address targets: Homeless, rural SA individuals, underserved racial/ethnic minorities and LGBTQ, persons with disabilities

## **LGBTQ:**

The BRFSS reports that the percentage of heterosexual/straight individuals in Maine has remained consistent between 2004 and 2010 at an average of 95.5%. During this same time period, those who reported being homosexual, gay, or lesbian have remained around 1.3% and those reporting to be bisexual increased from 0.6% to 1.1%. Those reporting to be of “Other” orientation decreased from 0.5% to 0.3%. Between 2004-2009, those identifying as LGBTQ had a decrease in the consumption of alcohol in the past 30 days. However, the percentage of those identifying as LGBTQ that consumed alcohol in the past 30 days is higher than it is for those identifying as heterosexual/straight. .

The MIYHS 2009 survey for high school students (grades 9-12) showed much higher rates of binge drinking, 30 day drinking, marijuana use, prescription drug misuse, and cigarette smoking in the Gay, Lesbian, Bisexual, and Questioning students than those who identified themselves as straight. 24.2% of students identifying as Gay/Lesbian compared to 16.2% of students identifying as straight reported binge drinking in the 30 days prior to the survey (in other words, GL students were 1.5 times as likely to have binge drank than straight students). Those identifying as Gay/Lesbian were 2.9 times as likely to have misused Prescription drugs, 1.8 times as likely to have used marijuana, and 2.4 times more likely to have smoked cigarettes than those identifying as straight.

**Prevention Targets:** Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to community, school, family, and business norms through laws, policy and guidelines enforcement.

The assessment process for 2014 prevention planning identified two priorities for prevention in Maine including: Alcohol use, marijuana use, prescription drug misuse and inhalant abuse for the 12-17 year old population and – binge/high-risk alcohol use, prescription drug misuse, and marijuana use for the 18-25 year old population.

The SAPT block grant supports environmental strategies statewide through grants to the Healthy Maine Partnerships in coordination with the Enforcing Underage Drinking Laws-funded initiatives working on environmental strategies through local law enforcement.

Current strategies work to address community norms through working with local retailers (RBS trainings and responsible server initiatives); local law enforcement (increased enforcement and communication with adults in the community); local businesses (Healthy Maine Works online assessment tool with resources and assistance to implement strategies in businesses); local schools (to implement a comprehensive substance abuse policy in their school district, as well as other prevention programming. Prevention providers across the state also engage with the Maine Alliance to Prevent Substance Abuse to educate the public about state-wide laws and policy initiatives.

Prevention Targets: Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

Maine's current level of resources for individual strategies is limited, therefore targets are limited.

SAPT BG supports a handful of evidence-based prevention strategies in schools and local agencies across Maine. SAMHS also supports 4 grantees who are implementing Student Intervention and Reintegration Program (SIRP), which is an evidence-based intervention for students referred to the program. This diversion program is based on Prime for Life curriculum.

For this coming year, SAMHS will determine next steps in universal, indicated and selected prevention strategies across the state as it relates to underage drinking, marijuana use, and prescription drug misuse. Within the State of Maine's Medicaid system (Maine Care) coverage for individuals who would thus be eligible in 2014 category already exists and will continue to be utilized. Maine would continue to obligate federal funding to those populations who would continue not to be eligible for Medicaid or other commercial insurances.

Recovery services have not been covered for the SA population in Maine as a "clinical" service under Medicaid. Most of Maine's providers are accessing the Medicaid system and if they are not, outreach. Recovery Systems of Care (ROSC) are being developed in Maine and A Recovery Center opened in Portland in March of 2012.

SMHA's and SSA's work together to provide guidance and leadership with respect to a bi-directional approach of behavioral health and primary care services by SAMHS has been participating in discussions regarding integration policy initiatives facilitated by the Maine Health Access Foundation (MEHAF) with a variety of state level stakeholders participating, from the Maine Primary Care Association, Maine Hospital Association, to Adult Mental Health to name a few. MEHAF has funded a few behavioral / primary care integration pilots in the state. SAMHS has begun the work to create connections with the primary care system. Work is underway to better screen for the presence of a SA disorder and create a process of access to appropriate resources whether they are in the facility or by referral. The provision of recovery support services for individuals with mental health or substance use disorders by The SAPTBG funding will be considered when developing adequate infrastructure to support Recovery Oriented is being conducted by the provider association in partnership with the Office of Substance Abuse and Mental Health Services

### **Planning Steps**

#### **Step 1**

Maine's Behavioral Health System is under the purview of the Maine Department of Health and Human Service. It currently consists of the following offices; Office of Substance Abuse and Adult Mental Health Services, Office of Child and Family Services, Office of Aging and Disability Services Office of Family Independence, The Maine Centers for Disease Control, and the Office of Maine Care Services.

The role of the SSA is to provide leadership in the realm of the prevention, intervention, treatment and recovery of individuals with addiction, their families and communities. The Office of Substance Abuse

and Mental Health Services collaborates with all state agencies and community partners, develops, monitors and improves the lives of those affected by substance use, abuse and addiction across the lifespan. Prevention services include environmental strategies through the Health Maine Partnerships within each of the 9 public health districts across the state, including the Tribal Public Health District added in Maine legislation; Student Intervention and Reintegration Program and a handful of model curriculum supported in schools throughout the state. Intervention Services include Maine Driver Evaluation and Education Program. Treatment Services include ASAM – PPC2 Levels of Care as listed in the following Detoxification Management, Residential Care, Intensive Out Patient, Out Patient, Co-Occurring Treatment and Medication Assisted Treatment.

The Office of Substance Abuse and Mental Health Services is centralized in the capital of the state, and contracts with providers statewide to administer necessary services. Through these contracts SAMHS contributes resources at the public health district level, though unlike other offices, do not have staff located at the public health district level. SAMHS staff is responsible for the contract monitoring, providing technical assistance, and site visits to ensure quality of services being provided. The Prevention system is currently supported at the state level with a variety of funding streams supporting a variety of initiatives.

Maine Office of Substance Abuse and Mental Health Services existing funders include for substance use prevention and treatment include:

- State of Maine General Fund
- Fund for Healthy Maine (Tobacco Settlement Funds)
- SAMHSA's Substance Abuse Prevention and Treatment Block Grant
- U.S. Department of Education (via MOU with Maine Department of Education (DOE))
- Building State Capacities Grant (close out September 30, 2011)

State Epidemiological Outcomes Workgroup grant (11/1/2011 – 10/30/2014)- This grant ended when Maine received the Partnerships for Success II SAMHSA Grant on October 1, 2012, however, the work of the SEOW continues through a mechanism called the Community Epidemiological Surveillance Network and through the work of the Partnerships for Success II grant.

Office of Juvenile Justice and Delinquency Prevention, Enforcing Underage Drinking Laws (EUDL)– Block Grant and Discretionary Grant. The EUDL Block Grant funding will end on May 30, 2014 and the Discretionary Grant ends on September 30, 2014.

SAMHS Partnerships for Success II Prevention Grant (October 1, 2012 through September 30, 2015)

A combination of funding streams support initiatives that support the prevention work in the community, such as the SAMHS Prevention media campaigns: MaineParents.net; PartySmarter; and WorkAlert. Enforcing Underage Drinking Laws grant supports alcohol compliance checks statewide, law enforcement mini grants, and the higher education alcohol prevention partnership.

From the 2013 Office of Substance Abuse and Mental Health Services State Prevention Plan, gaps identified in Maine's prevention system were:

- Need for consistent and adequate funding via the HMP infrastructure (Gap: end of SAMHSA Strategic Prevention Framework – State Incentive Grant.)
- Need for statewide consistent prevention messaging - media.
- Need for support of primary prevention in the schools (Gap: loss of SDFS funding and minimal other funding).
- Need for clear education/messaging that increases understanding of perception of harm and costs associated with use.

Maine's behavioral health shortage areas are Medication Assisted Treatment; comprehensive behavioral health services statewide – residential services for adolescent abusers with co-occurring disorders.

Maine has struggled with an aging workforce and little recruitment in the field of addiction services. We have been attempting to work with higher education to infuse addictions related coursework as a requirement in counseling and social work programs, but have repeatedly run up against the college's accreditation processes and licensing boards (Social workers, clinical counseling). Currently, we have one university that has taken this on in their community mental health program (Southern New Hampshire University). The COSII Initiative has sponsored a Committee focused on Workforce issues that has met with Licensing Boards and has partnered with academic and training programs to offer and require more integrated course work. The initiative has developed a Certificate program, has authored a curriculum on integrated care, and has offered statewide trainings on integration. With the movement in the Substance Abuse arena to a proposed national scope of practice and career ladder, Maine will need at least five to ten years to meet the criteria as it stands now. Additionally, more collaboration is needed with Department of Labor, whose efforts at workforce development tend to inadvertently neglect the behavioral health workforce issues and focus exclusively on physical health care workers. Progress with Licensing Boards and Academic programs continues to be spotty and slow until changes occur at the national level in terms of accreditation standards and licensing requirements.

Maine contracts with an intermediary to provide behavioral health workforce development and are in regular communication about what needs training and follow up is necessary to get providers ready for changes and entice others to enter the field. Some resources that would be helpful are: effective approaches to engage higher education in offering curriculum/programming that ready the existing workforce and encourage new people to enter it. The lack of legitimacy of the field has held down salary and wages so much that it is not a sustainable profession to be part of, so market analysis of the behavioral health field in terms of adequate/appropriate average salary could be beneficial in getting people interested in the this work.

These systems work in tandem to address the needs of diversity in the following ways: Provision within contracts that states there is "no wrong door" when accessing services, assurance of cultural considerations with regard to race, gender and ethnicity via non-discrimination clause in regulatory and contract language, provision of education and training to increase awareness and appropriate service matching.

## II: Planning Steps

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

### Narrative Question:

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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](mailto:planningdata@samhsa.hhs.gov).

### Footnotes:

Main data sources reviewed include:

TDS, NSDUH, BRFSS, MIYHS, YRBSS, UCR

Maine’s rates of persons who needed treatment but did not receive treatment has varied in the amount of decrease by age group, in age groups under 26. From the 2007-2008 and the 2010-2011 NSDUH reports for Maine rates went from, 5.02% to 3.68% of 12-17 year olds, 17.03% to 13.7% of 18-25 year olds, and 5.2% to 4.1% of 26+ year olds “needed but did not receive treatment for alcohol use”. During this same time frame, those who needed but did not receive treatment for illicit drug use went from, 4.31% to 3.3% of 12-17 year olds, 9.29% to 7.9% of 18-25 year olds, and 1.61 to 1.1% of those 26 years old or older. <http://oas.samhsa.gov/2k8State/stateTabs.htm>

Wait list data: During SFY 2012 there were 2280 people on the waiting list to enter treatment. During June 2012 there were 189 people on a waiting list to enter treatment at SAMHS contracted agencies. Nationally, as in Maine, alcohol is the drug of choice for both youth and adults. Youth Risk Behavior Surveillance System (YRBSS) data cannot be compared to the MIYHS so in order to compare Maine data to national data, YRBSS is used. In the 2011 data, 38.7% of high school students across the nation have had at least one drink in the 30 days prior to the survey compared to 28.7% of Maine high school students. For binge drinking the rate was 16.2% for Maine 9-12<sup>th</sup> graders and 21.9% for the nation. The percentage of high school students having used marijuana in the 30 days prior to the survey is 23.1% nationally and 21.2% in Maine.

2011 YRBSS Grades 9-12	Maine	National
30 Day Alcohol Use	28.7%	38.7%
30 Day Binge Drinking	16.2%	21.9%
30 Day Marijuana Use	21.2%	23.1%

Behavioral Risk Factor Surveillance System (BRFSS) data shows that Maine is higher than the national average when it comes to 30 day alcohol use for ages 18 to 24 at 65.3% and 55.5%, respectively. Maine has a higher percentage of binge drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) than the nation, 34.5% versus 29.2%. The same holds true for heavy drinking (adult men having more than two drinks per day and adult women having more than one drink per day) with Maine’s percentage of 18 to 24 year olds at 13% and the United States at 10.4%.

2011 BRFSS Ages 18-24	Maine	National
30 Day Alcohol Use	65.3%	55.5%
Binge Drinking (Alcohol)	34.5%	29.2%
Heavy Use (Alcohol)	13.0%	10.4%

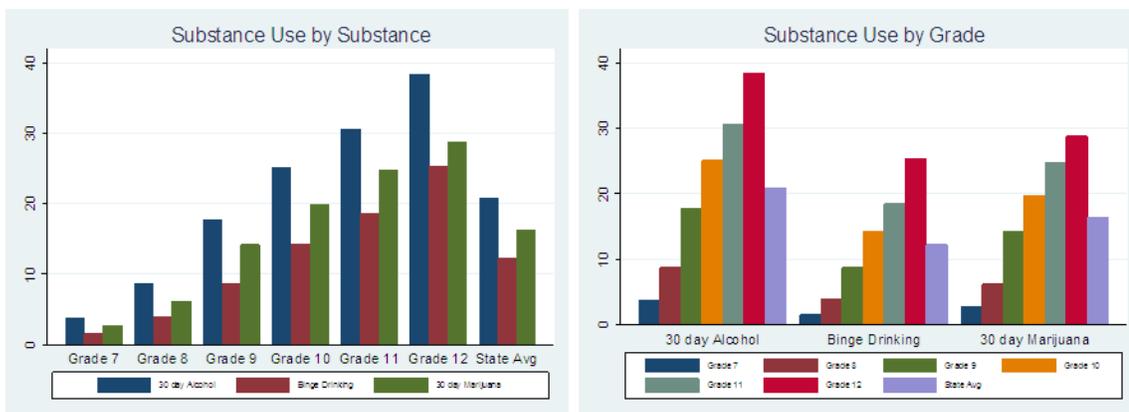
In 2004 the State of Maine, Office of Substance Abuse and Mental Health Services, was awarded a Strategic Planning Framework State Incentive Grant which allowed for the creation and support of a statewide prevention/health promotion infrastructure that:

- ensured every community in Maine had the opportunity to participate in strategic prevention planning;
- cultivated a skilled prevention workforce;
- implemented a prevention plan;
- implemented evidence-based and culturally competent prevention programs, policies, and practices; and
- evaluated results.

When the grant ended in 2010, there was movement in a positive direction that resulted in key data that can be used in further program planning at the State level. That data included ensuring the work that is being implemented statewide is focused and prescriptive that allows for the combination of strategies, yet flexible enough to meet community needs, making decisions both funding and programming, based on the available data, investing in workforce and systems development is the key to sustainability, and to evaluate the programming to ensure it is an effective and efficient use of funds.

As stated before, alcohol is the drug of choice in Maine. The 2011 MIYHS survey results show that 28.0% of Maine high school students had used alcohol in the 30 days prior to the survey. Approximately 16.9% had consumed five or more alcoholic drinks in one setting. Beginning in ninth grade over half the students who reported having drunk in the past 30 days also report having binge drank. Approximately 60.9% of tenth graders and 64.7% of eleventh and 70.7% of twelfth graders who reported having drunk in the past 30 days also report binge drinking.

The 2011 MIYHS data also reveals that substance use in all three categories (30 day alcohol, binge drinking, and 30 day marijuana us) increases the most between eighth and ninth grade.



Source: MIYHS, 2011.

According to the 2011 BRFSS survey, 65.3% of young adults in Maine age 18-24 consumed at least one alcoholic drink in the past 30 days, 34.5% binge drank (five drinks in one occasion), and 13% heavily used alcohol (more than one or two alcoholic drinks per day).

## II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Youth & Young Adults at risk for Substance Abuse
Priority Type:	SAP
Population (s):	
Goal of the priority area:	
Goal #1: Reduce the use, misuse, and abuse of alcohol, marijuana and prescription medications among youth age 12-17.	
Strategies to attain the goal:	
Strategy(ies):	
1. Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce use and misuse of alcohol.	
2. Support the PMP promotion project with resources to educate health care providers and the public about the misuse of prescription medications.	
3. Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices.	
4. Create statewide messages and material for use by prevention providers on alcohol, marijuana and prescription medications.	
5. Support the enforcing underage drinking laws environmental strategies statewide.	
6. Provide evidence-based universal, indicated and selected population prevention programming throughout the state based on data and evidence of effectiveness.	
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	30 day alcohol use
Baseline Measurement:	
First-year target/outcome measurement:	Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, MIYHS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

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Indicator #: 2

Indicator: 30 day marijuana use

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, MIYHS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

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Indicator #: 3

Indicator: 30 day prescription drug

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, MIYHS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

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Indicator #: 4

Indicator: Perception of risk from alcohol

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, MIYHS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

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Indicator #: 5

Indicator: Perception of risk from marijuana

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

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Indicator #: 6

Indicator: Age at first use of alcohol

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

Indicator #:

7

Indicator:

Age of first use of Marijuana or Hashish

Baseline Measurement:

First-year target/outcome measurement:

Reduce use, misuse

Second-year target/outcome measurement:

Reduce use, misuse

Data Source:

NSDUH, MIYHS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Pregnant Women with Substance Use Disorders

Priority Type: SAT

Population (s): IVDUs

Goal of the priority area:

Goal #1: IVDU Pregnant Women - To reduce morbidity for IVDU pregnant women in the state of Maine by 6/30/15.

Strategies to attain the goal:

1. Monitoring access and retention measures per contract with providers

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Completion of Treatment  
Baseline Measurement: Completion of Treatment rater of 38.3% as based on the average of the last three years.  
First-year target/outcome measurement: Increase retention by 1% in year one  
Second-year target/outcome measurement: Increase retention by 1% in year two  
Data Source:

TDS

Description of Data:

1. Treatment Data System (TDS) can give SAMHS data relative to A/R measures, completion of and time in treatment and services provided/referrals.

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: IVDU'ers

Priority Type: SAT

Population IVDUs

(s):

Goal of the priority area:

Goal #1 IVDU - To reduce morbidity and increase use of evidence-based practice for IVDU in the state of Maine by 6/30/15.

Strategies to attain the goal:

1. Monitoring access and retention measures per contract with providers

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Completion of Treatment  
Baseline Measurement: Completion of Treatment rate of 37.78% as based on the average of the last three years.  
First-year target/outcome measurement: Increase retention by 1% in year one  
Second-year target/outcome measurement: Increase retention by 1% in year two  
Data Source:

TDS

Description of Data:

1. Treatment Data System/Wait list (TDS) can give SAMHS data relative to Wait Lists, Retention measures, completion of treatment and services provided/referrals.

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Persons in Need of Intervention/Treatment (Targeted Population groups)

Priority Type: SAT

Population Other (Homeless)  
(s):

Goal of the priority area:

Goal #1: Homeless – Increase Access/Capacity and Stability in housing to this population by 6/30/15.

Strategies to attain the goal:

1. Employ NIATx process improvement aims at both provider and systems level

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Increase in housing stability  
Baseline Measurement: Homeless at Discharge of 6.9% as based on the average of the past three years.  
First-year target/outcome measurement: Decrease homelessness at discharge .5% in year one  
Second-year target/outcome measurement: Decrease homelessness at discharge by .5% in year two  
Data Source:

TDS

Description of Data:

Treatment Data System/Wait list (TDS) can give SAMHS data relative to living arrangements measures.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Youth & Young Adults at risk for Substance Abuse

Priority Type: SAP

Population (s):

Goal of the priority area:

Goal #2: Reduce the misuse of alcohol, prescription drugs, and marijuana among 18-25 year olds by 6/30/15.

Strategies to attain the goal:

Strategy(ies):

1. Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce misuse of alcohol.
2. Create statewide messages and material for use by prevention providers on high risk alcohol use, marijuana use, and prescription drug misuse.
3. Support the enforcing underage drinking laws environmental strategies statewide.
4. Provide evidence-based programming opportunities to institutes of higher education throughout the state based on data and evidence of effectiveness.
5. Support the PMP promotion project with resources to educate the public about the dangers of misusing prescription medications.
6. Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 30 day alcohol use

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, HEAPP, BRFSS,

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: 30 day binge drinking

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, HEAPP, BRFSS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

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Indicator #: 3

Indicator: 30 day marijuana use

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, HEAPP, BRFSS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

Indicator #: 4  
Indicator: 30 day psychotherapeutics

Baseline Measurement:  
First-year target/outcome measurement: Reduce use, misuse  
Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, HEAPP, BRFSS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

Indicator #: 5  
Indicator: Perception of risk from alcohol Ages 18+

Baseline Measurement:  
First-year target/outcome measurement: Reduce use, misuse  
Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, HEAPP, BRFSS

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

Indicator #: 6

Indicator: 30 day binge drinking among college students

Baseline Measurement:

First-year target/outcome measurement: Reduce use, misuse

Second-year target/outcome measurement: Reduce use, misuse

Data Source:

NSDUH, MIYHS, BRFSS, HEAPP

Description of Data:

SAMHS will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Pregnant Women with Substance Use Disorders

Priority Type: SAT

Population PWWDC

(s):

Goal of the priority area:

Goal #2: Pregnant Women - To reduce morbidity for pregnant women in the state of Maine by 6/30/15.

Strategies to attain the goal:

1. Monitoring access and retention measures per contract with providers

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase retention in treatment
Baseline Measurement:	Completion of Treatment baseline of 30%.
First-year target/outcome measurement:	Increase retention by 1 % in year one.
Second-year target/outcome measurement:	Increase retention by 1 % in year two.

Data Source:

TDS

Description of Data:

1. Treatment Data System (TDS) data can give SAMHS data relative to A/R measures, completion of treatment and services provided/referrals.

Data issues/caveats that affect outcome measures::

Access measures look good for the past three years with an average of .77 for median days to assessment access and .3 for median days to treatment.

Priority #: 7

Priority Area: Persons in Need of Intervention/Treatment (Targeted Population Groups)

Priority Type: SAT

Population Other (Women with Dependent Children)  
(s):

Goal of the priority area:

Goal # 2: Reduce Morbidity of WWDC– To reduce morbidity for women with dependent children by 6/30/15.

Strategies to attain the goal:

Treatment Data System/Wait list (TDS) can give SAMHS data relative to A/R measures, completion of treatment, services provided and referrals.

#### Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Increase Retention in Treatment.

Baseline Measurement:

Completion of treatment baseline of 38.2% as based on average of last three years.

First-year target/outcome  
measurement:

Increase retention by 1% in year one

Second-year target/outcome  
measurement:

Increase retention by 1% in year one in year two

Data Source:

TDS

Description of Data:

Treatment Data System (TDS) can give SAMHS data relative to A/R measures, completion of treatment, services provided and referrals.

Data issues/caveats that affect outcome measures::

Data issues/caveats that affect outcome measures: Access measures look good for the past three years with an average of 1 for median days to assessment access and 0 for median days to treatment.

Priority Area: Persons in Need of Intervention/Treatment (Targeted Population groups)

Priority Type: SAT

Population Other (Native Americans)

(s):

Goal of the priority area:

Goal # 3: Native Americans – Reduce Morbidity – decrease use of substances of abuse and mental illness symptomatology

Strategies to attain the goal:

Treatment Data System/Wait list (TDS) can give SAMHS data relative to A/R measures, completion of treatment, services provided and referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase access and retention in services by 1% over the next two years.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

TDS

Description of Data:

Treatment Data System/Wait list (TDS) can give SAMHS data relative to A/R measures, completion of treatment, services provided and referrals.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Persons in Need of Intervention/Treatment (Targeted Population groups)

Priority Type: SAT

Population TB

(s):

Goal of the priority area:

Goal # 4: TB- Reduce Morbidity in this population by 6/30/15.

Strategies to attain the goal:

Collaborate and blend funding with the Maine Centers for Disease control to screen, test, and treat this population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 1. Within SA services 100% of referrals for medical interventions as indicated

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

TDS

Description of Data:

Treatment Data System/Wait list (TDS) can give SAMHS data relative to Wait Lists, A/R measures, completion of treatment, and referrals for medical interventions.

Data issues/caveats that affect outcome measures::

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	\$4,893,381		\$54,000,000	\$1,000,000	\$12,520,168	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$4,893,381		\$54,000,000	\$1,000,000	\$12,520,168	\$	\$
b. All Other	\$		\$	\$	\$	\$	\$
2. Substance Abuse Primary Prevention	\$1,541,751		\$	\$2,124,122	\$1,994,398	\$	\$
3. Tuberculosis Services	\$		\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$90,000	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$268,130		\$	\$40,000	\$840,000	\$	\$
11. Total	\$6,703,262	\$	\$54,000,000	\$3,164,122	\$15,444,566	\$	\$

\* Prevention other than primary prevention

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
Specialized Outpatient Medical Services			\$
Acute Primary Care			\$
General Health Screens, Tests and Immunizations			\$
Comprehensive Care Management			\$
Care coordination and Health Promotion			\$
Comprehensive Transitional Care			\$
Individual and Family Support			\$
Referral to Community Services Dissemination			\$
Prevention (Including Promotion)			\$
Screening, Brief Intervention and Referral to Treatment			\$

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

Community Team Building (Community Based Process)				\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)				\$
Engagement Services				\$
Assessment				\$
Specialized Evaluations (Psychological and Neurological)				\$
Service Planning (including crisis planning)				\$
Consumer/Family Education				\$
Outreach				\$
Outpatient Services				\$
Evidenced-based Therapies				\$
Group Therapy				\$
Family Therapy				\$
Multi-family Therapy				\$
Consultation to Caregivers				\$
Medication Services				\$

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

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$
Personal Care			\$
Homemaker			\$
Respite			\$
Supported Education			\$
Transportation			\$
Assisted Living Services			\$
Recreational Services			\$
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$
Intensive Support Services			\$
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$

Assertive Community Treatment				\$
Intensive Home-based Services				\$
Multi-systemic Therapy				\$
Intensive Case Management				\$
Out-of-Home Residential Services				\$
Children's Mental Health Residential Services				\$
Crisis Residential/Stabilization				\$
Clinically Managed 24 Hour Care (SA)				\$
Clinically Managed Medium Intensity Care (SA)				\$
Adult Mental Health Residential				\$
Youth Substance Abuse Residential Services				\$
Therapeutic Foster Care				\$
Acute Intensive Services				\$
Mobile Crisis				\$
Peer-based Crisis Services				\$

Urgent Care			\$
23-hour Observation Bed			\$
Medically Monitored Intensive Inpatient (SA)			\$
24/7 Crisis Hotline Services			\$
Other (please list)			\$

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$4,893,381	
2 . Substance Abuse Primary Prevention	\$1,541,751	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$268,130	
6. Total	\$6,703,262	

\* Prevention other than primary prevention

\*\* HIV Early Intervention Services

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$134,616	
	Selective	\$134,616	
	Indicated	\$134,616	
	Unspecified	\$134,616	
	Total	\$538,464	
Education	Universal	\$52,907	
	Selective	\$26,453	
	Indicated	\$26,453	
	Unspecified		
	Total	\$105,813	
Alternatives	Universal	\$18,750	
	Selective		
	Indicated		
	Unspecified		
	Total	\$18,750	
Problem Identification and Referral	Universal	\$28,819	
	Selective	\$28,819	
	Indicated	\$28,819	
	Unspecified	\$28,819	
	Total		

	Total	\$115,276	
Community-Based Process	Universal	\$216,750	
	Selective		
	Indicated		
	Unspecified	\$72,250	
	Total	\$289,000	
Environmental	Universal	\$483,066	
	Selective		
	Indicated		
	Unspecified	\$161,022	
	Total	\$644,088	
Section 1926 Tobacco	Universal	\$100,000	
	Selective		
	Indicated		
	Unspecified		
	Total	\$100,000	
Other	Universal	\$127,069	
	Selective		
	Indicated		
	Unspecified	\$93,256	
	Total	\$220,325	
Total Prevention Expenditures		\$2,031,716	
Total SABG Award*		\$6,703,262	
Planned Primary Prevention Percentage		30.31 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

The category of "Unspecified" as identified on this table, is also captured within Table 4 under Substance Abuse Prevention and Treatment. This amount is \$489,963.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$290,494	
Universal Indirect	\$871,482	
Selective	\$189,888	
Indicated	\$189,888	
Column Total	\$1,541,752	
Total SABG Award*	\$6,703,262	
Planned Primary Prevention Percentage	23.00 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**footnote:**

The category of "Unspecified" as identified on Table 5a is not captured on this table, but is captured within Table 4 under Substance Abuse Prevention and Treatment. This amount is \$489,963.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	265257.00	41734.00		\$306,991	265257.00	41734.00		
2. Quality Assurance	0.00	52168.00		\$52,168		52138.00		
3. Training (Post-Employment)	18.00	20867.00		\$20,885	18.00	20867.00		
4. Education (Pre-Employment)	7.00			\$7	7.00			
5. Program Development	3.00	52168.00		\$52,171	3.00	52168.00		
6. Research and Evaluation	38200.00			\$38,200	38200.00			
7. Information Systems	37700.00	41735.00		\$79,435	37700.00	41735.00		
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$341,185	\$208,672		\$549,857				

footnote:

## IV: Narrative Plan

### C. Coverage M/SUD Services

#### Narrative Question:

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Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

## IV: Narrative Plan

### D. Health Insurance Marketplaces

#### Narrative Question:

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Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

## IV: Narrative Plan

### E. Program Integrity

#### Narrative Question:

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The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Encounter/utilization/performance analysis; and
  - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

#### Footnotes:

## IV: Narrative Plan

### F. Use of Evidence in Purchasing Decisions

Narrative Question:

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

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
  - a) What information did you use?
  - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
  - a) Educating State Medicaid agencies and other purchasers regarding this information?
  - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

## IV: Narrative Plan

### G. Quality

#### Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

#### Footnotes:

## IV: Narrative Plan

### H. Trauma

#### Narrative Question:

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In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

## IV: Narrative Plan

### I. Justice

#### Narrative Question:

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The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>42,43</sup> Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.<sup>44</sup>

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

#### Footnotes:

## IV: Narrative Plan

### J. Parity Education

Narrative Question:

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SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

## IV: Narrative Plan

### K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
  - a. heart disease,
  - b. hypertension,
  - c. high cholesterol, and/or
  - d. diabetes.

Footnotes:

## IV: Narrative Plan

### L. Health Disparities

#### Narrative Question:

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In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

## IV: Narrative Plan

### M. Recovery

#### Narrative Question:

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SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

### Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

### Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to 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:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

### Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Prior to the integration of the Office of Substance Abuse Services and the Office of Adult Mental Health Services, OAMHS had gone through a lengthy process with stakeholders to develop a definition of recovery, recovery-oriented care and Mental Health services: Practice Guidelines for Recovery Oriented Care. Expanding this into an integrated document is work that remains to be done. SAMHS has three staff positions that require that individuals hired be persons in recovery. These are positions that were formally within the Office of Consumer Affairs and are now a part of Recovery Supports.

The state's plan does include strategies to utilize person-centered planning, self-direction and participant-directed care through ISPs (Individual Support Plans) and treatment plans. These plans are to be based on individual's self-identified goals and the expectation is that individuals are partners with their providers in creating and implementing those plans.

Each consumer receiving mental health community support services 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. Self-directed support services include but are certainly not necessarily limited to:

- Supportive Housing
- Supported Employment
- Daily Living Support Services
- Social and leisure activities
- Social support activities
- Community integration
- Skills development
- Personal growth activities
- Mutual aid and peer support groups
- Education
- Referrals and assistance obtaining other services

Recovery Supports available and accessible include Recovery Coaching Training and Recovery Coaching, Recovery Peer Support Centers, statewide warm line, recovery telephone support, a peer crisis respite program, supported employment, clubhouses, long-term vocational support, peer support in emergency departments in some hospitals, peer support at Riverview Psychiatric Center, the STEP housing program and an Intentional Peer Support Training and Certification Program. Many of these supports are designed to be low-barrier and easily accessible for individuals. The state has an Intentional Peer Support Training and Certification Program in which peers can become Certified Intentional Peer Support Specialists. This training and certification was developed with peer stakeholder input and maintains a peer advisory committee.

Historically individuals in recovery from addictions and family members have been engaged sporadically in planning, delivery and evaluation of the state substance abuse treatment system. SAMHS conducts an Annual Client Satisfaction Survey for individuals in substance abuse treatment services, but this yields satisfaction only among the client/individual population.

Inclusion of individuals in recovery from addiction conditions is garnered via the client satisfaction survey and focus groups and surveys conducted by the women's Addiction Services Council (WASC), treatment specialists, and the Maine Alliance for Addiction Recovery which is funded through SAMHS. SAMHS will continue to invite tribal members to conferences, events and trainings. SAMHS will extend invitations for tribal members to participate on various planning committees, workgroups and/or advisory boards. Input from the tribal community and Recovery MAAR).

The Maine Alliance for Addiction and Recovery and their array of recovery communities across the state routinely involve recovering members in the discussions of increasing the development and access to recovery oriented services.

Through the subcontract with the Maine Alliance of Addiction and Recovery ongoing communication and scheduled trainings for the recovering community occur. This is inclusive of adults and family members currently. SAMHS also provides funding for

the Consumer Council System of Maine. The Consumer Council System of Maine (CCSM) is an independent, public instrumentality established by Maine law (Title 34-B, §3611). The CCSM is responsible for providing an independent and effective consumer voice into mental health public policy, services, and funding decisions. The CCSM consists entirely of past/present recipients of mental health services (consumer/peers), including all Statewide Consumer Council representatives and paid staff. Many of these individuals have also experienced co-occurring substance abuse conditions. 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 behavioral health care, directed by an informed, diverse grassroots consumer network. The strength of this organization is proving very helpful as we expand the opportunities for individuals in recovery from addiction and family members to engage in planning, delivery and evaluation of behavioral health services.

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

Through SAMHS 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, SAMHS 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 on their own and with other community members.

Our state funded Bridging Rental Assistance Program (BRAP) is a transitional housing voucher program and the principal resource for supporting the movement to less restrictive settings. Moving from state and private psychiatric hospital beds into the community is the number one priority of this program. The choice of who will provide and what services are to be utilized are also left to the client outside of any tenant agreement

BRAP is managed locally by Community Mental Health Centers. Utilizing the Housing First model, this program encourages but does not require services to go hand in hand with the voucher. The consumer has choice, independence, and control over where they live and what services are necessary in their recovery.

## IV: Narrative Plan

### N. Evidence Based Prevention and Treatment Approaches for the SABG

#### Narrative Question:

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As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

#### Footnotes:

A review of the data, including the development of the 2013-2018 Strategic Prevention Plan, yielded a finding that Maine needed to focus more efforts on the prevention of marijuana use and prescription drug misuse along with the predetermined goal of focusing on underage drinking. With the increase of youth perception that marijuana and prescription drug misuse is not harmful, we determined the need to focus our efforts on providing education and information on the risks associated with use for these substances. The SEOW/CESN reports as well as the MIYHS provided data that helped us reach this conclusion. Maine will continue to fund environmental evidenced based strategies at the community level throughout the state. A matrix of objectives and strategies includes many options related to education and information dissemination for the HMPs to select from. Along with funding to the HMPs, Maine will also continue to fund the Student Intervention and Reintegration Program which is an education program for students and youth who have substance related school or criminal violations. In addition, the Maine Youth Action Network is also being funded to support youth empowerment through education/training and funding from the SAPTBG is used for media development. The primary funding source for Prevention services in Maine comes from the SAPTBG. There is little to no other means of funding these services. Additional funds that are sought and awarded as the P4S2 grant are used to further the environmental strategies prevention efforts in the state. With the development of the Strategic Plan (2013-2018) Maine has identified the goal and plan to implement a credentialing system for Maine Prevention Specialists (through the IC/RC) within the next 5 years. In addition, we continue to have a statewide training and workforce development contract which provides prevention specialists with education and training to build workforce capacity. The data that Maine collects on funded prevention strategies is collected through the KIT Prevention database. This allows SAMHS staff to review regular progress or challenges that HMPs may be facing as well as specific strategies that are being implemented. Along with this database, SAMHS staff reviews the NSDUH, BRFSS, and MIYHS data to determine ongoing needs, and any potential changes to objectives and strategies that may need to be made to address changes in use patterns, perceptions of harm and risk, and other risky behavior. These data sources are also used to measure progress on long term outcomes. Maine has been very supportive of the ongoing work that the coalitions have done in the past regarding SPF-SIG. Nearly all of the coalition's currently receiving funding has been through the SPF-SIG model to develop their coalitions and assess for community needs. The funding continues with this work by providing opportunities for coalition growth and development through the use of the Strategic Prevention Framework. 14% of the SAPTBG set-aside goes to funding the Prevention Team and Information Resource Center Staff. The remaining 86% is used for funding at the community organization.

## IV: Narrative Plan

### O. Children and Adolescents Behavioral Health Services

#### Narrative Question:

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Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

## IV: Narrative Plan

### P. Consultation with Tribes

Narrative Question:

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

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which 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. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

SAMHS has developed some very positive working relationships with the tribes in Maine. Funding from the SAPT BG supports Prevention and Treatment within the Tribal public health district. Maine has tribal representatives participating in several work groups including the Prevention Advisory Council as well as other workgroups so that their input and insight is always being considered. SAMHS has also provided opportunities for collaboration and input on the BG application.

## IV: Narrative Plan

### Q. Data and Information Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

## IV: Narrative Plan

### R. Quality Improvement Plan

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this 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 emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

## IV: Narrative Plan

### S. Suicide Prevention

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

## IV: Narrative Plan

### T. Use of Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans 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;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

## IV: Narrative Plan

### U. Technical Assistance Needs

Narrative Question:

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States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. 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.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

## IV: Narrative Plan

### V. Support of State Partners

#### Narrative Question:

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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, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. 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, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and 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.<sup>45</sup> 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 justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

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<sup>45</sup> SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

#### Footnotes:

## IV: Narrative Plan

### W. State Behavioral Health Advisory Council

#### Narrative Question:

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Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

#### Footnotes:

## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
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No Data Available

Footnotes:

## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

## IV: Narrative Plan

### X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

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Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

## IV: Narrative Plan

### Y. Comment on the State BG Plan

Narrative Question:

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Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

The Behavioral Health Plan for FFY 2014 and 2015 will be available for public comment on the SAMHS website: [www.maine.gov/samhs](http://www.maine.gov/samhs)