State Information

Plan Year
Start Year 2020
End Year 2021

State DUNS Number
Number 809045594
Expiration Date 9/30/2019

I. State Agency to be the Grantee for the Block Grant
Agency Name Department of Health and Human Services
Organizational Unit Substance Abuse and Mental Health Services
Mailing Address 11 State House Station
City Augusta
Zip Code 04333-0011

II. Contact Person for the Grantee of the Block Grant
First Name Sheldon
Last Name Wheeler
Agency Name Office of Substance Abuse and Mental Health Services
Mailing Address 41 Anthony Ave
City Augusta
Zip Code 04333
Telephone 207-287-2595
Fax 207-287-4334
Email Address sheldon.wheeler@maine.gov

III. Third Party Administrator of Mental Health Services
Do you have a third party administrator? □ Yes □ No
First Name
Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)
From
To
VI. Contact Person Responsible for Application Submission

First Name  Victor
Last Name  Dumais
Telephone  (207) 287-2595
Fax  (207) 287-8910
Email Address  Victor.Dumais@Maine.gov
State Information

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

Fiscal Year 2020

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

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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.

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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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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).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee¹: ________________________________

Title: ________________________________ Date Signed: ________________________________

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

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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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

   a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
      a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
      b. Collecting a certification statement similar to paragraph (a)
      c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 workplace in accordance with 2 CFR Part 182 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 workplace 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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.

HHS Assurances of Compliance (HHS 690)


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee:  

Bethany L. Hamm

Signature of CEO or Designee¹:  

Bethany L. Hamm

Title:  
Deputy Commissioner

Date Signed:  
September 3, 2019

Date Signed:

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
August 14, 2019

Odessa Crocker
Grants Management Officer, Substance Abuse and
Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

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

Dear Ms. Crocker:

This letter is to serve as authorization for Bethany L. Hamm, Deputy Commissioner, Department of Health and Human Services, to sign for the SAMHSA Community Mental Health Services Block Grant Application and Assurances for the State of Maine.

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

Sincerely,

Janet T. Mills
Governor

cc: Jeanne Lambrew, Ph.D., Commissioner, Maine DHHS
Bethany L. Hamm, Deputy Commissioner, Maine DHHS
Sheldon Wheeler, Director of the Office of Substance Abuse and Mental Health Services, Maine DHHS
# State Information

## Disclosure of Lobbying Activities

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

### Standard Form LLL (click here)

<table>
<thead>
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<th>Name</th>
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<td>Title</td>
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<td>Organization</td>
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**Signature:**

**Date:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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**Footnotes:**

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Planning Steps

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

Narrative Question:
Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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

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

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

Maine has three primary CBSAs within its border. Maine’s CBSA populations are centered in the Cities of Portland, Bangor, and Lewiston-Auburn. The Portland CBSA totals 350,825, the Bangor CBSA totals 129,263, and the Lewiston Auburn CBSA totals 104,505 for a grand total of population of 743,708, or 55.9% of the total Maine population. This data is based on the most current US Census data for 2010. The population living outside Maine’s primary CBSA’s totals 584,593 or 44.01% of the population.

The rural nature of Maine has always posed challenges for adults, children, young adults and families seeking services. That condition is not likely to change, given the population distribution, the typical distance between where people live and where services have traditionally been located, and a lack of public transportation services outside the most populated regions.

The State of Maine Department of Health and Human Services (DHHS), Office of Substance Abuse and Mental Health Services (SAMHS) is the designated State Public Mental Health Authority for adults. The mission of SAMHS is to promote appropriate access to efficient and effective substance use and mental health services to adults in order to achieve improved outcomes for those with substance use disorders and mental illness. The DHHS Office of Child and Family Services (OCFS) is the entity responsible for providing mental health services for children and adolescents.

SAMHS provides statewide leadership in defining, measuring and improving the quality of services and supports to adults with severe and persistent mental illness. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide the array of services and support to the people of Maine. This Office is the Single State Administrative (SSA) authority responsible for the planning, development, implementation, regulation, and evaluation of substance use and mental health services.

The State of Maine operates the public behavioral health system under the guidance of a Consent Decree that was established as a result of lawsuit Bates v. DHBS in 1989. The Consent Decree requires the State of Maine to meet established goals or measures listed out in detail as part of the document that makes up the Consent Decree, to be reported to the court on a quarterly basis. Consent Decree rulings and amendments can be accessed here: https://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/amend_rule/home.html. Many of the intervention, treatment and recovery services carried out via provider contracts to independent...
licensed Mental Health Agencies across the state are resultant of the Consent Decree, e.g. those supporting leisure and recreation activities for those affected by mental illness. The central purpose of Maine’s Consent Decree is to provide those suffering from mental illness with the greatest possible support and opportunity to live fulfilling and self-directed lives in the community via three major goals: Continuity of care, services available close to an individual’s home, and an array of services available in a timely manner. SAMHS, in collaboration with other state agencies and community partners, develops, monitors, and seeks to improve the lives of those affected by addiction and mental illness as part of ensuring managed care for its recipients.

The Department has made significant strides towards Consent Decree compliance by meeting the majority of required Compliance Standards, and is committed to providing services that meet all requirements to the satisfaction of the court. Some examples of achievement under the Consent Decree include reduction of the waitlist for Community Integration services from more than 400 in 2016 to periods of functional zero from 2017 through present day, and upgrading the system’s assessment procedures with the ANSA tool.

The State of Maine of Maine is also regulated by specific statutes such as Maine Revised Statutes title 22-A: HEALTH AND HUMAN SERVICES HEADING: PL 2003, c. 689, Pt. A, §1 (new) as well as Maine’s Medicaid Program (MaineCare) which covers many services for adults and children. The MaineCare Benefits Manual can be accessed here: https://www1.maine.gov/sos/cec/rules/10/ch101.htm. Services funded by SAMHS for individuals who do not receive Medicaid support are entirely consistent with this manual.


Major Initiatives in Policy Development and Implementation across offices

Rule Making efforts to revise the MaineCare Benefits Manual have served to implement and enforce evidence-based best practices such as those listed below:

- Section 17: In addition to the 7-Day rule mentioned elsewhere in this application, substantial edits include the implementation of a functional diagnostic tool, the Adult Needs and Strengths Assessment (ANSA), used to provide enhanced assessment of consumer needs and to better define acuity by matching the right level of care for each diagnosis.
- Section 92: The Behavioral Health Home (BHH) initiative has helped support the long-awaited integration of primary health care and mental health care. The BHH model utilizes a hub-and-spoke approach to integrating healthcare, which has been identified within the state and nationwide as an effective emerging practice for improved outcomes.
- Section 93: Maine DHHS has implemented an Opioid Health Home (OHH) system of care, modeled after the BHH with focus on treating individuals with opioid use disorders.
• Section 65: The mandate to provide concurrent behavioral health therapies with the administration of Methadone or Suboxone, otherwise known as medication assisted treatment, is now a standard of service provision. Reimbursement rates for section 65 services were increased in 2018 to provide greater opportunity for behavioral health programs to build and flourish.

• Prescription Monitoring Program: Implementation of landmark legislation, known as the Act to Prevent Opiate Abuse by Strengthening the Controlled Substance Prescription Monitoring Program, has resulted in Maine receiving accolades throughout New England.

Summary of Treatment and Recovery Services

Crisis

SAMHS contracts with statewide provider agencies to administer the Maine 24-hour Crisis hotline. In addition, crisis mobile response services are immediate, crisis-oriented, on-scene services engaged toward stabilization of an acute, emotional disturbance to ensure the safety of a consumer, and the community, in the least restrictive setting. The emphasis that emergency rooms are to be used as a last resort for crisis response in contractually mandated. "On-scene" includes, but is not limited to member homes, shelters, schools and emergency rooms. Services are provided and available 24 hours per day, 7 days per week, to all persons requesting services from the crisis provider. The provider shall focus on intervention, de-escalation, stabilization, recovery, referral to needed services, short term treatment and follow-up for up to 30 days as clinically appropriate. This service domain received a complete design overhaul in 2018 to address longstanding concerns regarding the system’s efficiency. The system is now run through a single central call hub, which distributes calls and coordinates services statewide to reduce inefficiencies and inconsistencies between service areas. See: http://www.maine.gov/dhhs/samhs/mentalhealth/rights-legal/index.html

Crisis Services are provided to consumer(s) of all ages who exhibit disturbed thought patterns or behavioral and/or emotional disturbances and report a crisis in need of intervention. Services are also provided to consumers with dual diagnoses including chemical dependency and/or intellectual disabilities with psychiatric symptoms.

Crisis Services staff must complete Competency Based Mental Health Rehabilitation Technician/Crisis Services Provider (MHRT/CSP) training and successfully pass the tests for the Certificate. This must be registered with the University of Southern Maine (USM) Muskie School of Management, who authorizes the MHRT/CSP in associative collaboration with SAMHS. See http://muskie.usm.maine.edu/cfl/MHRTCSPOverview.html.

Services to be provided include ‘mobile,’ which is clinically appropriate services which are flexible and creative through their mobile outreach team, as well as walk in services which are available and accessible 24 hours per day for face-to-face crisis assessments. Memorandums of Understanding (MOU) between providers and area hospitals are in place to ensure the minimum Crisis Service System requirements are achieved and continuity of care is optimal.
This Service is supported with both MaineCare and State general funding with collaboration between SAMHS, Office of Child and Family Services, and Office of Aging and Disabilities all under DHHS.

**Intensive Case Management (ICM) Team**

SAMHS provides Intensive Case Management (ICM) services to individuals with mental illness who are incarcerated. The goal is to provide individuals who are integrating back into community with immediate intervention and connections to established services by way of coordinated discharge planning. These staff provide assistance to incarcerated individuals to re-enter the community with appropriate supports which are demonstrated to reduce recidivism.

**Prescription Monitoring Program:**

Maine’s Prescription Monitoring Program (PMP) is a secure, online database that is used across the State of Maine to improve public health. All prescribers and dispensers are able to review their patient’s controlled substance drug history prior to prescribing or dispensing any Schedule II – IV drugs. The PMP helps to prevent adverse drug-related events, through monitoring, education, and academic detailing. This program is focused on the reduction of overprescribing Schedule II-IV drugs. Maine is an active member of the PMP Interconnect (PMPi) through the National Association of Boards of Pharmacy (NABP). PMPi allows participating states to be linked and be more effective in combating drug diversion and drug abuse on a national scale. Maine is currently connected with 33 states including the Military Health System. Maine also has a standing recurring meeting with New Brunswick in Canada to assist them with building the foundation to begin international data sharing. Maine has recently had legislative mandates that now require prescribers to review a patient’s PMP report prior to prescribing an opioid or benzodiazepine medication every 90 days so long as the prescription is active. This new mandate also includes limiting chronic opioid prescriptions to a 30 day supply, acute opioid prescriptions to a 7 day supply, electronic prescribing of all opioid medications, and decreasing the allowable daily morphine milligram equivalent from 300 to 100.

**Driver Education and Evaluation Program (DEEP)**

The Driver Education and Evaluation Program (DEEP) is legislatively mandated (5 MRSA c.521, Sub-c. V) as the Operating under the Influence (OUI) countermeasure program in the state of Maine. The goal of the program is to lessen the incidence of injury, disability and fatality that results from alcohol and other drug related motor vehicle crashes and to reduce the risk of re-offense for OUI.

**Behavioral Health Homes**

DHHS’s MaineCare Services (state Medicaid program) created and launched the first state of its Health Homes initiative for members in chronic condition in January 2013. Building off the Maine multi-payer Patient-Centered Medical Home model starting April 1, 2014, the Department launched Behavioral
Health Home services to manage the physical and behavioral health needs of eligible adults and children via comprehensive and integrated service delivery. Behavioral Health Homes are an important component of Maine's Value Based Purchasing strategy, a multi-pronged MaineCare initiative designed to improve the healthcare system, improve population health, and reduce cost. Behavioral Health Homes are a partnership between a licensed community mental health provider (the "Behavioral Health Home Organization" or BHHO) and one or more Health Home practices (HHP) to manage the physical and behavioral health needs of eligible adults and children. Both types of organization receive a per member per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers.

Participation in Behavioral Health Home services is entirely voluntary and members can opt out of the service at any time.

**Community Based Residential Treatment Programs (PNMI Private Non-Medical Institution)**

A community residence (PNMI) provides integral mental health treatment and rehabilitative services, and is licensed and funded as a mental health residential treatment or supportive housing service by SAMHS.

A residential treatment community residence for persons with mental illness is a facility with integral mental health treatment and rehabilitative services. Community residences for persons with mental illness also include residential services for the integrated treatment of persons with dual disorders, which provide mental health and substance use treatment services to individuals with co-occurring disorders.

Services include mental health treatment, substance use treatment, rehabilitative services and/or personal care services. Mental health treatment and rehabilitative services refer to direct services provided for reduction of a mental illness and restoration of a member to his/her highest possible functional level. These services focus on the establishing or regaining of functional skills; the increase of self-understanding, crisis prevention and self-management; socialization and leisure skill development; vocational training if appropriate; the development and enhancement of social roles within the context of natural supports, the consumer’s community, and others within the residential treatment facility; and other activities connected with the rehabilitation goals and objectives identified in the plan of care. One of the key elements reflected in the services provided by the facility is that of the expectation of growth and recovery.

Integrated treatment services also include independent living skills and social skills services necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives are documented in each member’s individual service plan according to individual strengths and needs, as identified in a comprehensive assessment including ANSA.

SAMHS administers policies and procedures to ensure that Maine's two psychiatric state hospitals can discharge patients in a timely manner and prevent back up due to lack of placement and to insure
priorities placements in PNMI Residential facilities. Priority for placement in a PNMI are listed as 1) discharge from a State Psychiatric hospital, 2) discharge from a community psychiatric hospital 3) Discharge from a jail and 4) Homelessness. SAMHS currently supports 684 PNMI slots (“beds”) at 23 provider sites statewide for a cost of approximately $103 million per year. SAMHS monitors PNMI services through site reviews and on-site visits, and acts as a liaison between state psychiatric hospitals and PNMI providers.

The Adult Needs Strengths Assessment (ANSA) Tool for was implemented in 2017 in all PNMI facilities as part of the comprehensive assessment and Individual Service Plan (ISP) process, which involves required update of assessment (including ANSA) at least every 90 days.

SAMHS attends many meetings with providers for complex individuals and works with other state entities on developing “out of the box” solutions to address consumer’s needs.

SAMHS oversees discharges from PNMI placements and grants permission for PNMI placements as outlined in the Consent Decree to ensure access to Mental Health/Behavioral Health Services and other needs identified in a given client’s ISP. SAMHS also manages Medicaid spend down for consumers in PNMI residences.

**Recovery**

SAMHS supports many services that emphasize support, education/training, rehabilitation, and recovery, including natural and community supports and collaborative systems to support SAMHSA’s four pillars of recovery. SAMHS strongly supports the recovery process and has designed our office to specifically include recovery as a critical element in the available array of services. Recovery supports available to consumers include recovery coaching training and recovery coaching; Substance Abuse Peer Support Recovery Centers (SAPSRCs); mental health peer support centers; a statewide Warmline; recovery telephone support; supported employment; the clubhouse model; long-term vocational support; peer support in emergency departments, peer support at Riverview Psychiatric Center, and an Intentional Peer Support Training and Certification Program. Recovery supports are designed to be low-barrier and easily accessible for individuals.

The Annual HOPE Conference is planned and designed by consumer and allies for persons in recovery, consumers, survivors, service providers, and family and community members. The goals for the conference are for participants to gain a greater understanding of what recovery/ wellness is from the many paths and different perspectives on the journey of life. The conference offers a chance for participants to learn from each other, network, and gain greater understanding about recovery and wellness. This conference is presented by SAMHS in collaboration with the Consumer Council System of Maine and the Maine Association of Peer Support and Recovery Centers.

The Peer Run Warmline:
The Warmline provides support for people sixteen (16) years of age and older, living in Maine, and experiencing issues related to mental illness or co-occurring substance use disorders, emotional distress, and trauma, who are not in Behavioral Health Crisis by providing supportive conversation with trained peer support professionals. The Warmline operates twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) day per year. 4,084 unduplicated individuals utilized the Warmline from 7/1/18-6/30/19 according to provider report.

Peer Run Recovery Centers

Peer-run recovery centers are open to Adults with SMI, SUD, and/or co-occurring SUDs. Services are offered consistent with the COSP model, which has been evidenced to effectively promote empowerment and hope of recovery among participating adults diagnosed with severe mental illness. The Department has contracted with an independent evaluator to apply the Fidelity Assessment/Common Ingredients Tool (FACIT) as a core measure of the performance for mental health peer centers, which may be used to influence future funding of this service. Centers provide peer support through facilitated support groups and through educational activities focused on goal planning, self-management and problem-solving skills, as well as vocational preparedness. Centers work to build collaborative relationships with local community mental health, substance abuse, and community service agencies and shall assist with successful Linkages.

There are currently 10 mental health peer support centers and 9 SAPSRCs providing services within the state.

Mental Health Psychosocial Clubhouse Services

Maine has four psychosocial clubhouses accredited with Clubhouse International. Clubhouse services are provided both as a MaineCare service and as a grant funded service for uninsured individuals. Total average daily attendance was 255 members, and 716 unique individuals were served in clubhouses during SFY19 Q3. Of these participants, 24.5% were employed. High Hopes Clubhouse in Waterville, Maine boasts the highest employment rates of any clubhouse in the world, as reported by Clubhouse International. More information about this service type may be found here: https://clubhouse-intl.org/.

Certified Intentional Peer Support Specialists Training Program (CIPS) and Peer Support 101

In collaboration with Sherry Mead, the founder of Intentional Peer Support, the former Office of Consumer Affairs and consumers from throughout Maine developed a trauma-informed curriculum called, "Intentional Peer Support: An Alternative Approach." This curriculum is used for the Certified Intentional Peer Support Specialist training program as well as other trainings offered through SAMHS. To become a Certified Intentional Peer Support Specialist (CIPSS), one must complete this eight-day training. CIPSS credentialing is a requirement for Peer Support Specialists working within the Maine Warmline, Emergency Departments, Behavioral Health Homes; State Psychiatric Hospitals; Mental
health peer support centers; and on ACT teams. Topics covered include; creating learning environments, first contact, language, listening differently, challenging situations, and working in the system.

**Consumer Groups in Maine**

The Consumer Council System of Maine (CCSM) is an independent organization established by Maine law (Title 34-B, §3611). 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. CCSM welcomes and needs the participation of all mental health consumers/peers from all over Maine.

The QIC (Quality Improvement Council) is a federally mandated planning and advisory council for the State of Maine. The council members are a diverse group of individuals with lived experiences receiving, accessing and providing mental health and substance use services. The QIC reviews, monitors and advises the state mental health and substance abuse system in a variety of areas (including contributing to the MHBG application). QIC main focus is the SAMHSA Block Grant allocations which include behavioral, developmental and substance abuse issues for children, youth, family, young adults and adults.

**Housing**

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

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

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

- To the greatest extent practicable, SAMHS allocates tenant-based housing vouchers which empower consumers and enhance individual choice, independence, and allow the consumer to control their housing and the amount and type of services they choose to receive.

- Independent housing vouchers deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care.

- Vouchers can be used in either the community or group settings at the consumer’s discretion. Independent housing vouchers are a logical extension of the concept, “Money Follows the Person,” in which the consumer directs their own care, and in this case, their housing as well.
Since the inception of the Consent Decree, Maine’s DHHS has supported voucher programs (BRAP and Shelter plus Care) that are built on the premise of not demanding participation in any particular service program as a pre-condition of housing. Vouchers provide the consumer with choice, independence, and control over where they live and what services they choose to engage in. In 2016 BRAP and Shelter plus Care participants alone received over $48.5 million of MaineCare reimbursable services helping to keep them successfully housed in the community.

Maine inserted ‘homelessness’ into the eligibility sections of State Medicaid Plan, Section 13, 17, 65. New for 2017 was the implementation of the Adult Needs Strengths Assessment Tool (ANSA) for all PNMI to complete on each consumer every 90 days to review status, document changes, show improvement in client functioning as noted in their quarterly ISP. Homelessness was built into the ANSA tool as a risk factor. The ANSA tool was also put into MaineCare rule under Section 17 Community Support Services.

Community Mental Health agencies are the administrators for BRAP, Shelter Plus Care, and PATH. All are mandated utilizers of Maine’s Homeless Management Information System (HMIS), administered by the Maine State Housing Authority.

Adherence to the CLAS standards

Maine behavioral health providers adhere to the enhanced National Standards for Cultural and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This includes:

Contracted Mental Health Agencies train their employees in diverse cultural health beliefs and practices. Mental Health Providers continue to engage in cultural training to meet the ongoing needs of the populations they serve in urban and rural areas. Mental Health Providers will access Maine Department of Health and Human Services, which promotes health and wellness in Maine’s racial and ethnic minority communities for further information and trainings.

Preferred languages – interpreter and translated materials are available 24/7 for non-English speaking clients as well as those who speak English, but prefer materials to be translated in their primary language. The Maine Department of Health and Human Services is committed to providing services that are accessible to people who have Limited English Proficiency (LEP). To LEP individuals seeking services from DHHS, qualified interpreters are available at no cost to the client to help access Department services and programs. Important documents are being identified and gradually translated into the predominant languages spoken in Maine. Maine is one in 9 states that does not have a pre dominate second language. Mental Health providers will be encouraged to utilized DHHS/Office Multicultural Resources to access this service for minority populations they serve.

Health literacy and communication are available 24/7 for all non –English speaking clients that access services for all of DHHS. Mental Health providers receive training on using the 24/7 interpretation services available in settings where it is needed. Mental Health providers will be encouraged to utilize Maine Department of Health and Human Service to access this service for minority populations they
serve. The State of Maine Office of Health Equity is dedicated to supporting the Maine CDC and our partners throughout the state to address the CLAS Standards.

Tribal Outreach

To improve coordinated delivery of essential public health services, Department of Health and Human Services (DHHS) and the Maine Legislature approved the establishment of eight public health districts. District boundaries were established using population size, geographic areas, hospital service areas, and county borders. A District Liaison coordinates a Public Health Unit with co-located Maine CDC staff in one DHHS regional office for every District. The Tribal Health District was established as one of these districts, with its boundaries determined by the Tribal Health Center service areas and services staffed by a Tribal District Health Liaison.

The vision of the Tribal Public Health Unit is to improve the overall health status of the Maine Tribes and American Indian & Alaska Native (AL/AN) populations in our service areas. The Mission of the Tribal Health District Unit is to collaborate and provide public health infrastructure by responding to the Native American people’s needs by:

- Ensuring the effective delivery of the Ten Essential Public Health services through respect of the people and culture.
- Focusing on health issues by providing health promotion, prevention, and education.
- Collaborating, creating and sustaining partnerships with federal, state and local entities.
- Promoting tribal-wide collaboration in public health assessment, planning, implementation, and evaluations.

Tribal Health Facilities are located in the following counties of the state:

Micmac Service Unit, Presque Isle - Aroostook County.

Houlton Band of Maliseet Health Department, Littleton - Aroostook County

Indian Township Health Center, Indian Township-Washington County

Penobscot Nation Health Department, Indian Island- Penobscot County

Pleasant Point Health Center, Sipayik –Washington County

Tribal Health Liaisons:

The Tribal Health Liaisons work in partnership with the Tribes, DHHS districts, state public health entities, Tribal Health Directors, and the Division of Local Public Health. Additionally, the Tribal Liaisons, serve as tribal representatives for Aroostook Public Health District Coordinating Council (DCC), Penquis Public Health District Coordinating Indian Township Health Center, Indian Township Council (DCC) and Down east Public Health District.
Established in 1996, Wabanaki Health and Wellness is a not-for-profit organization for tribally-enrolled Native Americans, serving the Penobscot, Washington and Aroostook Counties of Maine. Located in Bangor, the agency provides case management, administers free HIV testing and hosts wellbriety meetings, among other services. Its board is intertribal, comprised of Native people. Its board members bring a variety of professional expertise and client perspectives to their work. Formerly known as Wabanaki Mental Health Association, Wabanaki Health and Wellness is affiliated with Cornerstone Behavioral Health for clinical case management programs.

**Maine PATH Program and outreach to literally homeless populations in urban and rural areas.**

Maine is one of the most rural states in the United States, and is fairly homogenous. Diverse populations are centered within the urban areas of Maine. One of the more challenging aspects of the PATH program in Maine has been in identifying and understanding the differences in rural homelessness versus urban homelessness. The less populated areas in Maine pose the greatest challenge in serving homeless populations as service delivery is more costly, poverty is higher, and there are fewer resources available. The State of Maine, being identified as 82% rural, has adjusted resources and implemented a system change which reflexes an increase in funding and PATH presence in the identified rural areas throughout the State of Maine. This allows the ability of the PATH program to identify, outreach, and enroll homeless individuals in rural areas, not just urban areas. In addition, these changes will allow PATH navigators to reach out to the tribal centers in Maine, and state PATH program managers have concluded these to be effective strategies to increase outreach and engage Maine’s tribal populations.


**STEP 1: STRUCTURE OF THE SYSTEM OF CARE**

Maine’s mental health authority for children’s mental health services is Children’s Behavioral Health Services (CBHS) unit within the Office of Child and Family Services (OCFS) of the Department of Health and Human Services. Children’s Behavioral Health Services staff provides leadership in systemic planning and policy development, budget oversight, interdepartmental collaboration, legislative initiatives and systems advocacy on behalf of children with emotional and behavioral needs and their families. Mental health services for children are delivered at the local level through a regional structure. The statutory authority for the Children’s Mental Health Program is cited in PL1998, Chapter 790.

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

OCFS does not provide direct service to families, rather it contracts with community providers who deliver the services to families and children. OCFS ensures that the contracted providers follow the contractual obligations and that families and youth show improvement in functioning because of participating in services. All services provided must be Trauma Informed, Family Centered, and Culturally Competent. OCFS services are funded by Medicaid, Block Grant and State General Funds.

**Target Populations**

Children’s Behavioral Health Services has three operational target populations:

a. Children who have developmental disabilities or severe developmental delay, birth through 5;

b. Children and adolescents, from birth to their 21st birthday, who have emotional/behavioral needs including children with Serious Emotional Disturbance;

c. Children, birth to their 21st birthday, who have Intellectual Disability, Autism Spectrum Disorders

In accord with P.L. 102-321, Maine defines Serious Emotional Disturbance in alignment with the Federal definition.

**State/Local Administrative Structure**

OCFS: Children’s Behavioral Health Services is responsible for:

- Ensuring that any child identified as needing a behavioral health intervention who is eligible for Medicaid (MaineCare) between birth and their 21st birthday, and their family, have access to, and receive this service in the most effective, and least restrictive setting possible. Services will ensure that:
  - Youth transition successfully to adulthood,
  - All possible employment options are sought for youth,
  - Underserved populations, such as ethnic minorities, LGBTQ youth, tribal youth and those with correctional involvement are served within our System of Care,
  - OCFS Request for Proposals and subsequent contracts mandate that these underserved populations are addressed by the services purchased.

- Ensuring that children receive Evidence-Based Practices (EBPs) whenever possible,
- Oversight and review of youth receiving residential treatment In-State and Out of State,
- Oversight and review of Reportable Events (events that occur during provision of Behavioral Health Services, to include dangerous situations, medication-related events, rights limitation/restriction, serious injury to youth),
- Reviewing suicides and serious suicide attempts,
- Collaborating and consulting on Child Welfare cases, for youth with behavioral health needs,
- Work with the Office of MaineCare Services in developing and implementing policy related to Children’s Services,
- Overseeing the Block Grant for Community Mental Health Services funding and implementation,
- Overseeing Homeless and Transitional Living Programing for youth,
- Providing program leads and content expertise for all contracts, i.e. respite, crisis, family support, BHP training, deaf services, etc.
Other Units within the Office of Child and Family Services

**Children’s Licensing & Investigation Services** is responsible for:

- Issuing Child Care Center Licenses, Nursery School licenses, and Children’s Residential licenses;
- Monitoring compliance with regulations set by the Department of Health and Human Services under direction of the Maine Legislature;
- Creation and maintenance of licensing rules to support childcare services in meeting children’s psychosocial and developmental needs, while also providing a safe, healthy and secure environment;
- Investigation of Out of Home placements (foster homes, Children’s Residential, etc.).

**OCFS: Child Welfare Services** is responsible for:

- Prevention services which seek to promote the health, well-being, and safety of children and families, by reducing the risk and effects of adverse childhood experiences (such as neglect, trauma, or exposure to violence);
- Administering best practice services that create a community of caring for intergenerational members focused on increasing protective factors such as: health, education and safety promotion, parenting education, social connections and family strengthening supports; and Early Quality Child Care and Education;
- Assessing the safety of children in the custody of their parents or caregivers, and developing plans to insure safety of children in their homes;
- When children cannot be cared for safely in their homes, petitioning the court for custody;
- Licensing alternative living situations, which provide safety and stability for children in DHHS custody;
- Rehabilitative and reunification services are provided to families when their children are removed from their care;
- Adoption services are provided for families who are interested in adopting children in DHHS custody, when the Court terminated their parent’s legal rights;
- Provide transitional services for youth in care who have reached the age of 18 and need assistance to reach their educational and vocational goals.

**OCFS: Technology and Support** consists of the following positions:

- **Information Systems Manager** provides oversight and management of Information services and data related to OCFS business and programs. The Information Systems Manager supervises several staff that oversees electronic data management systems, and assists OCFS with data collection and distribution. This information is used to adjust programming as needed.
- **ICPC/LOC Manager** Supervises staff who are responsible for ensuring that Levels of Care are determined for youth in Maine’s foster care system, and coordinating the Interstate Compact for the Placement of Children—children who are in the custody of Child Welfare and need to be placed outside of Maine, as well as children who are in the custody of their parents and need to be placed in Residential Treatment outside of Maine.
- **Federal Plan/QA Manager** Supervises the nine Quality Assurance Specialists, who provide QA reviews for Child Welfare districts statewide. Also, oversees the four staff responsible for the Rapid Safety Feedback Program and its associated activities.

This unit is responsible for managing and directing the Office’s operational activities, services include:

- Internal quality assurance program for Child Welfare as well as Rapid Safety Program;
- Informational services systems including the database for Child Welfare (Maine Automated Child Welfare Information System/MACWIS) and Behavioral Health (Enterprise Information System/EIS);
- Technology and reporting services;
- Services related to the Interstate Compact for the Placement of Children (ICPC);

**CHILDREN’S BEHAVIORAL HEALTH SERVICES TEAM**

The Director of OCFS oversees all operations of the Office of Child and Family Services, both Child Welfare and Children’s Development and Behavioral Health Services; is responsible for financial oversight of the budget; develops and implements policies relevant to OCFS; represents the Department on issues affecting services for families, to include
strategic planning, and work with the Maine Legislature; oversees contract development and provides leadership within the entire OCFS.

**Medical Director of the OCFS** a part time Child Psychiatrist, contracted through Massachusetts General Hospital, who provides clinical expertise, consultation on clinical and programmatic issues, and promotes evidence-based and best practices in the field. The Medical Director consults with, and supports field staff, and provides clinical recommendations to OCFS.

**Associate Director of Children’s Development & Behavioral Health** manages all activities statewide pertaining to the development and delivery of early intervention Child Care services behavioral health and rehabilitative services for children and their families. The AD is also responsible for the implementation of the delivery of mental health services to youth in the Department of Corrections Youth Development Facility and Juvenile Services Regional offices. This position manages the following staff:

- **Program Coordination Team Leader:** Responsibilities include supervision of the Program Coordinators; troubleshooting youth with challenging Mental Health needs on a daily basis, ensuring all youth receive the appropriate level of care, that their needs are met in least restrictive setting available; is the OCFS Lead for Transition and Out of State liaison for all residential and community programming; and also, serves as the OCFS liaison to designated stakeholder groups.
  - **Program Coordinators** are responsible for ensuring that youth with social and emotional challenges receive the most effective treatment services in the least restrictive environment. They provide behavioral health education and resources to Child Welfare Staff and the community, as well as on-call coverage for out of state hospitalization. They monitor youth who are placed in various levels of care, including residential placement, both in the State of Maine and outside of Maine. This team works to ensure that youth are placed in the correct level of care, and advocates for movement when youth are ‘stuck’ in various placements. This team reviews children between the ages of 16 and their 21st birthday who have a developmental disability, to ensure a smooth transition to adulthood. Program coordinators are also assigned to the juvenile corrections system, to ensure that youth involved in corrections have their mental and behavioral health needs met.

- **Clinical and Community Resource Team Leader:** Responsibilities include supervision of the Children’s Resource Coordinators and the Care Coordination team, is the OCFS Lead for Residential Programming and Waitlist Monitoring as well as provision of CBHS training to the community and Child Welfare staff statewide. Participates in statewide OCFS team responsible for ongoing development, implementation, and monitoring of behavioral health prevention and treatment programs; consults with other Department offices, such as the Office of MaineCare Services, Child Welfare, Attorney General’s office; serves as the OCFS liaison to designated stakeholder groups.
  - **Resource Coordinators:** Resource Coordinators recruit, vet, develop and maintain a comprehensive array of behavioral health resources for children with Autism, Intellectual Disabilities, and Severe Emotional Disturbance. They are the primary contact for agencies seeking to provide behavioral health services for children, and for agencies seeking information and/or technical assistance from the Department. They ensure there is clear communication between the Department and the children’s services providers, and disseminate information regarding Department policies and legal requirements. They develop resources to meet needs in underserved areas.
  - **Care Coordination:** A combination of Clinical Social Workers, Master’s Level Social Workers and Nursing Staff are responsible for ensuring that youth in treatment services are receiving effective, quality treatment, and are safe within their treatment environment. Tasks include: review and follow up on Reportable Events; monitoring youth in DHHS custody who are taking psychotropic medication; providing behavioral health training to Child Welfare Staff and Community Providers; participating in program reviews to provide support and feedback to providers, and providing oversight and recommendations for the comprehensive health care needs of youth entering the custody of DHHS. Additionally, two Clinical Social Workers are located at Long Creek Youth Detention Center to work with detained youth to ensure that they have their mental and behavioral needs met.
  - **Behavioral Health Policy Coordinator:** Policy Coordinator works closely with the Office of MaineCare to write and implement Maine Care Policies that govern services for children in need of behavioral health treatment; creates and implements standards of care for Treatment Services; ensures
that Evidenced-Based Practices are used as much as possible and work to increase the use of EBP in children’s behavioral health service; creates performance measures for children’s behavioral health services; works closely DHHS’s contracted Administrative Services Organization (ASO) KEPRO, which provides comprehensive healthcare management; and reviews and analyzes children’s behavioral health data. Policy Coordinator also provides program oversight for contracted services.

- **Child and Family Program Specialist:** Responsibilities include supervision of the Family Information Specialist and the Project AWARE Co-Coordinator; manages the Community Mental Health Block Grant and the associated contracts, and First Episode Psychosis/Coordinated Specialty Care programming; Is the OCFS Lead for the following services: Respite Services for youth with behavioral health diagnoses, Statewide Crisis Services for children/youth/families, Autism Support and Information, and Family and Youth Peer Support; serves as the OCFS liaison to designated stakeholder groups.
  - **Family Information Specialist:** A parent peer who assists families seeking access to services for their child/youth. Provides information to parents about community services, transition services, and maintains updated information about behavioral health providers statewide. This person also receives and processes grievances filed with the Department on behalf of families, and processes requests for Individualized Planning Funds.
  - **Project AWARE Co-Coordinator:** OCFS partnered with the Department of Education on a 5-year, SAMSHA-funded initiative to help Maine develop a comprehensive framework and infrastructure to support student mental health through state and local collaboration between education and health providers. The project aims to implement evidence-based universal positive behavior and social emotional learning supports, coupled with universal behavioral health screening, to help schools and communities focus intensive resources on students and families with the greatest need. The project also aims at developing coordinated support services at the school level, so that school clinical capacity is maximized and well-articulated with the community’s therapeutic resources. Three pilot schools were selected and are very engaged—the hope is to create statewide policy based on the results of this grant.

- **Child Care Services Program Manager:** Responsibilities include administer of the Child Care and Development Block Grant (CCDBG), Maine’s Child Care Subsidy Program, and oversees the following contracts for the State; Child Care Professional Development contract, Maine’s Quality Rating Improvement System, Maine’s Market Rate Survey, and Head Start. Collaborates with Children’s Licensing Unit, Department of Education (DOE), Office for Independence (OFI), Center for Disease Control and Prevention (CDC), and Public Safety to ensure state and federal laws, policies, and procedures are in compliance with CCDBG. Partnered with DOE on the Preschool Development Grant (PDG-5). This grant works to build coordination across State departments and system’s and to build community relationships with a key focus on parent engagement.
  - **Prevention Services Coordinator:** Manages the Child Abuse and Neglect contracts. Assists the Child Care Service Program Manager on the QRIS Revision Project. Collaborates with CDC, DOE, and Maine Roads to Quality / Professional Development Network (MRTQ/PDN) on CCDBG. CCDBG supports a ‘warm line’ to provide consultation for child care providers and other early childhood settings, provides technical assistance around all issues involving social/emotional learning as well as the Child Care Choices website, Maine’s child care provider search engine, and consumer education website. This position also works closely with DOE on the PDG-5.
  - **Child Care Subsidy Supervisor:** Supervises the statewide Child Care Subsidy Program’s Financial Resources Specialists. Ensures compliance of state and federal policies and procedures for financial and program eligibility for both families and CCSP Child Care Providers. This work include collaboration with OFI and Children’s Licensing Unit. Coordinates with OIT on the state’s databases that include MACWIS, FORTIS, and ACES.

**AVAILABLE SYSTEM OF TREATMENT, REHABILITATION AND SUPPORT SERVICES**

For all services delivered to families and children, OCFS ensures that contracted providers have access to interpreter services so that language is not a barrier to families receiving proper treatment for their family. Additionally, contracts with provider agencies include language that ensures cultural competence, and that the needs of diverse ethnic, racial and sexual gender minorities as well as American Indian populations are served, (ex: “ensure services are available to specific underserved individuals, such as individuals who have encountered the criminal justice system, LGBT individuals, and Indian Tribal Members.”)
**Children’s Mental Health Services:** CBHS contracts with private community-based agencies to provide the following Behavioral Health Services: case management; crisis services; Family Peer Support; Youth Peer Support; clinical home and community-based behavioral health treatment; rehabilitative community support services; outpatient counseling and therapies; respite services; medication management; and short-term, intensive residential treatment services. Individual Planning Funds are also available to families who apply and are approved.

**Intellectual Disability and Autism Services:** CBHS contracts with private community-based agencies to provide the following Behavioral Health Services to youth with ID and Autism: home and community-based services; identification and assessment; rehabilitative and community services; personal supports; case management; crisis services; medication management; short-term residential treatment, and respite. Individual Planning Funds are available to families who apply and are approved.

**Mental Health and ID/Autism Service Components:** Six core mental health service components are described below. Each core service is available in varying degrees of intensity, depending on the level of need. In addition to the core services, flexible resources (called individual planning funds) are available to provide for individual needs identified through the individualized planning process that cannot be addressed through categorical services, or other funding sources. In Maine, the core service array is intended to provide a blueprint for developing service capacity in each geographic area of the state. The core service array with service components is summarized as follows:

- **Prevention/Consultation Services** include early intervention services for pre-school and very young children and includes identification of at-risk children, clinical consultation and information/education components. Services are designed to identify challenges and intervene early.

- **Crisis Intervention and Stabilization Services** are accessed through a single statewide, toll free crisis telephone line. Services include mobile crisis outreach services, crisis resolution, and short-term crisis stabilization units. Crisis services provide support and stabilization services to children and youth in their homes, schools or other community settings. Services are available 24 hours a day, 7 days a week. Crisis outreach includes an assessment of risk, identification of immediate needs, and development of a crisis stabilization plan, a crisis plan to follow in the event of re-occurrence, referral and follow up.

- **Targeted Case Management Services** consist of screening and assessment, and individual service planning. Case management services for children entail an individualized planning process. Assessment involves determination of an individual or family’s strengths and needs, contributing factors, and existing assets and resources, as well as screening instruments that profile the child’s functional abilities. The assessment instrument, the Child and Adolescent Needs and Strengths (CANS) Assessment Tool, is administered at the time of service entry, and re-administered every ninety days, and at completion of services.

- **Family and Child Supports** include respite care, parent and youth peer support services, and individual planning funds. These natural and extended supports are designed to strengthen the ability of families/caregivers to maintain children in their home and community. Family support and respite provide a planned intentional break from caregiving, and support for each caregiver’s problem-solving, communication skills, behavioral interventions, and advocacy skills.

- **Community Outpatient and Treatment Services** consist of neuropsychological/psychological/psychiatric evaluation; medication management; individual, group, and family counseling; children’s home and community-based treatment services that include evidence-based practices as well as skill building services. Clinical services represent a wide range of community-based treatment, including specialized interventions for substance abuse, trauma, etc. Problem-oriented counseling, skills training, and in-home behavioral treatment services to strengthen and stabilize the family living environment are designed to minimize the risk of out-of-home placement. School-linked mental health services provide a variety of educational/psychological assessment and referral, individual and family counseling, special education, and other support services geared specifically to support the child or youth in the school environment.

- **Residential Services**
  - Therapeutic Foster Care: out of home care by foster parents with specialized training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social issues, or medical needs.
INTEGRATION OF CHILDREN’S SERVICES
The Office of Child and Family Services has developed strong relationships with other child-serving state agencies, notably the Department of Corrections (DOC), Juvenile Services, the Department of Education (DOE), the Office of Aging and Disability Services (OADS), the Center for Disease Control and Prevention (CDC) and the Office of Substance Abuse and Mental Health Services (SAMHS).

These relationships are strengthened through active collaboration within the system of care. Partnerships are developed at the regional level where services are delivered to children and their families; at the policy level where strategies are formulated and values are supported; and at the practice level where behavioral health services are shaped, evaluated, and promoted, based on outcomes beneficial to children and their families.

OCFS is also connected with other state agencies and entities that are not directly involved with services for children and their families, but are important potential, future service providers for some youth as they begin to transition to adulthood. These agencies include SAMHS, which may be a provider for young adults with Serious Mental Illness (SMI), and OADS, a potential provider for youth with Intellectual Disability or Developmental Delay, and whose needs require intensive and long term attention and support that would be available under the Home and Community-based Waiver offered through that office.

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

Geographic Areas within Children’s Integrated System of Care
The Department of Health and Human Services, Office of Child and Family Services (OCFS), is organized and administered through eight district offices, covering the sixteen counties in Maine.

The Department of Corrections, Division of Juvenile Services is divided into three regions, covering the sixteen counties in Maine, in addition to Long Creek Youth Development Center in South Portland. Regionally-based Juvenile Community Corrections Officers (JCCO’s) serve as the correctional case managers for juveniles who are under the supervision of the Corrections, regardless of their status within the legal system. OCFS Children’s Behavioral Health Services personnel are assigned to offices and facilities. The behavioral health and juvenile corrections systems are fully integrated and have established exceptional working relationships.

The Department of Education (DOE) conducts central administrative functions in addition to providing funding and oversight to state and federal education projects and programs. The Department serves a diversified public school constituency at the local level, providing technical assistance, professional development, regulatory oversight, and material support to school districts. DOE’s Office of Student Support Services coordinates programs relating to Special Education services, student health and wellness, and economically disadvantaged students. During the 2017-2018 school year, 45.5% of Maine students were designated as “economically disadvantaged,” meaning that they qualified for free/reduced price meals, versus 24% of students nationwide. Maine currently has 178,613 students and 15,242 FTE teachers across 242 school administrative units, with a total of 737 schools statewide- 620 of which are public schools and 117 are approved private schools. Maine has nine Charter Schools, two of which are online schools. There is one Charter School in the application process; there is a ten-school cap of total Charter Schools, per legislation. There are 2455 students attending Charter Schools in Maine.

Child Development Services (CDS) is an Intermediate Educational Unit that provides both Early Intervention (birth through two years) and Free Appropriate Public Education (for ages three through five years) under the supervision of the Maine Department of Education. CDS consists of nine regional sites and a central state office. The state CDS office maintains a central data management system, system-wide policies and procedures, and provides centralized fiscal services for regional CDS sites. Regional CDS sites provide case management and direct instruction for families with children from birth through age five. Each site conducts Child Find, which is the process of identifying children with disabilities. Screenings and evaluations are provided to identify children who are eligible for services. Regional CDS sites
arrange for local services that include early intervention and special education and related services for eligible child from birth to age five and their families.

**System of Integrated Services: Chapter 790, Public Law 1997 - A Coordinated System of Children’s Mental Health Services**

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

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

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

**Section 15002: Children’s Mental Health Program:**

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

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

Fundamental values endorsed by the LD 1744 planning process are made explicit for all children and families. They include a child and family centered program and planning process, focusing on child and family strengths as the starting point for an individualized plan of services. Principles of care delivery stress local service provision, prevention and early intervention services, and choice of care through a case management system. The program must implement uniform intake and assessment protocols and identify a central location for obtaining information and access to the program. The OCFS is the single point of accountability for the system of care.

**Section 15003: Responsibilities of the Departments:**

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

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

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

7
Management information systems focus on care and support services delivered, needs and unmet needs for care, waiting lists, resource development, and costs of the program. Information is kept by treatment need, care provided, geographic area, and Departmental involvement. Information covers children placed out of state who transfer to care in the State of Maine.

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

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

CBHS, in consultation and cooperation with the other child serving departments, was charged to develop a comprehensive system of services for children with autism, developmental disabilities, and intellectual disability. In designing the service system, the Department utilized the framework of the Children’s Mental Health Program. OCFS has fully integrated children with intellectual disability and autism spectrum disorders into the system of services developed for children with mental health needs.

**Interdepartmental Collaboration**

Chapter 790, beginning with Memoranda of Agreement linking children’s services and each of the three child-serving state agencies, has promoted a high level of interdepartmental collaboration since that time. Children’s Behavioral Health Services collaborates closely with the following entities: Department of Corrections – Juvenile Justice Services; SAMHS; DOE and Child Development Services; and OADS.

**SYSTEMS ACCESS: PROGRAM AND UTILIZATION REVIEW**

**Inpatient Services and Hospital Capacity:** As of July 2019, the number of beds for children and adolescents at Maine inpatient psychiatric hospitals totaled 99 and were allocated as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Location</th>
<th>Service Type + amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring Harbor Hospital</td>
<td>Westbrook</td>
<td>Child=14, Adolescent=14 MR/DD/Autism Unit = 12</td>
<td>40</td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td>Lewiston</td>
<td>Child/ Adolescent = 20</td>
<td>20</td>
</tr>
<tr>
<td>Northern Maine Medical Center</td>
<td>Fort Kent</td>
<td>Serves age range from 4-17</td>
<td>7</td>
</tr>
<tr>
<td>Acadia Hospital (Bangor)</td>
<td>Bangor</td>
<td>Child=12, Adolescent=20</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total Maine Inpatient Psychiatric Beds</strong></td>
<td></td>
<td></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

Maine has two privately operated psychiatric facilities: one is in Bangor with a child and adolescent unit of 32 beds; and one is in Portland with two child and adolescent units of 14 each, as well as a 12-bed unit for individuals with ID/DD/ASD. There are two general hospitals with child psychiatric units: a 7-bed unit in northern Maine (Fort Kent); and a 20-bed unit in central Maine (Lewiston).

**Residential Treatment Services: Intensive Temporary Residential Treatment Services (ITRT) Policy**

ITRT is defined as an intensive level of care that provides treatment for children and adolescents in a structured out of home setting that includes availability of a therapeutic on-site staff response on a 24-hour basis. Treatment services/out of home placements are provided for children who do not require hospital level of care. These services cannot be delivered in a home setting, due to the unsafe behaviors of the child.

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

ITRT residential data reflects all children who have received residential treatment. In FY19, a total of 659 children received residential treatment services. CBHS continues to monitor these numbers to ensure that children in Maine receive the most effective treatment services in the least restrictive environment possible.

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

The census of children who were placed out of state in July 2019 was 63, and the census of children placed out of state in June 2017 was 19, a net change of +44 children over two years. In 2019, the Maine Legislature passed a Resolve, LD 984, “To Develop Plans to Return to the State Children Housed in Residential Treatment Systems outside of the State

Resolved: That the Department of Health and Human Services through its case managers shall coordinate with families of children who are receiving residential treatment services for behavioral health issues out of state to develop plans to bring the children back to the State to receive the required services that would be received under rule Chapter 101: MaineCare Benefits Manual, Chapter II, Section 97, Private Non-Medical Institution Services. The department shall negotiate reimbursement rates as necessary to find providers under Section 97 to provide services to children returning to the State, including deviating from the reimbursement rates established by department rules in order to access additional services.”

Office of Substance Abuse and Mental Health Services (SAMHS): Co-Occurring/Dual Diagnosis Services Services to children and adolescents with co-occurring mental health/substance abuse needs are provided by the Department of Health and Human Services through SAMHS.

The following agencies have specific programs for youth that are funded through SAMHS to provide substance abuse treatment to youth. Residential – Day One (3 sites with 27 beds); Intensive Outpatient - Day One; Outpatient Program – Day One (providing services to youth placed at Long Creek Correctional Facility, as well as in the community), and SequelCare of Maine. While these programs have specific programs for adolescents, most substance abuse providers in the State of Maine do work clinically with adolescents as well as adults.

Medical/Dental Services for Children

Publicly funded dental services for Maine children under the age of 21 are available through the MaineCare program. Access to these services is limited to children eligible for MaineCare, and by the numbers and locations of dentists who are enrolled as approved vendors. OCFS district offices maintain an informal list of dental providers who are willing to accept MaineCare insurance.

Medical services for children are provided through MaineCare. Public health services are provided through the Department of Health and Human Services (DHHS), Center for Disease Control. OCFS does not provide medical services beyond those that are characterized as behavioral health services. Maine expanded medical coverage for many children beginning in 1998 through the Cub Care program, which is now part of the State Children’s Health Insurance Plan (SCHIP). Covered MaineCare services include, but are not limited to: hospital, physician, therapies (OT, PT, and Speech), medication, lab and x-ray, durable medical equipment, vision and hearing, ambulance, transportation, behavioral health, family planning and case management. The table below indicates the total number of MaineCare enrollees between 0-20 years of age, as well as the portion of the population that had a KEPRO-authorized MaineCare service.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Enrollees 0-20 years of age</th>
<th>Total Authorizations for a MaineCare Service for the 0-20 MaineCare Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>119,105</td>
<td>18,921</td>
</tr>
<tr>
<td>2018</td>
<td>107,749</td>
<td>19,789</td>
</tr>
<tr>
<td>2019</td>
<td>102,474</td>
<td>19,049</td>
</tr>
</tbody>
</table>
Rehabilitation and Employment Services
OCFS/CBHS works collaboratively with adult service systems regarding appropriate services and supports, including employment, during the transition planning phase – beginning usually two years or more before a young person enters adult services. Activities include an agreement with the Office of Aging and Disabilities Services (OADS) to begin early collaborative planning for young people at age 16, so that the adult service system can begin resource planning for future needs.

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

Department of Education
The Maine Department of Education publishes an annual count of the total number of students in Maine ages 3-21 receiving special education and related services as qualified under the Individuals with Disabilities in Education Act (IDEA). Child count data is reported by school administrative units and the nine regional Child Development Services (CDS) sites. It reflects all students with Individual Educational Plans (IEPs), regardless of placement. During FY16-17, 33,125 students ages 3-21 received services under the IDEA, part B. During this same period, 915 children ages birth-2 years old receiving early intervention services under the IDEA, part C.

The special education child count lists 14 areas of Disability/Exceptionality classified under the IDEA. Six specific areas among these represent a range of disabilities that are likely to be included in the children’s system of behavioral health care. These include Autism Spectrum Disorder, Emotional Disturbance, Intellectual Disability, Multiple Disabilities, Other Health Impairment, and Traumatic Brain Injury.

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

- For FY19, in the IDEA (Part C) program for children ages 0-2, there were 3,347 referrals made for this age group, and 2,133 were determined eligible for services and served.
- The program for children ages 3-5 (Part B—619), there were 4,922 referrals made for this age group, and 4,748 were determined eligible for services and served. For FY19, the total served under both parts C and B was 6,881 children. The services that each child receives are determined by either an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP) which is developed by the child’s early childhood services team.

B. Services Provided by Local School Systems
The Maine Department of Education (DOE) provides services and supports to Maine’s students identified with disabilities per the IDEA through school subsidies, contractual, and federal funding. These services include the following:

- Certified Educational Personnel which include: Administrator of Special Education, School Education Consultant, School Psychological Service Provider, Vocational Education Evaluator, Speech and Hearing Clinician, School Nurse, Teacher of Students with Disabilities, Teacher-Severe Impairments, Teacher-Hearing Impairments, Teacher-Visual Impairments, and Adapted Physical Education.
- Licensed Providers, employed or contracted, includes persons licensed by appropriate state agencies to provide supportive services to students with disabilities, including: Audiologists, Interpreter/Translator, Licensed Clinical Professional Counselors, Licensed Social Workers (LCSW, LMSW-cc, or LSW), Occupational Therapists, Physical Therapists and Physical Therapy Assistants, Psychologists, Speech-Language Pathologists, Speech-Language Pathology Aides and Assistants, and Attorneys.
- Auxiliary Staff, which include Educational Technician, levels I, II, and III approved by the DOE Office of Certification and assigned full or part time to provide special education services. Schools also contract or employ
Behavioral Health Professionals (BHP) as certified by the Maine Department of Health and Human Services to provide individual behavior support and services to students with mental health conditions.

MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

Target Population Defined by Chapter 790

Maine’s legislation for children’s mental health, Chapter 790, defines a “child”, for purposes of children’s mental health services, as follows:

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

A. A disability, as defined by the Diagnostic and Statistical Manual of Mental Health Disorders published by the American Psychiatric Association;

B. A disorder of infancy or early childhood, as defined in the Disorders of Infancy and Early Childhood Disorders published by the National Center for Clinical Infant Programs;

C. Being assessed as at risk of mental impairment, emotional or behavioral disorder or developmental delay due to established environmental or biological risks using screening instruments developed and adopted by the departments through rulemaking after consultation, review and approval from the Children’s Mental Health Oversight Committee; or

D. A functional impairment as determined by screening instruments used to determine the appropriate type and level of services for children with functional impairments. The functional impairment must be assessed in 2 or more of the following areas:

1) Developmentally inappropriate self-care;
2) An inability to build or maintain satisfactory relationships with peers and adults;
3) Self-direction, including behavioral control;
4) A capacity to live in a family or family equivalent; or
5) An inability to learn that is not due to intellect, sensory or health factors.

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

Maine continues to define children with Serious Emotional Disturbance (SED) in accordance with the accepted federal definition for this segment of the target population covered under the Children’s Block Grant for Community Mental Health Services State Plan. The FY2016 State SED population figure for the 0-17 years of age was 26,519.

Sources of Data and Information in this Application

The FY20/21 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plans. OCFS Children’s Behavioral Health Services utilize the following sources of data and information:

- **Year End Contract Reports** Office of Child and Family Services (OCFS) contracts with providers to deliver all community-based behavioral health services. Providers report performance data, numbers served and a variety of quality improvement indicators on a quarterly basis. State Fiscal Year (SFY) 4th quarter (year-end) reports are a major source of data used by the Department, and are referenced in this application. Contract reports show unduplicated counts of children served for the service component under contract. However, when different types of services are added together, the total number is a duplicated client count.

- **KEPRO** Maine’s Administrative Services Organization responsible for prior authorization and utilization review. The system provides OCR with many data points about authorization and utilization, including: client level and aggregate date, demographic information, CANS assessment tool information, unduplicated count per service area, unmet needs as evidenced by waitlists, and much more.

- **Enterprise Information System (EIS)** A comprehensive and integrated information system that supports planning, management, and quality improvement for all aspects of the department’s operations across all its categorical services, including adult mental health, children’s services, and adult intellectual disabilities. This integrated information system facilitates the planning, development, and maintenance of a responsive, quality, and cost-effective service system to meet the needs of its service recipients, as well as the government agencies and programs serving them. OCFS currently utilizes EIS for Individual Planning Funds, Reportable Events, Grievance, CBH documentation, Mobile Crisis, Out of Home Request Form, and Transition Process between OCFS Children’s Behavioral Health Services and the Office of
Aging and Disability Services. Additional projects under development are Contract Reviews and complaints in the system.

- **Advantage ME** is the current State financial information system. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY14 data used to calculate and document the State’s total current expenditures for all mental health services provided by the Department of Health and Human Services for children, through the Office of Child and Family Services, and for adults, through the Office of Substance Abuse and Mental Health Services.

**Children Receiving Publicly Funded Services**

OCFS Children’s Behavioral Health Services accounts for the number of children served using Departmental funds by three primary sources: (1) Year-end contract reports submitted to the Office of Child and Family Services by provider agencies that include both general-funded and MaineCare-funded children; (2) Information from internal accounting systems capturing services provided on a per diem basis for children served in residential treatment programs - known as Intensive Temporary Out of Home Treatment Services; (3) MaineCare-only funded programs such as Children’s Home and Community-Based Treatment (HCT), and Rehabilitative Community Services (RCS) and supports for children who have emotional/ behavioral needs. Contracted services are listed below for FY16, using information reported to OCFS/CBHS field personnel, Office of Contract Management contract administrators, and/or the Office of Quality Improvement for MaineCare services. The ITRTS count is derived from residential placements for both youth in the care of OCFS, paid through the OCFS room and board account, and youth who remain in the custody of their parents, as they cannot be safely cared for in the family’s home.

**Behavioral Health Services**

**Children Served, by Program Type Under Community Provider Contract SFY19**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th># Served</th>
<th>Type of Service</th>
<th># Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>5,353</td>
<td>Outpatient Services</td>
<td>22,927</td>
</tr>
<tr>
<td>Crisis Services Resolution</td>
<td>2,083</td>
<td>Medication Management</td>
<td>3,710</td>
</tr>
<tr>
<td>Crisis Stabilization/Residential</td>
<td>99</td>
<td>Rehabilitative Community Treatment</td>
<td>3,573</td>
</tr>
<tr>
<td>Residential PNMI in Maine</td>
<td>567</td>
<td>Residential PNMI Outside of Maine (OOS)</td>
<td>92</td>
</tr>
<tr>
<td>Individual Planning Funds</td>
<td>15</td>
<td>Multi-Systemic Therapy (MST)</td>
<td>283</td>
</tr>
<tr>
<td>Functional Family Therapy (FFT)</td>
<td>76</td>
<td>Behavioral Health Home</td>
<td>8,050</td>
</tr>
<tr>
<td>Treatment Foster Care</td>
<td>285</td>
<td>Home and Community-based Treatment (HCT)</td>
<td>2,118</td>
</tr>
</tbody>
</table>

**Total count of Youth Served by a MaineCare Billable Service in 2019**

**This is not unduplicated across all services, but is unduplicated within each service category**

41,181

<table>
<thead>
<tr>
<th>Non-MaineCare Services:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Services</td>
<td>1,296</td>
<td>Parent Self Help/Support</td>
<td>147</td>
</tr>
<tr>
<td>Behavioral Health Respite</td>
<td>680</td>
<td>Youth Peer Support</td>
<td>115</td>
</tr>
</tbody>
</table>

**Total count of Youth/Families Served by a Non-MaineCare Service in 2019**

2,238
Estimation of Unduplicated Count of Children Served

Individual service categories reported above provide an unduplicated count of all children who received that service during FY19. However, when a series of individual service categories are added together, the total represents the number of services delivered to all children, and is not an unduplicated count of all children served because children are likely to receive multiple services.

Per MaineCare Claims Data: The unduplicated count of children 0-17 served by Medicaid-billable mental health service was 19,953 in FY19; adding 18, 19 and 20 year-olds—the unduplicated count of children/youth 0-20 served by Medicaid-billable mental health service was 23,523.

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

Outreach to Homeless Youth

The table below illustrates the current services available for youth who are homeless in Maine. The table shows geographic areas where homeless services are now available for youth. The services were awarded through a competitive bid process. The State of Maine has recently completed a Request for Proposal for youth homeless services for each Region, and the new contracts are scheduled to go into effect in January 2020.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Service Area Focus</th>
<th>Service Type</th>
<th>FY19 Total Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day One-SA &amp; MH Treatment</td>
<td>Cumberland County, Region I</td>
<td>Outreach</td>
<td>134,500</td>
</tr>
<tr>
<td>Shaw House—Clinical Consultation/Training</td>
<td>Penobscot County, Region III</td>
<td>Day Drop In Center</td>
<td>30,109</td>
</tr>
<tr>
<td>Preble Street Resource Center</td>
<td>Cumberland County, Region I</td>
<td>Shelter</td>
<td>100,000</td>
</tr>
<tr>
<td>Opportunity Alliance</td>
<td>York and Cumberland Counties, Region I</td>
<td>Transitional Living</td>
<td>168,459</td>
</tr>
<tr>
<td>New Beginnings</td>
<td>Androscoggin County, Region II</td>
<td>Outreach</td>
<td>120,000</td>
</tr>
<tr>
<td>Shaw House</td>
<td>Penobscot County, Region III</td>
<td>Day Drop In Center</td>
<td>75,000</td>
</tr>
<tr>
<td>Penquis Cap</td>
<td>Penobscot County, Region III</td>
<td>Shelter</td>
<td>106,858</td>
</tr>
<tr>
<td>FY19 Total funding by service</td>
<td></td>
<td>Transitional Living</td>
<td>342,080</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>2,603,891</td>
</tr>
</tbody>
</table>

STATEWIDE TOTALS, HOMELESS YOUTH SERVICES (includes state general funds and federal grant funds) 2,603,891

Services in Rural Areas

The State of Maine is essentially a rural state, considering its land area is 30,862 square miles, and the total population of 1,328,301 per the most current estimate of the United States Census (2010), and the distribution pattern of the population within the geographic area, including Maine’s island communities. Given these conditions, for purposes of planning the term “rural” means any area of Maine not identified by the United States Census Bureau to be a Core Based Statistical Areas (CBSAs).
Maine has three primary CBSAs within its border. Maine’s CBSA populations are centered in the Cities of Portland, Bangor and Lewiston-Auburn. The Portland CBSA totals 350,825, the Bangor CBSA totals 129,263, and the Lewiston Auburn CBSA totals 104,505 for a grand total of population of 743,708, or 55.9% of the total Maine population. This data is based on the most current US Census data for 2010.

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

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

- Health Technology/ Tele-Health: Given today’s technological possibilities in communication, Maine has moved forward to provide professional behavioral health consultation services using telecommunications as a medium. A first step was the addition of formal rules that recognize tele-medicine as a legitimate medium to provide consultation through broadcast sites that connect the behavioral health professional with another professional (or with a client in a direct service encounter) which is capable of reaching people in remote and or rural areas. The Office of MaineCare Services has developed a MaineCare policy that includes tele-psychiatry as a reimbursable Medicaid service. This policy has expanded access to, and allows for financial support of psychiatric services for children and their families who are in rural or remote sites, and who would otherwise not have access to these services. Telemedicine is primarily being utilized by hospitals, at this point; however, it is available to be used with any MaineCare billable service.

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

### NUMBER of PROVIDERS LOCATED IN REGIONAL GROUPINGS (FY19)

<table>
<thead>
<tr>
<th>SERVICE PROVIDED</th>
<th>Number of Providers</th>
<th>Statewide Unduplicated # Providers by Service</th>
<th>Region 1</th>
<th>Region 2</th>
<th>Region 3</th>
<th>Statewide # of Provider Locations by Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted Case Management</td>
<td>74</td>
<td>23</td>
<td>28</td>
<td>23</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>Behavioral Health Home</td>
<td>28</td>
<td>14</td>
<td>27</td>
<td>22</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>74</td>
<td>27</td>
<td>23</td>
<td>24</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>20</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative and Community</td>
<td>60</td>
<td>20</td>
<td>19</td>
<td>19</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Support Services (RCS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Home and Community-</td>
<td>35</td>
<td>12</td>
<td>9</td>
<td>14</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Based Treatment (HCT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Services</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Respite Care Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
Peer/Family Support | 2 | 2 | 2 | 2 | 6
Homeless Services | 7 | 3 | 2 | 2 | 7
Assertive Community Treatment | 2 | 1 | 1 | 0 | 2
PNMI (some providers have multiple service locations within each region—there are nine providers serving 39 different buildings across Maine) | 9 | 3 | 2 | 3 | 39

**Unduplicated count of Providers statewide** | 134 | Most providers deliver multiple services for children and families; of the 28 Behavioral Health Home providers, all but 2 also provide a CBH service

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**Intended Use of CMHS Block Grant Fund**

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

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

The Block Grant for Community Mental Health Services distribution among specific contracts are made at the central office level, identifying programs that: are not MaineCare billable, that serve children who are not covered by MaineCare and programs that are recommended by the Quality Improvement Council of Maine.

### CBHS BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES

**ALLOCATION SFY 2019**

<table>
<thead>
<tr>
<th>VENDOR</th>
<th>SERVICE</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis and Counseling, GEAR Parent Network; RFP for this service will be published in late summer 2019</td>
<td>Family Support Statewide Network</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>THRIVE, Youth Move Maine closed business on 12/31/18; RFP will be published in late summer 2019</td>
<td>Youth Support Statewide Network</td>
<td>$339,294.11</td>
</tr>
<tr>
<td>Maine Medical Center</td>
<td>PIER Program, First Episode Psychosis treatment and training/expansion</td>
<td>$375,387.66</td>
</tr>
<tr>
<td>Quality Improvement Council</td>
<td>State Mental Health Advisory Board - operations</td>
<td>$</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state’s priorities and goals. 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 sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative 16 HHS has identified a broad set of indicators and goals to track and improve the nation’s health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

Broadly, unmet service needs and critical gaps in the system of behavioral healthcare in Maine relate to an individual's inability to access the services they need when and where they need them. As discussed elsewhere within this application, Maine is a largely rural state with a widely dispersed population. The below are identified domains in need of improvement during the coming grant period. These areas of need have been identified via a continuous quality assessment and improvement process undertaken by the Department to improve access and quality of services available statewide. This process includes direct discussions with providers, annual client surveys, stakeholder engagement (including groups such as The Consumer Council System of Maine, Intentional Peer Support Advisory Council, Quality Improvement Council, Substance Use Disorder Services Council, and others), legislative collaboration, and public forums such as those described in Environmental Factors and Plan #21. Data from these sources are collected and analyzed by SAMHS and other offices throughout the Department on a continual basis throughout the year, and influence policy and program development.

**Transportation:** Transportation has been identified as perhaps the greatest single barrier to treatment and recovery in most regions of the state. Public transportation is extremely limited in Maine, with bus systems available only in the most populated regions and very little passenger rail. Providers and consumers regularly reflect that those with MH/SU disorders are often without a driver’s license and/or access to reliable transportation of their own, and are thus dependent upon the system of care for transit to and from treatment, as well as to access their basic daily needs.

SAMHS has adopted several approaches to make an impact in this domain, including contracting with behavioral health providers directly to provide transportation for individuals with MH/SU disorders; supporting behavioral health services that involve provision of transport, such as targeted case management; improvements to telehealth systems (see below); and is investigating further innovative solutions, including mobile response teams. A comprehensive solution to this issue remains elusive, and the Department is continuously seeking innovative interventions to improve access to care by improving access to transportation.

**Workforce:** Behavioral health providers report consistent difficulties finding, recruiting, and retaining qualified staff, including psychiatric physicians, case managers, mental health counselors, substance use counselors, certified intentional peer support specialists, recovery coaches, DATA-waived physicians, nurses, and others.

The Department has worked with the Governor’s office and the legislature to remedy this area of need. Reimbursement rates for many behavioral health services were raised in 2018 in an attempt to provide remunerative inducement for professionals to enter and remain in the field (e.g. all Section 65 services were increased at least 2%). In June 2019, a bi-partisan budget was signed by the Governor’s office including a 3.3% increase in higher education and training programs; an additional $3m for the Maine State Grant Program; an additional $5m for domestic violence and sexual assault services; $125m for Medicaid expansion; and 62 new Child and Family Services staff, among other new and continuing
funds. Maine also offers a competitive Student Loan Reimbursement program to attract young talent, and SAMHS employs a management-level position solely invested in developing Maine’s mental health workforce through training and support programs as well as professional certification.

Telehealth: At this time, Maine providers have limited access and expertise with telehealth, which has been identified as a significant opportunity to address consumers’ difficulties with access to treatment. As an additional barrier, much of the state is still without broadband access, making high-speed connections few and far between in many rural regions including some of those hardest hit by the opioid epidemic.

SAMHS is presently engaged in a comprehensive review of the extant and needed telehealth capabilities of providers and consumers within the behavioral health system, engaging with contract employees to develop institutional knowledge and provide the foundation for innovative change.

Housing: Maine boasts robust and highly successful housing assistance programs (including BRAP and PATH, discussed elsewhere in this application), but housing remains a significant barrier for individuals struggling with MH/SU disorders in the state. Shelters in Portland (the state’s largest metropolitan area) report a state of demand that is consistently beyond their capacity to handle, and providers statewide report that lack of stable housing is among their greatest sources of client attrition in treatment as well as a frequent contributing factor to relapse. Although the state’s housing programs have been very successful in housing individuals and families in need, there remain waitlists to access these programs, as well as a shortage of appropriate housing stock—as many as 200 individuals currently provided with vouchers for housing are reportedly currently unable to find housing that will accept these vouchers as of August 2019.

Innovative solutions for this issue are being sought and implemented in Maine. SAMHS is currently working with the Maine Association for Recovery Residences to increase the number of certified, high-quality recovery residences in the state, as well as with housing providers statewide to design and implement a voucher-based housing assistance program specifically for individuals with SUD, targeting groups in shelters and being released from jail as high-priority populations. Maine continues to grow its stock of PNMI beds (see Planning Step 1) for those suffering from acute mental illness, and is seeking to support innovating housing development options for those seeking residences.

Residential Treatment: Waitlists continue to exist for individuals seeking residential treatment for SUD. This is largely related to a relative dearth of providers available statewide, and results in individuals seeking levels of care either too high or too low to meet their needs.

The Department is consistently seeking new providers for this service type, offering contractual funding agreements on a willing-and-qualified basis.

Continuity of care: Providers have identified a key element in relapse and attrition for individuals with MH and SU disorders in Maine relates to smooth transitions between treatment providers of various intervention types and levels of care. The need for improved processes and standards regarding “warm hand-offs,” has been identified, discussed, and addressed, though this remains an ongoing target issue
for SAMHS. Consumers and consumer groups have also noted that clients who may be faring well at one level of care often “fall off,” and lose some of the gains made in treatment when transitioning to a new level of care or a new care provider. Especially difficult, as noted by providers, consumers, legislators, and other state departments (e.g. the Department of Corrections), are transitions from incarceration to the general public, with this difficulty being greatest for individuals with SMI and/or SUD.

SAMHS has implemented several innovative projects to improve continuity of care over the past several years. The following are in addition to standard and continuing approaches including support of targeted case management, intensive case management, and community integration.

- SAMHS houses a team of staff dedicated to helping individuals transition from mental hospitals to PNMLs (as described elsewhere in application).
- SAMHS launched a pilot project to employ two full-time peer navigators in one of the state’s non-hospital-based detoxification programs. This service type had been identified as one in which clients tended to return frequently to the same level of care due to a lack of ongoing care following discharge. In this program, individuals with lived experience meet with patients while they are receiving medical and clinical care in the NHBD, develop an understanding of their needs and preferences in a collaborative approach with treatment providers, and connect patients to feasible treatment options before and during the discharge process. This project has been identified as a success in aiding individuals seeking treatment, and is scheduled to go to RFP for both the state’s NHBD programs in 4/2020.
- SAMHS has launched pilot projects in several county jails that implement MAT programs within those jail settings and include extensive treatment planning and resource connections for individuals with SUD to continue treatment upon release. These projects will be evaluated for efficacy throughout implementation in 2019-2020 and may be extended into long-term programs if proven effective.
- SAMHS has partnered with Maine Department of Corrections to engage a team of peer recovery coaches and peer navigators within the state’s prison system. This program’s primary purpose is to connect individuals nearing release with the recovery community so that they may have supportive social contacts and engagements upon release back into the general public. This program will be evaluated throughout implementation and may be extended into long-term programs in 2020-2021 if proven efficacious.
- SAMHS has investigated technological tools purported to improve communication between service providers for purposes of facilitated referral processes, and will continue this investigation during the coming grant period.

**Stigma and “Attitudinal/evaluative barriers”:** Consumers, consumer groups, and consumer advocates continue to identify stigma as a significant barrier to engagement in mental health and substance use treatment and/or recovery services. Multiple reputable research sources indicate that attitudinal and/or evaluative barriers are among the most important barriers to treatment engagement among individuals with mental health disorders (e.g. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128692/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128692/); [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182106/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182106/)), further supporting the view that public
perception of pathology, treatment, and recovery services remain very relevant factors in an individual’s willingness or ability to seek treatment.

SAMHS seeks to address stigma and willingness to enter and remain in treatment through several projects and ongoing engagement with the public. SAMHS and the prevention team at Maine Center for Disease Control have ongoing collaboration to address this issue via public awareness campaigns, and SAMHS has investigated and initiated unilateral awareness campaigns to reduce stigma. In addition, SAMHS has worked with the Quality Improvement Council toward local implementation of the Yellow Tulip Project (https://theyellowtulipproject.org/) to increase awareness regarding mental illness. SAMHS maintains contracts with the National Alliance for Mental Illness (NAMI) to train individuals in the general public as well as police officers in understanding of mental health disorders and how to respond helpfully to someone who is struggling with symptoms related to SMI. SAMHS is dedicated to continuing progress in normalizing and familiarizing the public with the realities of SMI and SUD in an effort to bring more individuals in contact with services that may improve their quality of life.
STEP 2: OCFS UNMET NEEDS and CRITICAL GAPS

OCFS/Children’s Behavioral Health Services identifies system needs each year and includes the most pressing and significant of those needs in the priorities section of the Block Grant for Community Mental Health Services application/plan. Progress and outcomes for these areas and topics are accounted for in the subsequent plan. Identification of needed services comes from the district level, and from Resource Coordination activities, as well as from ongoing discussions among Maine’s child-serving state agencies.

Sources of Data and Information
The FY20/21 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes. OCFS Behavioral Health Services for Children utilize the following sources of data and information:

- **Year End Contract Reports** Office of Child and Family Services (OCFS) contracts with providers to deliver all community-based behavioral health services. Providers report performance data, numbers served and a variety of quality improvement indicators on a quarterly basis. State Fiscal Year (SFY) 4th quarter (year-end) reports are a major source of data used by the Department, and are referenced in this application. Contract reports show unduplicated counts of children served for the particular contracted service. When different types of services provided by one provider are added together, the total number is a duplicated client count. CBHS generally requests both unduplicated and duplicated count for services delivered.

- **Maine Integrated Health Management Solution (MIHMS)** This is the current MaineCare claims management system. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.

- **EIS** The Maine Department of Health and Human Service began using the Enterprise Information System in 2002, and it was upgraded in 2017. It is a comprehensive and integrated information system that supports planning, management, and quality improvement for all aspects of the Department’s operations across the following service areas: adult mental health, children’s services, and adult intellectual disabilities. This integrated information system facilitates the planning, development, and maintenance of a responsive, quality, and cost-effective service system to meet the needs of its service recipients, as well as the government agencies and programs serving them. OCFS currently utilizes EIS for Individual Planning Funds, Reportable Events, Grievance, CBH documentation, Out of Home Request Form and Transition Process between OCFS Children’s Behavioral Health Services, Office of Aging and Disability Services and the Office of Substance Abuse and Mental Health Services.

- **Advantage ME** is the current State financial information system. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY19 data used to calculate and document the State’s total current expenditures for all mental health services provided by the Department of Health and Human Services for children, through the Office of Child and Family Services, and for adults, through the Office of Substance Abuse and Mental Health Services. These expenditures are the source for reporting the State’s general fund contributions to the maintenance of effort data that is required by CMHS and reported Block Grant for Community Mental Health Services application and plan.

Service Gaps and Unmet Needs
KEPRO, Maine’s Administrative Services Organization (ASO), provides Behavioral Health Prior Authorization and Utilization Review for services, and generates data to track children who have requested, are waiting for, and utilizing all MaineCare billable behavioral health services. OCFS receives data on a weekly basis about prior authorization and utilization review. Service utilization, wait list data, outcomes, service gaps and trends are examined by OCFS staff; OCFS and KEPRO meet regularly to review, discuss and make changes as needed.
At this time, OCFS has identified a critical gap, and is focused on ensuring that contracted providers deliver in home supports, such as Home and Community Treatment (HCT) and Rehabilitative Community Support (RCS), in a timely manner to children who have been approved to receive the services. These services provide behavioral support and skill building to youth and families, with a goal of reducing the likelihood that a more restrictive level of care is needed. At present, children and families across Maine are unable to receive supports in a timely manner, due in part to staffing shortages statewide. There are ample providers to serve every child, but provider agencies are unable to retain the necessary staffing to work with families; Maine is experiencing significant behavioral health workforce issues. As of 8/16/2019, the waitlists were as follows: 228 children waiting for Specialized RCS services between 3 and 983 days; 426 children waiting for Non-Specialized RCS services between 2 and 556 days; and 483 children waiting for HCT services between 2 and 667 days. For Evidence Based Services, there are 6 children waiting between 92 and 233 days for MST, and there are 6 children waiting between 87 and 340 days for FFT. CBHS has focused on extensive service development to address wait time issues; wait times for these services will continue to be monitored in FY20/21. This item continues to be a priority area in this year’s MHBG application and will be monitored.

There is also a shortage of psychiatry in Maine in general, particularly of child psychiatrists. MaineCare has developed policy that would enable all billable services to utilize Telemedicine, however it continues to be underutilized. It was anticipated that by putting Telemedicine in MaineCare rule, it would increase provider’s ability to serve the most rural parts of Maine: families would not have to find transportation to appointments and the providers could increase their catchment area significantly. At this time, only hospitals are using this technology.

Residential Providers are experiencing challenges in staffing—workforce development is a huge issue in Maine and the consequence to Residential Providers is that, whereas they may have open beds per their license, they cannot safely fill them due to shortages in staffing. Many providers have attributed the staffing challenges and workforce development issues to the increase in Maine’s minimum wage, which occurred in 2018. Maine’s minimum wage has increased from 9.00 an hour to the current 11.00 an hour, and on 1/1/2020 it will again increase to 12.00/hour. Behavioral Health providers report that their potential workforce can work for the same wage at an entry-level job (such as fast food) and not be subjected to extreme behavioral outbursts. This is a huge problem in Maine, and the consequence is that many Maine Youth are placed in Out of State Residential Care, far from their families and community. As of 8/16/19, there were 52 youth approved for Residential Care, days of waiting range from 1 to 298 days.

Youth continue to present with very high behavioral health needs; they need to be served safely and appropriately in their communities using Evidence Based Practices. This has prompted OCFS to look at the System of Care to determine if Maine can adequately care for each individual youth in need of treatment within the current array of services available. A focus of Children’s Behavioral Health Services has been supporting providers who utilize Evidence Based Practices. In late fall 2019, contracts will be established to support providers of MST and FFT in the payment of fidelity consultation and monitoring—activities that are not included in the negotiated MaineCare Rate. It is the hope that this support will allow the providers to continue to support the families they serve, and even expand their teams if possible.

**Assessment of Children’s Behavioral Health Services**

In 2018, CBHS contracted with an independent consultant, Public Consulting Group (PCG), to evaluate Maine’s system of care, identify strengths and unmet needs, and guide the State in the process of change. The focus of the work has been to develop, with stakeholder participation, a Strategic Plan, to guide the functions of CBHS as a whole. The following graphic highlights the Vision, Guiding Principles, Strategies and Outcomes for Children’s Behavioral Health Services, developed in conjunction with Maine Stakeholders (Parents, Providers, other State Departments and Advocacy Groups) and PCG.
In addition to the Strategic Planning work, PCG spoke with almost 1000 stakeholders to obtain feedback about Maine’s System of Care, and made 28 very specific recommendations for improvement. Stakeholders worked together to prioritize the recommendations, the top twelve were selected for immediate action (within the next several years), and are identified on the Vision Document under ‘Strategies’. CBHS plans to use the recommendations to make clear, measurable and tangible changes to Maine Children’s Behavioral Health System of Care. This list of 28 recommendations clearly identifies unmet service needs and critical gaps in the current system, and indicates timeframes for anticipated change (Short-term vs Long-term):

Maine CBHS Recommendations
July 2019

Overview
The overall goal of the 28 listed recommendations below is to improve the children’s behavioral health system of care through services that are built upon the Guiding Principles included in the Children’s Behavioral Health Services (CBHS) Vision Document. These recommendations are intended to emphasize services that are the least restrictive, most effective, and safe; address issues as early as possible; and ultimately lower costs and reliance on intensive interventions in Maine.

<table>
<thead>
<tr>
<th>#</th>
<th>RECOMMENDATION</th>
<th>CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clarify existing roles at OCFS and consider any new roles needed to support the newly defined CBHS mission and responsibilities.</td>
<td>Short-term</td>
</tr>
<tr>
<td></td>
<td>1. Perform a time study and/or a random moment survey to understand the time that each part of the work done by existing staff takes and to monitor fluctuations in that workload over different periods of time.</td>
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<td></td>
<td>2. Shadow CBHS staff to better understand each current role and the way that role varies across employee. Engage actively in conversations about what works well and what is challenging.</td>
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<td>3. Conduct a review of existing job duties and update responsibilities and titles as is appropriate based on current processes.</td>
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<tr>
<td>#</td>
<td>RECOMMENDATION</td>
<td>CATEGORY</td>
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<tr>
<td>2</td>
<td>Develop clear and efficient procedures, policies and practices using organizational and change management methodologies.</td>
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<tr>
<td></td>
<td>1. Invest in robust technology that supports the array of CBHS stakeholders, streamlines data collection and improves OCFS' ability to measure and track data.</td>
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<td></td>
<td>2. Institutionalize knowledge-sharing through the development of procedures for each role.</td>
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<td></td>
<td>3. Create a change team to develop updated procedures based on changes in purpose and tasks.</td>
<td>Short and Long-term</td>
</tr>
<tr>
<td>3</td>
<td>Establish advisory committee(s) that includes child-serving agencies and stakeholders to improve outcomes for children.(^1) Support the reconvening of the Children's Mental Health Oversight Committee.</td>
<td>Short-term</td>
</tr>
<tr>
<td>4</td>
<td>Hire a full-time on-site OCFS Medical Director.</td>
<td>Short-term</td>
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<tr>
<td>5</td>
<td>Amend current service definition for Section 28 (Rehabilitative and Community Services) to focus on effective, targeted interventions for I/DD and Autism.</td>
<td>Short-term</td>
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<tr>
<td>6</td>
<td>Revise the waitlist procedure for home- and community-based services to ensure optimal client/provider assignment.</td>
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<tr>
<td></td>
<td>1. Develop a working group with the ASO, representative stakeholders to develop a process for providers to systematically communicate with the ASO what their availability is when accepting new children off the waitlist.</td>
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<td></td>
<td>2. Require providers requesting cases off the waitlist to include all available areas where staff can serve a child – not limited to zip code.</td>
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<td></td>
<td>3. Conduct further analysis of the current waitlist for home- and community-based services.</td>
<td>Short-term</td>
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<tr>
<td>7</td>
<td>Expand access to respite care services for families.</td>
<td>Short-term</td>
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<tr>
<td></td>
<td>1. Explore the development of a MaineCare funded respite care service.</td>
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<td>2. Explore the use of participant-directed respite care services.</td>
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<td>3. Amend definition of respite to allow for more flexibility with state general funds and contracts.</td>
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<td>8</td>
<td>Improve coordination for youth transitioning from child to adult behavioral health services.</td>
<td>Short-term</td>
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<tr>
<td></td>
<td>1. Strengthen existing resources for transition services by developing a role at OCFS that is primarily responsible for transition services.</td>
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<td></td>
<td>2. The OCFS webpage for transition services should be updated and regularly maintained with information for families and youth about the transition across the system of care, including services for youth with mental health conditions and I/DD or Autism.</td>
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<td></td>
<td>3. OCFS may also want to develop a specific working group around transition services which includes youth or young adults and that engages providers across both systems of care to identify policy changes, programs, and other opportunities that can facilitate successful transition for young people.</td>
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<tr>
<td>9</td>
<td>Facilitate access to services that can help parents and families better support children with behavioral health needs.</td>
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<td></td>
<td>1. Explore developing a MaineCare service definition for parent-only therapy which allows providers to work with the parent/caregiver without the child present.</td>
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<td></td>
<td>2. Explore developing a MaineCare service definition to explicitly support EBPs that enhance parenting skills, such as Triple P or Incredible Years.</td>
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<tr>
<td>10</td>
<td>Build capacity for evidence-based parenting skills development</td>
<td>Long-term</td>
</tr>
<tr>
<td></td>
<td>1. Continue to build capacity to deliver Mental Health First Aid (MHFA).</td>
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<td></td>
<td>2. Explore expanding access to peer and family support through MaineCare service.</td>
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<tr>
<td>11</td>
<td>Explore a statewide or regional “single point of access” for all children/youth to be screened for behavioral health issues under a uniform set of protocols and screening tools and be referred to the appropriate services for their level of need.</td>
<td>Long-term</td>
</tr>
<tr>
<td>12</td>
<td>Explore regional Care Management Organizations (CMOs) to provide intensive care coordination for children with moderate to high behavioral health needs to perform the following functions:</td>
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<td></td>
<td>- Assessments – provide comprehensive assessments for children at periodic intervals to monitor progress and ongoing need for services.</td>
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<tr>
<td></td>
<td>- Treatment Plans – develop individualized treatment plans in collaboration with the Child.</td>
<td>Long-term</td>
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</tbody>
</table>

\(^1\) Per Recommendation #26 (strengthen relationship between juvenile justice and CBHS), include DOC in committees.
and Family Treatment Team (CFTT) and review plans periodically, including at regularly scheduled CFTT meetings.

- Child and Family Treatment Team – convene and facilitate the CFTT and address any barriers to participation in meetings.
- Referrals – provide referrals to both MaineCare and non-MaineCare services.
- Coordination – maintain records of the child’s treatment and services and serve as the primary point of contact for the family, available 24/7.

**RECOMMENDATION**

<table>
<thead>
<tr>
<th>#</th>
<th>RECOMMENDATION</th>
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<tbody>
<tr>
<td>13</td>
<td>Review and align residential services to best practices and new federal quality standards (Family First Prevention Services Act).</td>
</tr>
<tr>
<td>1.</td>
<td>Explore developing a MaineCare service definition for residential providers to provide time-limited support following discharge from residential services.</td>
</tr>
<tr>
<td>2.</td>
<td>Consider utilizing state funds to support transportation for families who have to travel to visit their children in residential programs.</td>
</tr>
<tr>
<td>3.</td>
<td>Contracting and oversight practices should be strengthened and include monitoring activities to ensure that residential interventions are consistently safe, high quality, and effective.</td>
</tr>
<tr>
<td>4.</td>
<td>A stakeholder group could be created to inform the residential services redesign effort which includes families and youth advisors.</td>
</tr>
<tr>
<td>5.</td>
<td>Establish clear performance standards for residential services and may want to tie these to incentive-based payments.</td>
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<tr>
<td>6.</td>
<td>A web-based daily census system should be developed and implemented for children’s residential services.</td>
</tr>
<tr>
<td>14</td>
<td>Develop and implement plans to establish one or more PRTFs within Maine to ensure a full continuum of care options within the state as part of a strategy to reduce or eliminate out of state placements.</td>
</tr>
<tr>
<td>15</td>
<td>Improve the quality, responsiveness, and role of children’s behavioral health crisis services.</td>
</tr>
<tr>
<td>1.</td>
<td>Establish single point of access with triage.</td>
</tr>
<tr>
<td>2.</td>
<td>Establish more comprehensive Mobile Response and Stabilization Services.</td>
</tr>
<tr>
<td>3.</td>
<td>Improve coordination and relationships between the MRSS provider and other child serving agencies.</td>
</tr>
<tr>
<td>4.</td>
<td>Develop a training model for improved MRSS service delivery.</td>
</tr>
<tr>
<td>5.</td>
<td>Continue to support crisis providers to receive training on how to safely manage and support children across the spectrum of behavioral health needs.</td>
</tr>
<tr>
<td>6.</td>
<td>Continue to work with SAMHSA, who administers these contracts, to increase the quality of crisis provider reporting and ensure that the information collected is meaningful to children’s behavioral health services.</td>
</tr>
<tr>
<td>7.</td>
<td>Review the current fee-for-service funding model for crisis providers to determine if this is impacting their ability to adequately staff their programs and respond rapidly to families in crisis.</td>
</tr>
<tr>
<td>8.</td>
<td>DHHS could play a key role in brokering discussions and formalized agreements between crisis providers and hospitals on admission criteria and processes.</td>
</tr>
<tr>
<td>16</td>
<td>Expand the use of evidence-based models and evidence-informed interventions. Select evidence-based practices that align with best practices and new federal quality standards (Family First Prevention Services Act), including FFT, MST, and TF-CBT.</td>
</tr>
<tr>
<td>17</td>
<td>Explore developing MaineCare funded out of home placement for children with behavioral health issues (aka Treatment or Therapeutic Foster Care).</td>
</tr>
<tr>
<td>18</td>
<td>Continue to review how Accountable Communities can support the behavioral health needs of children in Maine.</td>
</tr>
<tr>
<td>1.</td>
<td>Continue to expand the number of children enrolled in ACs.</td>
</tr>
<tr>
<td>2.</td>
<td>Ensure that ACs are responsible for the full service array of children’s behavioral health services.</td>
</tr>
<tr>
<td>3.</td>
<td>Require ACs to maintain responsibility when children are in out of home treatment.</td>
</tr>
<tr>
<td>4.</td>
<td>Identify additional quality measures relevant to children’s behavioral health services.</td>
</tr>
<tr>
<td>19</td>
<td>Conduct further analysis on the coordination between behavioral health services and substance use disorder treatment for youth.</td>
</tr>
<tr>
<td>20</td>
<td>Develop a statewide strategy to address shortages in the behavioral health care workforce.</td>
</tr>
<tr>
<td>1.</td>
<td>Maine should engage the major stakeholders in the behavioral health care sector to develop a statewide, strategic plan to address workforce challenges.</td>
</tr>
<tr>
<td>2.</td>
<td>The strategic plan should pay particular attention to the challenges in rural areas of Maine.</td>
</tr>
<tr>
<td>3.</td>
<td>Collect and analyze data on the current behavioral health workforce to understand capacity.</td>
</tr>
<tr>
<td>#</td>
<td>RECOMMENDATION</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>4.</td>
<td>Follow current workforce issues across the adult and children’s behavioral health system and develop comprehensive recommendations to improve the workforce.</td>
</tr>
<tr>
<td>21</td>
<td>Clarify roles, responsibilities, and mechanisms to ensure that children’s behavioral health services are safe, effective, and high quality.</td>
</tr>
<tr>
<td>1.</td>
<td>Convene a workgroup from the relevant oversight agencies to review the current roles and responsibilities related to quality assurance for children’s behavioral health services.</td>
</tr>
<tr>
<td>2.</td>
<td>Strengthen provider contracts to create greater accountability for quality.</td>
</tr>
<tr>
<td>3.</td>
<td>Develop logic models that define the expected inputs, processes, outputs, and outcomes for CBHS services and develop performance standards derived from the logic model.</td>
</tr>
<tr>
<td>4.</td>
<td>Explore which children’s behavioral health services would be well-suited to performance-based contracting.</td>
</tr>
<tr>
<td>5.</td>
<td>Increase public transparency on the quality of services through provider scorecards and/or public reporting dashboards.</td>
</tr>
<tr>
<td>22</td>
<td>Establish local Care Review processes to support team decision making and best practices (local multi-disciplinary teams, with no direct involvement with the cases they review).</td>
</tr>
<tr>
<td>23</td>
<td>Expand access to high-quality children’s behavioral health expertise across the state (hub and spoke platform). In these models, experts who reside in more populated areas of the state are connected to practitioners in more rural parts of the state to provide expertise, case consultation, training, etc. to develop capacity beyond the “hubs”.</td>
</tr>
<tr>
<td>24</td>
<td>Consider behavioral health urgent care clinics and implement as appropriate.</td>
</tr>
<tr>
<td>25</td>
<td>Explore the use of Pay for Success to leverage philanthropic investments in evidence-based practices.</td>
</tr>
<tr>
<td>26</td>
<td>Strengthen the relationship between juvenile justice and CBHS.</td>
</tr>
<tr>
<td>1.</td>
<td>Develop a protocol and best practices for managing cases with juvenile justice and behavioral health involvement.</td>
</tr>
<tr>
<td>2.</td>
<td>Develop a common vision and measurable objectives for DOC and DHHS around mutual youth.</td>
</tr>
<tr>
<td>3.</td>
<td>Collect data on dually-served youth to drive decision-making and inform service array. Examine specific points of interactions such as entry/exit from juvenile justice or behavioral health services.</td>
</tr>
<tr>
<td>4.</td>
<td>Organizational changes to move juvenile justice from DOC to OCFS.</td>
</tr>
<tr>
<td>27</td>
<td>Conduct further analysis on the coordination between behavioral health services and the educational system.</td>
</tr>
<tr>
<td>28</td>
<td>Support initiatives to enhance skills of early childhood and home-based workers to address challenging behaviors in young children.</td>
</tr>
<tr>
<td>1.</td>
<td>Implement a statewide early childhood consultation program to help teachers and families strengthen supports for children with challenging behavior.</td>
</tr>
<tr>
<td>2.</td>
<td>Create a partnership with the Technical Assistance Center on Social-Emotional Intervention (TACSEI) in order to expand the state’s capacity for professional development.</td>
</tr>
<tr>
<td>3.</td>
<td>Leverage and coordinate federal, state, and local funding for parent engagement.</td>
</tr>
<tr>
<td>4.</td>
<td>Develop and implement consistent screening and assessment tools for three-to-five-year old’s, using the same process the Developmental Screening Initiative used to implement screening and assessment for zero-to-three-year-old’s.</td>
</tr>
<tr>
<td>5.</td>
<td>Establish the Help Me Grow (HMG) system in Maine. HMG is a systems-level initiative that connects early learning providers, healthcare providers, and child-serving state and local agencies to help families find medical homes and access timely developmental screening, assessment, and services for their young children. Maine Quality Counts for Kids has already completed the planning to bring HMG to Maine.</td>
</tr>
<tr>
<td>6.</td>
<td>Develop voluntary guidelines for suspension and expulsion that rely on evidenced-based practices for use by early childhood programs.</td>
</tr>
</tbody>
</table>
### Priority Area: Child -- Safety  
#### Priority Type: MHS  
#### Population(s): SED

**Goal of the priority area:**

Improve safety of Youth, Families and Communities

**Objective:**

Increase Provider's ability to safely serve high needs Youth effectively in Maine.

**Strategies to attain the objective:**

Create action steps to address system's barriers impacting the increase in number of youth being placed in Residential Facilities outside of Maine; Focus on strengthening and developing Maine's Behavioral Health Workforce; Analyze Rates associated with PNMI and determine the barriers for PNMI Resource development in Maine; Provide training and technical assistance to Maine's Residential Providers, increasing their skill and confidence in dealing with highly behavioral Youth.

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** 90% of youth eligible and receiving residential treatment are served in Maine.

**Baseline Measurement:** 86% of youth eligible and receiving residential treatment are served in the State of Maine (567/659 youth)

**First-year target/outcome measurement:** Increase the number of youth receiving residential treatment in Maine by 3%-89% shall be served in Maine

**Second-year target/outcome measurement:** Increase the number of youth receiving residential treatment in Maine by 3%-92% shall be served in Maine

**Data Source:** KEPRO-Prior Authorization and Utilization Review and MaineCare claims data.

**Description of Data:** Count of Youth approved and placed in PNMI both within Maine and Out of State.

**Data issues/caveats that affect outcome measures:**

Authorization data is not the same as Claims data. Providers have up to a year to submit a claim, so there's a chance that when calculating, not every Youth is accounted for, as they have not been billed.

---

**Priority #:** 2

**Priority Area:** Child -- Evidence Based Practices

**Priority Type:** MHS

**Population(s):** SED

**Goal of the priority area:**

Improve stability, health and well-being of youth and maintain them in their family and community
Objective:
Increase access to Evidence Based Children's Behavioral Health Services

Strategies to attain the objective:
Support current Evidence Based Practices including: Applied Behavior Analysis (ABA), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), Multi-Systemic Therapy, Problem Sexualized Behavior (MST-PSB), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Encourage all providers to participate in the EBP Rate Study with MaineCare and consultant; Continue to focus on the expansion of all EBPs with the State of Maine.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Children receiving Evidence Based Treatment modalities will increase by 10%</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>In FY19, the following Youth received Evidence Based Treatment: FFT - 76; MST - 283; ABA - 858; In 2020, TF-CBT should have its own rate, baseline will be established</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase number of youth receiving each Evidence Based Treatment by 5%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase number of youth receiving each Evidence Based Treatment by 5%</td>
</tr>
<tr>
<td>Data Source:</td>
<td>KEPRO-Prior Authorization and Utilization Review and MaineCare claims data.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Count of Youth approved for and receiving Evidence Based Treatment.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>Authorization data is not the same as Claims data. Providers have up to a year to submit a claim, so there’s a chance that when calculating, not every Youth is accounted for, as they have not been billed.</td>
</tr>
</tbody>
</table>

---

Priority #: 3
Priority Area: Child -- Transition to Adulthood
Priority Type: MHS
Population(s): SED, Other (Persons with Disabilities)

Goal of the priority area:
Ensure that Youth and Families transitioning to adulthood have the information they need to make informed decisions for their Young Person.

Objective:
Improve all Youth's ability to transition successfully to adulthood through identification, planning and employment services.

Strategies to attain the objective:
OCFS will monitor youth in need of assistance with transition to adulthood; Reports will be monitored and staff will make contact with families and case management agencies to facilitate transition.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>80% of families with a Youth transitioning to Adulthood, who is also a MaineCare member diagnosed with ID/ASD and SED will receive guidance through the transition years.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>14% of families of</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>80% eligible families will have had a discussion with a TCM or Family Information Specialist about guardianship, evaluation and adult services.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>85% eligible families will have had a discussion with a TCM or Family Information Specialist about guardianship, evaluation and adult services.</td>
</tr>
</tbody>
</table>
**Data Source:**
EIS, KEPRO

**Description of Data:**
KEPRO identifies the Youth, based on authorizations for services, and EIS is utilized for tracking purposes—of contacts made and of CANS assessments for qualifying youth.

**Data issues/caveats that affect outcome measures:**
Only youth/families who receive MaineCare will be able to be contacted, those with private insurance and qualifying diagnoses will not be contacted, because Maine does not have a mechanism to see/track individuals who do not have MaineCare.

Transition is an issue that has been identified as a priority for reform in Maine—recommendations have been made to improve the transition process for youth and families, and decisions need to be made about how it will look in the future. It may include changes to the EIS database to hold case managers more accountable for transition work with youth and families. The current structure of having one person making and documenting phone calls with over 300 families a month is not effective, our system needs to be changed.

**Priority #:** 4
**Priority Area:** Child -- Statewide Peer Support
**Priority Type:** MHS
**Population(s):** SED

**Goal of the priority area:**
To provide a statewide Youth and Family Peer Support Network that is Youth or Family Driven.

**Objective:**
Individuals participating in Peer Support Services will experience an improvement in overall functioning and well-being.

**Strategies to attain the objective:**
Ensure that individuals receive 1:1 support and training as needed; ensure that peer supporters have Lived Experience; Ensure that venues of support include drop-in, group educational opportunities, and 1:1 support; Ensure that those involved in peer support are invited to be part of the Quality Improvement Council, and that their voices are heard at the State level.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Improved functionality and well-being through Recovery and Resiliency of individuals living with SED, SMI or Co-Occurring SUD.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>Needs to be established, Youth Peer Support contract begins 1/1/20</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Establishing Baseline first year</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Youth Peer Support Network program participants who demonstrate improvement in functioning and well-being (5% increase from baseline).</td>
</tr>
</tbody>
</table>

**Data Source:**
The 1:1 Individual Support Survey; to be measured at program entry, six months and at discharge from the program.

**Description of Data:**
The survey tool was developed in 2019, in conjunction with Youth Move National. It will be provided to the provider who is selected to deliver statewide Youth Peer Support, and through contract, it will be expected that the Provider will deliver the survey to Youth entering the program, and every three months thereafter.

**Data issues/caveats that affect outcome measures:**
OCFS will rely upon the objective reporting of the provider to measure progress in this area; the survey requires a willing participant, and if Youth are unwilling to fill it out, the data will not be reliable.
Indicator #: 2
Indicator: Improved functionality and well-being through Recovery and Resiliency of individuals parenting youth with SED.
Baseline Measurement: Needs to be established, New Family Peer Support contract begins 1/1/20
First-year target/outcome measurement: Establishing Baseline first year
Second-year target/outcome measurement: Family Peer Support Network program participants who demonstrate improvement in functioning and well-being (5% increase from baseline)

Data Source:
ACEs Questionnaire (Adverse Childhood Experiences), FJA-Family Journey Assessment tool, and contract reporting

Description of Data:
ACEs Questionnaire--to be completed when the family becomes involved in Family Peer 1:1 support
FJA--the provider will be required to contract with Georgetown University to utilize the tool and report de-identified data to Georgetown on a quarterly basis.
Assessments are completed at program entry, six months and at discharge from the program. All data is reported to OCFS on a quarterly basis.

Data issues/caveats that affect outcome measures:
OCFS relies upon the objective reporting of the contracted provider to measure progress toward this objective.

Priority #: 5
Priority Area: Adult - Psychiatric Readmissions
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Reduce readmission to inpatient psychiatric hospitals within 180 days.

Objective:
By FY 20, to reduce the number of re admissions to inpatient psychiatric hospitals within 180 days of discharge to 30% in FY 20.

Strategies to attain the objective:
This will be accomplished by the dissemination of available housing options to providers and PNMI contract performance measures

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Reduce adults who are discharged from in-patient psychiatric facilities who are readmitted within 180 days
Baseline Measurement: Inpatient re admissions is 24.5% (174 of 710) as reported on 3/31/18
First-year target/outcome measurement: 30%
Second-year target/outcome measurement:

Data Source:
1. KePRO Acquisitions – Utilization Management Services

Description of Data:
Number of adults discharged from in-patient who are readmitted to any inpatient psychiatric facility within 180 days as reported Quartery
Priority #: 6  
Priority Area: Adult - Crisis  
Priority Type: MHS  
Population(s): SMI  

Goal of the priority area:  
Reduce use of Emergency Department for initial point of contact in the Crisis System  

Objective:  
By FY 20, to reduce use of Emergency Department for initial point of contact in the Crisis System from 66.7% (FY17Q4) to 50% or less  

Strategies to attain the objective:  
Through new contracts and performance measures  

Annual Performance Indicators to measure goal success  

Indicator #: 1  
Indicator: Reduce use of Emergency Department for initial point of contact in the Crisis System  
Baseline Measurement: Crisis baseline is 59.8% (4906 of 8204)  
First-year target/outcome measurement: 55%  
Second-year target/outcome measurement: 50%  
Data Source: SAMHS Crisis DB  
Description of Data: The number of individuals receiving crisis services in the Emergency Department is provided by contracted provider agencies who submit reports monthly to SAMHS Data team who create an integrated report quarterly “Integrated Quarterly Crisis Report”  

Data issues/caveats that affect outcome measures:  
Reliant on crisis providers providing accurate data  

Priority #: 7  
Priority Area: Adult - Employment  
Priority Type: MHS  
Population(s): SMI  

Goal of the priority area:  
Increase the number of recipients of mental health services with an individual service plan to become competitively employed  

Objective:  
By FY 20, To Increase the number of recipients of mental health services with an individual service plan to become competitively employed Increase from 18% (2016) to 20%  

Strategies to attain the objective:  
Through training and education of employment assessment tools and contract enforcement of performance measures requiring employment assessments
Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase the number of recipients of mental health services with an individual service plan to become competitively employed
Baseline Measurement: Employment baseline is 19% (1170 of 6264) in FY19
First-year target/outcome measurement: 19%
Second-year target/outcome measurement: 20%
Data Source: EIS
Description of Data:
Individual service plan data is captured through the EIS system and a SAMHS Data Team member pulls ISP and MaineCare ID and matched with data received by the Office of Family Independence by MaineCare ID and employment financial data. Now being created quarterly.
Data issues/caveats that affect outcome measures:
Only reflects those individuals with a MaineCare ID and ISP

Priority #: 8
Priority Area: Adult - PNMI
Priority Type: MHS
Population(s): SMI
Goal of the priority area:
Decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score
Objective:
By FY 20, to decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score from 20% to 5%
Strategies to attain the objective:
By coordinating efforts of the Utilization Review Nurse and the Complex Care Unit, the Office of Aging and Disability Services, and Community Provider agencies

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score
Baseline Measurement: PNMI baseline is 97% (are placed with a 23 or greater.)
First-year target/outcome measurement: 13%
Second-year target/outcome measurement: 7%
Data Source: Kepro Acquisitions – Utilization Management Services
Description of Data:
The number of individuals in PNMI Services by Locus Score is captured in KEPRO as submitted by providers and report is produced as needed.
Data issues/caveats that affect outcome measures:

LOCUS system will be eliminated upon the successful implementation of the ANSA assessment. A new computation system is being developed using ANSA to determine appropriate placement.

Priority #: 9
Priority Area: Adult - Access
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Increase timely access to mental health treatment services

Objective:
by FY 20, to increase timely access to mental health treatment services from 86% to 95%

Strategies to attain the objective:
Through contract performance measures and contract enforcement

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Increase timely access to mental health treatment services through contract performance measures and contract enforcement</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>7 day access baseline is Unknown - 74.9% (134/179) in FY19</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>90%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>95%</td>
</tr>
<tr>
<td>Data Source</td>
<td>Kepro Acquisitions – Utilization Management Services</td>
</tr>
<tr>
<td>Description of Data</td>
<td>The number of non-hospitalized applicants who are assigned CI or ACT services is captured through Prior Authorization for Services at the application and approval for service through Kepro and is reported in the Adult System Goals Measures Quarterly Report.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>Currently, wait lists for grant-funded reflect functional zero. Focus is to affect change through the OMS (MaineCare funded recipients)</td>
</tr>
</tbody>
</table>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
### Planning Period Start Date: 7/1/2019      Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
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<td></td>
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<tr>
<td>b. All Other</td>
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<tr>
<td>2. Primary Prevention</td>
<td></td>
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</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
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</tr>
<tr>
<td>b. Mental Health Primary Prevention*</td>
<td>$0</td>
<td>$9,349,524</td>
<td>$0</td>
<td>$2,066,152</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td>$1,086,294</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$5,517,740</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>7. Other 24 Hour Care</td>
<td>$0</td>
<td>$175,730,761</td>
<td>$0</td>
<td>$16,761,702</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$3,708,420</td>
<td>$308,443,829</td>
<td>$13,136,130</td>
<td>$37,353,372</td>
<td>$0</td>
<td>$0</td>
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</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)*****</td>
<td>$603,516</td>
<td>$0</td>
<td>$0</td>
<td>$15,817,554</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>10. Total</td>
<td>$0</td>
<td>$5,398,230</td>
<td>$493,524,114</td>
<td>$13,136,130</td>
<td>$77,516,520</td>
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</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
Footnotes:
Other 24 hour care = 0
Ambulatory/community non-24 hour care = $3,708,420 for two years supporting all MHBG direct services
Evidence Based Practices (10% set-aside FEP) = $1,086,294 for two years of contract with MMC/PIER
Administration 5% = $269,910 for two years. **333,606 in NonDirect. MHBG total for two years = $5,398,230
*State contract planning processes experienced delays in FY20; information subject to revision.
### Planning Tables

#### Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019  
MHBG Planning Period End Date: 06/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$0</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$175,329</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$10,000</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$0</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$0</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$156,803</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$342,132</strong></td>
</tr>
</tbody>
</table>

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**Footnotes:**

Partnerships, community outreach, and needs assessment: Salary/Fringe of Grant Manager (98,458 yearly); Non-contract Expenditures (travel, training, supplies yearly 18,433); and Indirect Costs (43,438 annually). Training and Education: Peer Recovery Training with Sweetser.
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

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

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


26 http://www.samhsa.gov/health-disparities/strategic-initiatives


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   **Adults:**
   
   Maine was fourth in the nation in the implementation of Opioid Health Homes, and has extended access to the uninsured via direct contracts between SAMHS and OHH/BHH providers. Maine is linking Integrated Primary Care practices with Behavioral Health Treatment infrastructure. Behavioral Health Homes allow for Telehealth capabilities, and several of the BHHS are using Telehealth in rural areas of the state. Behavioral Health Homes and Opioid Health Homes have to be co-occurring capable, and are required to do the AC-OK screening for each individual. BHH and OHH engage primary care providers as central treatment hubs, with an integrated network of care providers, designed to provide comprehensive medical and behavioral health support. In addition to BHH, OHH, SAMHS has engaged with the Maine Association of Psychiatric Physicians in a program that recruits psychiatric physicians to provide free consultation to primary care and other physicians statewide who may not have direct access to psychiatric practices to which they can refer their clients. MAPP also operates a Listserv exclusively for practicing physicians statewide, where they can crowdsource consultations on challenging psychiatric issues. SAMHS has also launched several projects designed to integrate medical and behavioral health care through emergency rooms, including incorporating peer support staff into existing EDs, where they can connect with the patient, provide peer support, and help the patient access an established network of healthcare providers statewide.

   **Children:**
   
   Behavioral Health Home (BHH) designs are services designed to meet the needs of Children and Families using a team-based approach. BHHs coordinate medical and mental healthcare enabling individuals to reach their optimal wellness. The BHH team collaborates with families to help them achieve the goals that are established in the planning process. BHH services are delivered in your community and are highly flexible, based on each family’s unique needs. Behavioral Health Home teams consist of: Care Coordinator, Family Support Partner, Nurse Care Manager, Peer Supporter, and Clinical Supervisor. All MaineCare services encourage the use of telehealth, to serve rural Maine. BHHs are co-occurring capable and per contract Rider, completion of the AC-OK is required of each individual served. In addition to the BHH model, Mental Health and Substance abuse treatment for adolescents is provided statewide by licensed clinicians in outpatient or residential settings. The purpose of treatment is to intervene early in a youth’s development, to help the youth build skills to manage their emotional, psychological, and psychiatric needs in a healthy way that replaces the use of substances. In addition to programs that specifically serve adolescents, other substance use treatment providers across the state who serve adults also serve adolescents. Many outpatient providers who serve adolescents for mental health diagnoses also provide substance use treatment as well.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Adults:
Maine has dedicated significant funding toward integrated systems through Behavioral Health Homes and Opioid Health Homes. Adcare of Maine, SAMHS-contracted workforce development training provider, is responsible for providing co-occurring training statewide, as well as academic detailing for physicians.
Ground-breaking efforts have been made in bi-directional sharing of information between Behavioral Health Homes and Primary Care, resulting in a comprehensive approach to each individual.
Funding Strategies include Accountable Care Communities and pay for performance measures public reporting.
SAMHS has initiated a project to support parenting women with SUD and co-occurring disorders via comprehensive care that includes medical care; substance use and mental health counseling; home supports; after-school programming; housing assistance; employment/vocational support; and parenting education. This project was initiated using the RFP process, and constitutes a significant increase in support for comprehensive care for women with children 10 years or younger. The program, called Integrated Treatment and Recovery Services for Families (ITRSF) is a product of legislative mandate that was modeled after an existing Maine program called McAuley House. SAMHS had provided funding for parenting education at McAuley House previously, and now will fund an entirely new program in a rural part of the state beginning 2020.
SAMHS funds Medication Assisted Treatment programs statewide utilizing a payment structure that supports services for individuals with co-occurring disorders. These contract agreements provide a flexible program structure that allows providers to provide and bill for services that target mental health and substance use disorder symptoms in an integrated care setting, whether or not the client has insurance/Medicaid support. Insurance coverage has historically been a major barrier for many families who cannot afford private insurance, and via Medicaid expansion in 2018 and funding programs for co-occurring programs to provide for the uninsured, this population has been targeted for improved service delivery toward improved outcomes and quality of life throughout this grant period. These approaches will be employed in the coming grant period, as well as any innovative programs that may be identified and implemented.

Children:
• MEPP: From 10/2016 to 5/2019, OCFS funded the Maine Enhanced Parenting Project, which combined Intensive Outpatient Program with Positive Parenting Program for families who were involved with Child Welfare Services and were in need of substance abuse treatment. Whereas the OCFS funding for this project ended in May 2019, some providers continued to use the model using alternative funding sources. Funding ceased when a federal evaluation of this Demonstration Project indicated no statistically significant difference in outcomes between families who participated in the services under the Demonstration Project and those who received traditional IOP and parenting education services.
• Family Drug Court: The Family Treatment Drug Court is a specialty docket located in the Maine District Courts that works with families whose children have been at risk of abuse or neglect due to parental abuse of drugs or alcohol. These specialty courts are located in Augusta, Lewiston, and Bangor. Research has demonstrated that a very high proportion of child protective cases involve parental substance abuse. Family Treatment Drug Courts have demonstrated improved retention by parents in substance abuse and other treatment, reduced time in foster care, and expedited permanency plans for children. Through judicial accountability and enhanced access to comprehensive treatment services, the Family Treatment Drug Court improves the safety and welfare of children and supports the recovery of their parents from alcohol and drug abuse as well as co-occurring disorders.
• Public Health Nurses and the Home Visitation Program offers extra home visits for families with Substance Use Disorder. Maine Families is a statewide network of community teams serving the needs of pregnant women and parents with newborns. Educational visits offer parenting guidance and connect families to community-based supports for those who have children under the age of 2 years in their home.
• Maine plans to submit an application for federal support through the Maternal Opioid Misuse Initiative, a program to address the widespread impact of the opioid epidemic, including supporting pregnant women and mothers with integrated treatment and recovery supports and reducing the number of drug-affected births in Maine.
• Some Children’s residential providers provide treatment for co-occurring disorders: When youth with co-occurring SUD/MH qualify for out of home/residential care, the treatment team develops a service delivery specific to meet all the needs of the youth. If they present with substance use issues, the residential provider would coordinate services to address the need, if they were not able to provide the service themselves. All of the three homeless shelters are able to provide MH/SUD treatment on-site as well.
• The Governor’s Opioid Summit worked to draw attention to the need for supports and services: A Day-long summit was held on July 15, 2019, bringing together national and state leaders to collaborate on the state’s ongoing response to the opioid crisis and help inform future initiatives to combat it. It brought together members of the public, health providers, experts, affected individuals and families, and law enforcement officials from across Maine to foster collaboration on the state’s ongoing response to the opioid crisis. The summit featured national policy experts: Michael Botticelli, President Barack Obama’s Director of National Drug Control Policy, and Sam Quinones: journalist and author of the landmark book, Dreamland, which chronicles the national opioid crisis and is widely credited with awakening public interest in the issue. The summit featured additional presentations on actions taken by neighboring states and new threats such as the emergence of deadly synthetic drugs. According to the Attorney General’s Office’s 2018 Drug Death Report, drug overdose deaths decreased in 2018, but Maine’s opioid crisis continues to be a public health epidemic requiring a comprehensive response from jurisdictions inside and outside of state and local government. While the total number of 354 drug fatalities during 2018 was lower than the 417 deaths reported in 2017, 80 percent were caused by opioids, often in combination with other drugs or alcohol. At least 89 percent of those deaths were attributed to accidental overdoses.
DHHS contracts with substance abuse treatment programs to provide youth with residential treatment, outpatient treatment and Intensive Outpatient Programming. All providers are co-occurring capable and trauma informed.

3.  a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  
   b) and Medicaid?

4.  Who is responsible for monitoring access to M/SUD services by the QHP?

5.  Is the SSA/SMHA involved in any coordinated care initiatives in the state?

6.  Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      ii) heart disease
      iii) hypertension
      iv) high cholesterol
      v) diabetes
   c) Recovery supports

7.  Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8.  Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

9.  What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\(^\text{42}\), Healthy People, 2020\(^\text{43}\), National Stakeholder Strategy for Achieving Health Equity\(^\text{44}\), and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)\(^\text{45}\).

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

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”\(^\text{46}\)

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status\(^\text{47}\). This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations\(^\text{48}\). In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.


\(^{44}\) [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

\(^{45}\) [http://www.ThinkCulturalHealth.hhs.gov](http://www.ThinkCulturalHealth.hhs.gov)
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - a) Race [ ] Yes [ ] No
   - b) Ethnicity [ ] Yes [ ] No
   - c) Gender [ ] Yes [ ] No
   - d) Sexual orientation [ ] Yes [ ] No
   - e) Gender identity [ ] Yes [ ] No
   - f) Age [ ] Yes [ ] No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? [ ] Yes [ ] No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? [ ] Yes [ ] No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? [ ] Yes [ ] No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? [ ] Yes [ ] No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? [ ] Yes [ ] No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section


OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( (V = \frac{Q}{C}) \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”

SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.


53 http://psychiatryonline.org/

54 http://store.samhsa.gov

55 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.*"

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   ☐ Yes ☐ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   ☑ Yes ☐ No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   The State of Maine supports Evidence Based Treatment of First Episode Psychosis utilizing the components of Coordinated Specialty Care (CSC) approach as developed via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Maine has contracted with Maine Medical Center’s Portland Identification and Early Referral Program (PIER) to provide treatment to up to 30 individuals yearly.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   Maine Medical Center’s PIER program is the first FEP treatment provider in Maine. They are contracted to not only provide for those experiencing FEP, but also train and supervise two community mental health providers model.

   Each youth referred receives individualized from program; all components of coordinated care available each individual/family, it up individual how they will receive services offered by program.

treatment for those experiencing FEP, but also to train and supervise two community mental health providers in the PIER model. Each youth referred to the PIER program receives individualized treatment from the program; all components of coordinated care are available to each individual/family, and it is up to each individual how they will receive the services offered by the program.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ☐ Yes ☑ No

5. Does the state collect data specifically related to ESMI? ☑ Yes ☐ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☐ Yes ☑ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI. The State of Maine chosen EBP for the 10 percent set aside is utilizing components of the Coordinated Specialty Care approach as developed via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis? Maine Medical Center /Portland identification and Early Referral (MMC/PIER) an evidence-based treatment program located at Maine Medical Center in Portland, Maine, the Department’s contract provider will continue the expansion of early identification programs and evidence-based treatment programs for young people ages ten (10) through twenty-six (26) experiencing First Episode Psychosis (FEP) symptoms. Expansion efforts will focus on rural areas of district three (3) (Androscoggin, Franklin, and Oxford counties) for the FY 20 contract. The MMC/PIER services provide evaluations and treatment for persons at risk for, or experiencing onset of psychotic symptoms or actual psychosis. In addition, MMC/PIER provides education to a variety of community stakeholders who are likely to encounter youth ages ten (10) through twenty-six (26) about First Episode Psychosis (FEP). MMC/PIER will continue to offer training, outreach, education and consultation with existing trained Mental Health Agencies in Androscoggin and Kennebec counties. MMC/PIER shall provide training, certification and supervision to a selected group of service providers on Evidence Based Practices of treatment. MMC/PIER will continue to provide referral, evaluation and evidence-based treatment services to qualifying individuals, and will train and incorporate a collaborative arrangement with Certified Youth Peer Supporters as part of the current evidence-based treatment model that the Provider presently has in use. In addition, MMC/PIER will provide outreach education and training services to targeted audiences. MMC/PIER to conduct one large community event for a minimum of 125 community statewide stakeholders, that is free and accessible, includes identifying the FEP system of care, the referral pathways, a component of the Family Psychoeducation training and requirement to become certified in the Coordinated Specialty Care model, and recruitment of clinicians for the Family Psychoeducation training in this forum. Following the community trainings. MMC/PIER will conduct surveys to demonstrate all participants are able to state that training improved their ability to identify early warning signs of psychosis and increased their willingness to refer individual ages 15-26.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI. Individual level and aggregate data are collected by MMC/PIER reported to the DHHS on a quarterly basis. The following examples of outcomes that tracked: school participation, legal involvement, program improved system, substance use, psychiatric hospitalization, use emergency rooms, suicidality, global functioning, employment, social connectedness, emotional well-being, physical health.

10. Please list the diagnostic categories identified for your state’s ESMI programs. Schizophrenia, Schizoaffective Disorder, Bipolar Disorder with Psychosis.

Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning?
   - Yes
   - No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   Through MaineCare Rule making, the state has implemented the use of the ANSA (Adult Needs and Strengths Assessment Tool) that is completed annually to engage consumer and their care givers in creation of their person centered plans. Adult Needs and Strengths Assessment (ANSA) is a multipurpose tool that assesses the needs and strengths of adults seeking behavioral health services. The ANSA may be used to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. This is used in concert with the LOCUS (Level of Care Assessment), which is completed based on an intake interview with adults 18 years and older experiencing mental health challenges and provides a numerical score that can be used to identify level of care indicated.

   Through the Person Centered Planning Process a life plan developed with measurable goals and objectives and is reviewed and changed every 90 days with the consumer and their care provider.

4. Describe the person-centered planning process in your state.

   Rights of Recipients of Mental Health Services; Part B - II. Individualized Support Planning Process
   A. The individualized support planning (ISP) process will result in the development of a life plan based upon the wants and needs of the recipient.

   B. All recipients with severe and prolonged mental illness have the right to an ISP presentation and, if they so choose, an ISP.

   C. For those recipients who accept the ISP process, the following stages will occur:

      A life plan will be developed with the recipient, based upon the recipient's vision of his or her future and will include consideration of all areas that the recipient deems relevant. The time frame of the life plan will be defined by the recipient.

      A list of needs will be developed with the recipient, including those things that need to occur for the recipient to move toward his or her vision of the future. This list should include those needs that appear as unlikely to be met at the time the list is developed.

      The recipient will select the areas that he or she wishes to target for immediate activity, in order to move toward his or her life plan.

      Action plans will be developed in instances in which recipients and providers agree to work toward the achievement of a goal. The action plan will be consistent with the recipient's life plan, priority needs and targets. The action plan will contain the following:
      a. Measurable outcomes;
      b. Criteria for success;
      c. Time frames; and
      d. Assignment of responsibilities.

      D. All unmet needs identified in the ISP process will be reported to the Division of Mental Health. E. ISP's will be reviewed with the recipient no less frequently than every 90 days and revised as needed.
families to address the functional impact of Behavioral Health challenges. The Children’s Behavioral Health Services (CBHS) planning process is a shared partnership between the child/youth and family and the case manager. Children, youth, and families are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources. TCM and BHH ensure available resources are efficiently accessed and being used in a timely and cost effective manner. The CBHS Planning Process is the required planning process for children receiving Children’s Targeted Case Management (TCM) or Children’s Behavioral Health Home (BHH) services funded through the Office of MaineCare Services (OMS). The process is youth guided and family-driven, and while the child/youth is the primary focus, parents and guardians play key roles in identifying needs and preferences for their children as well as services and resources that will be coordinated through TCM and BHH services.

CBHS Planning Process Components:
- Comprehensive Assessment
- Child Adolescent Needs & Strengths (CANS) tool
- Client Personal Profile
- Individual Plan of Care (IPC) with CANS driven goals
- Crisis Plan: Client Specific
- Transition Planning: Client Specific (14+ years)
- Discharge Planning

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

**Footnotes:**
Environmental Factors and Plan

6. Program Integrity - Required

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: [http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf](http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf). States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? [Yes] [No]

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? [Yes] [No]

3. Does the state have any activities related to this section that you would like to highlight?

Maine State contracts, under Rider B Payment and Other Provisions, indicates the Federal Fund Agreement Amount, lists the funding source, CFDA# 93.958 Block Grants for Community Mental Health Services, BO9SM010025-16 Substance Abuse and Mental Health Service Administration.

Additionally, State Planners conduct periodic announced site visits to ensure compliance and understanding of the fiscal and program expectations.

The following language is entered into all SAMHS direct service contracts:
Client Coverage Screening and Billing Methods: MaineCare and Private Health Insurance
1. Ensure that before being provided with services under this Agreement, it shall be determined whether each individual possesses either private health insurance or is a MaineCare Member. If it is determined that the individual:
   a. Is a MaineCare/Medicare Member, then MaineCare/Medicare shall be billed for all services under this Agreement. Payment by MaineCare shall be subject to the standard terms of MaineCare reimbursement;
b. Is a MaineCare Member with a Medically Needy Deductible, then the Recipient of services shall pay for all services provided under this Agreement until the Medically Needy Deductible is met. Once the Medically Needy Deductible has been met, then MaineCare shall be billed for any further services provided under this Agreement. Payment by MaineCare shall be subject to the standard terms of MaineCare reimbursement. Exceptions to this provision may be granted upon written Department approval;

c. Has private health insurance, bill the individual's health insurance carrier for all services provided under this agreement; or
Is neither a MaineCare/Medicare Member, nor has private health insurance, is considered uninsured, then bill the Department for all services provided under this Agreement. Payment by the Department shall otherwise be subject to the standard terms of MaineCare reimbursement.

2. Provide assistance to each individual who is found not to have Mainecare and is receiving services under this Agreement in applying for MaineCare benefits within fourteen (14) days of the date such services are initiated.

Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

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

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

To improve coordinated delivery of essential public health services, Department of Health and Human Services (DHHS) and the Maine Legislature approved the establishment of eight public health districts. District boundaries were established using population size, geographic areas, hospital service areas, and county borders. A District Liaison coordinates a Public Health Unit with co-located Maine CDC staff in one DHHS regional office for every District. The Tribal Health District was established as one of these districts, with its boundaries determined by the Tribal Health Center service areas and services staffed by a Tribal District Health Liaison.

The vision of the Tribal Public Health Unit is to improve the overall health status of the Maine Tribes and American Indian & Alaska Native (AL/AN) populations in our service areas. The Mission of the Tribal Health District Unit is to collaborate and provide public health infrastructure by responding to the Native American people’s needs by:
• Ensuring the effective delivery of the Ten Essential Public Health services through respect of the people and culture.
• Focusing on health issues by providing health promotion, prevention, and education.
• Collaborating, creating and sustaining partnerships with federal, state and local entities.
• Promoting tribal-wide collaboration in public health assessment, planning, implementation, and evaluations.

Tribal Health Facilities are located in the following counties of the state:
- Micmac Service Unit, Presque Isle - Aroostook County.
- Houlton Band of Maliseet Health Department, Littleton - Aroostook County
- Indian Township Health Center, Indian Township - Washington County
Please indicate areas of technical assistance needed related to this section.

Footnotes:
Please respond to the following items

**Criterion 1**

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   Adult: Services and resources available for outpatient care are: Adult-- Mental health services are primarily accessed through MaineCare (Maine’s Medicaid program) Section 13 (Targeted Case Management); Section 17 (Community Support Services); Section 65 (Behavioral Health Services); Section 92 (Behavioral Health Home); Section 93 (Opioid Health Home); and through state general funds.

   Direct Treatment Services are provided by contracted agencies and include: peer to peer services, Community Integration/case management, residential supports and services, daily living supports, Community Rehabilitation Services, Crisis and mobile crisis and crisis outreach services/intervention, outpatient counseling, Jail diversion, Intensive Case Management Program, and Supportive Employment/Long Term Supportive Employment. Evidence based practices such as accredited Club Houses under the International Club House Model, Assertive Community Treatment, Medication Management, Trauma Informed Care, and Behavioral Health Home Models are provided via MaineCare and to individuals without insurance via contract using federal and state funding.

   Children: Youth Peer Support, Targeted Case Management, Behavioral Health Home, Rehabilitative and Community Services, Home and Community Treatment (including EBPs: MST/FFT/MST-PSB/TF-CBT), Crisis Resolution, Respite, Medication Management, and Outpatient Mental Health Services.

   For all MaineCare billable services, assessments are required to determine frequency, intensity and duration of treatment. Some examples of assessments used are: ANSA, CANS, LOCUS, Vineland Adaptive Behavior, ABAS. Each MaineCare billable service requires a different assessment for prior authorization and utilization review. The least restrictive service in the least restrictive setting is always sought for individuals. Prior to authorization for higher levels of care, such as inpatient or residential care, individuals have to have tried outpatient services unsuccessfully.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health
   b) Mental Health
   c) Rehabilitation services
   d) Employment services
   e) Housing services
   f) Educational Services
   g) Substance misuse prevention and SUD treatment services
   h) Medical and dental services
   i) Support services
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   k) Services for persons with co-occurring M/SUDs

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3. Describe your state's case management services

   Adult:
   This service type is defined in the MaineCare Manual Chapter II, Section 17 (Community Supports), as well as Section 13 (Targeted Case Management).

   Section 17:
   17.04-1 Community Integration Services. Community Integration Services involve biopsychosocial - assessment of the member, evaluation of community services and natural supports needed by the member who satisfies the eligibility requirements of Section 17.02, and rapport building through assertive engagement and linking to necessary natural supports and community services while providing ongoing assessment of the efficacy of those services.

   Community Integration Services involve active participation by the member or guardian. The services also involve active participation by the member’s family or significant other, unless their participation is not feasible or is contrary to the wishes of the member or guardian. These services are provided - as indicated on the ISP. These services may not be provided in a group.

   A Community Support Provider furnishing Community Integration Services must employ a certified MHRT/C who performs the following:

   17.04 COVERED SERVICES
   A. Identifies the medical, social, residential, educational, vocational, emotional, and other related needs of the member;
   B. Performs a psychosocial assessment, including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs;
   C. Facilitate formal and informal opportunities for career exploration during service delivery time for working-age and transition age youth participants;
   D. Provides assertive, persistent engagement to build rapport and trust with individuals who may be reluctant to accept those services necessary to meet their individual goals;
   E. Develops an ISP that is based on the results of the assessment in Section 17.04-1(B), which includes:
      1. Statements of the member’s desired goals and related treatment and rehabilitation goal(s);
      2. A description of the service(s) and natural support(s) needed by the member to address the goal(s);
      3. A statement for each goal of the frequency and duration of the needed service(s) and support(s);
      4. The identification of providers of the needed service(s) and natural support(s);
      5. The identification and documentation of the member’s unmet needs; and
      6. A review of the plan at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary.
   F. A goal addressing the member’s needs and access to primary care, specialty care, and routine appointments.
   G. Coordinates referrals, and advocates access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan;
   H. Participates in ensuring the delivery of crisis intervention and resolution services, providing follow-up services to ensure that a crisis is resolved and assistance in the development and implementation of crisis management plans;
   I. Assists in the exploration of less restrictive alternatives to hospitalization;
   J. Makes face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate - services for the member per their ISP;
   K. Contacts the member’s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings;
   L. Provides information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence; and
   M. Assists the member in restoring and improving - communication skills needed to request assistance or clarification from supervisors and co-workers when needed and in -enhancing skills and employing strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job.
   N. Documents evidence of the member’s access to primary and specialty care appointments, to minimally include an annual primary care provider visit. This can be in the form of a clinical note or after visit summary.
A Covered Service is a MaineCare service for which payment can be made by the Department. The following services are covered when provided to an eligible member by an approved Targeted Case Management Agency and qualified staff:

A. Comprehensive Assessment and Periodic Re-assessment of an eligible member to determine service needs, including those activities that focus on needs identification, to determine the need for any medical, educational, social or other services. The comprehensive assessment and re-assessment must be conducted through face-to-face contact with the member and, where appropriate, consultation with other providers and with the member’s family. A comprehensive assessment must be completed within the first thirty (30) days of initiation of services, and reassessment must occur as change in the member’s needs warrants or at a minimum on an annual basis. These activities include but are not limited to the following:

1. Taking client history;
2. Identifying the needs of the individual and completing related documentation; and
3. Gathering information from other sources (family members, medical providers, social workers, and educators) if necessary, to form a complete assessment.

B. Development and Periodic Revision of the Individual Plan of Care is based on information collected through a comprehensive assessment or re-assessment that:

1. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. Because the assessment of the member’s needs must be comprehensive, the individual plan of care must also be comprehensive to address all identified needs. Re-evaluation of the individual plan of care must occur as a change in the member’s needs occurs or at a minimum every ninety (90) days. A member may decline to receive services that have been identified as needs in the individual care plan. If the member declines services listed in the individual care plan, this must be documented in the individual’s case record. This 90 day re-evaluation may be completed by the comprehensive case manager.
2. Develops and periodically revises the Individual Care Plan and to the extent possible:
   a. Ensures the active participation of the member and as appropriate, the member’s parent(s) or legal guardian;
   b. Works with the member (and others as appropriate) to develop goals; and
   c. Identifies a course of action to respond to the member’s assessed needs. For a child, the plan of care must be developed with a Child and Family Team.

C. Referral and Related Activities that help an eligible member obtain needed services. As part of the coordination function, the comprehensive case manager must avoid the duplication of services. The case management referral activity is completed once the referral and linkage has been made. (Referral and related activities do not include providing transportation to the service to which the member is referred, escorting the individual to the service, or providing child care so that an individual may access the service.) These activities are for the purpose of linking the member with medical, social, educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

These activities include:
1. Making referrals to providers for needed services, including documentation, and
2. Scheduling appointments for the member.

D. Monitoring and Follow-Up Activities that include activities and contacts that are necessary to ensure that the individual care plan is effectively implemented and adequately addresses the needs of the eligible member. This includes contact with the member as needed to monitor the care plan objectives and, if appropriate, periodic contact with the member’s family, providers, or other entities. Monitoring may involve either face-to-face or telephone contact. These activities may be conducted as frequently as necessary, but not less than annually, to help determine whether:
1. Services are being furnished in accordance with the individual care plan;
2. Services in the care plan are adequate to address the needs of the member; and
3. Needs or status of the member has changed which requires necessary adjustments in the care plan and service arrangements with providers or service termination.

Children:
Specific Eligibility Requirements for Section 13, Case Management Services:
In order to receive Targeted Case Management Services, members must meet criteria for one of the four following target groups:
A. Members must meet the eligibility criteria for one of the following targeted population groups:
1. Case Management Services for Children with one of the following:
   a. Behavioral Health Disorders,
   b. Developmental Disabilities, and/or
   c. Chronic Medical Conditions.
2. Case Management Services for Adults with one of the following:
   a. Developmental Disabilities,
   b. Substance Abuse Disorders, and/or
   c. HIV.
3. Case Management Services for Members Experiencing Homelessness AND
   B. Render a diagnosis, if a diagnosis is a requirement of a Targeted Case Management Eligibility Group. The diagnosis must be rendered, within the scope of the individual’s license, by a physician, a physician assistant or an independently licensed clinician (as defined in state statute or rule). Functional limitations, must be identified, supported, and documented in assessments using
4. Describe activities intended to reduce hospitalizations and hospital stays.

Adult:
Structured assessment procedures (including ANSA and LOCUS) are implemented to identify appropriate level of care, the lowest of which is eligible for reimbursement. This is enforced to reduce unnecessary usage of higher-than necessary levels of care (as well as ensure clients’ needs are met according to their presentation).
Maine’s PIER program, utilizing the FEP set-aside, emphasizes development of support structures outside the hospital setting within the community, designed to reduce unnecessary hospitalization within this high-risk population.
Maine has recently implemented programs in 10 counties to connect individuals presenting in emergency departments (among other settings) with symptoms related to SUD/co-occurring disorders with high-quality, supervised recovery coaching services in an effort to bring individuals into the recovery community and therein reduce need for high-level services such as hospitalization.
Maine has implemented a pilot project to engage homeless individuals with opioid use disorders and co-occurring disorders with low-barrier MAT, including peer services, intensive case management, and substance use and mental health counseling within the state’s largest metropolitan area, which holds the largest contingent of homeless in the state. This project targets a high-risk, high-need population known to utilize hospital-level services at a high rate, and delivers evidence-based treatment and recovery solutions to reduce relapse in substance use and mental health conditions.

Children:
Resource Coordinators target and develop/increase capacity in communities where children are waiting for community behavioral health services: HCT and Rehabilitative and Community Services. Currently, due to the workforce in Maine, many children are waiting on wait lists for community services. The extended wait times is negatively impacting families, and youth are escalating to higher levels of care as a result of lack of treatment--including hospitalization and Residential Care.
Despite the fact that youth who are exiting hospitals and residential care are automatically placed as a priority on the referral management / wait list for services, the severe shortage of behavioral health workforce has limited the numbers of youth served by each provider. As a consequence, youth remain in higher levels of care for longer periods of time, waiting for a provider to serve them when they go home; this takes up spots for youth who really need the higher level of care.
Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>40,508</td>
<td>15.77% (40,508/256,829)</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>19,049</td>
<td>18.59% (19,049/102,474)</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Prevalence is the total unduplicated count of persons participating in services designed to treat SED/SMI.

Incidence is the percent of the total enrolled population who utilizes services designed to treat SED/SMI.

Maine contracts with KEPRO to provide Prior Authorization/Utilization Review of all MaineCare billable services. KEPRO provides DHHS with the data, and it is used in resource and policy development.

FY19 Total Enrollees 0-20 years of age = 102,474; Total Authorizations for a MaineCare service for 0-20 = 19,049
**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a) Social Services</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
<tr>
<td>b) Educational services, including services provided under IDE</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
<tr>
<td>c) Juvenile justice services</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
<tr>
<td>d) Substance misuse prevention and SUD treatment services</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
<tr>
<td>e) Health and mental health services</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
<tr>
<td>f) Establishes defined geographic area for the provision of services of such system</td>
<td>![Yes]</td>
<td>![No]</td>
</tr>
</tbody>
</table>
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

a. Describe your state’s targeted services to rural population.

Maine SAMHS is currently engaged in research and development of telehealth systems to target rural populations, especially those with limited access to broadband internet.

SAMHS is currently in early stages of development for mobile counseling and medication management units to serve rural populations, especially those with limited access to broadband internet.

Recent legislative projects assigned to SAMHS have featured targeted programs for rural populations, including the geographic location of 7 substance abuse peer support centers (SAPSRCS) in 2018, and the program for individuals who are homeless with opioid use and co-occurring disorders discussed in Criterion 4.b. Washington County, one of Maine’s most sparsely populated counties and among the hardest hit by the opioid epidemic, will also be targeted by a recent legislative initiative as the pilot site to develop advanced and comprehensive referral systems, including a 24/7 referral hotline that is operated by individuals who can provide counseling services.

Transportation to services remains a perennial barrier to services for rural populations, as discussed elsewhere in this application (incl. Planning Step 1 and Environmental Factor and Plan #21). No single comprehensive approach to solve this issue has been identified; however, in addition to the above-discussed tactics, SAMHS has entered into agreements in particularly challenged regions with treatment agencies to directly fund transportation for individuals who achieve reliable transport via other means (especially uninsured populations who cannot access Medicaid-funded transport).

Transportation and telehealth will remain central issues of focus for the Department during the coming grant period.

OCFS-CBHS uses wait list data to perform targeted recruitment of providers in rural Maine. Resource Coordinators are constantly monitoring wait lists for community behavioral health services and have brokered deals with providers to work together to serve youth (ie: one provider has a clinician and the other provider has the BHP--they work together in the HCT team approach to deliver services to a family). This utilization of resources is critical in rural areas of Maine, where wait lists tend to be the longest.

Telehealth is a highly accessible and very under-utilized modality to deliver behavioral health services to rural Maine. Resource Coordinators, provider meetings and the email listserv have been utilized to notify behavioral health providers that telehealth available to them at no additional cost--and allows them to bill MaineCare the same rate as an in-person therapy session.

Finally, transportation is available to MaineCare members in rural Maine for non-emergency transportation needs and is paid for by Medicaid, and includes: NEMT to covered MaineCare or CHIP services; transit to pharmacy for MaineCare covered medications; -Related travel expenses; -Minors traveling with adult due to no child care. OCFS has a transportation contract in place for families participating in reunification with their children for the following transports: Those described in case plan, including: - visits/placement, -healthcare appointments, -therapy/evaluations, & -court dates.

b. Describe your state’s targeted services to the homeless population.

Adult:

To address the SMI/SED and co-occurring substance use disorders in homeless populations, SAMHS administers the PATH program (Projects for Assistance in Transition from Homelessness). The PATH statewide program has been re-designed to more effectively target the rural SMI literally homeless populations in the state. Conducting outreach to the extremely rural homeless populations and ensuring access to services among the same population is a complex issue, and has been reorganized within SAMHS under Resource Development to align it with SAMHS housing resources, the state funded Bridges for Rental Assistant Program (BRAP) and HUD Shelter plus Care Programs. The PATH program measures the following resources on individuals enrolled in the program: housing, medical, behavioral health or mental health resources or a veterans Administrative Service resource as well employment/education. Maine’s PATH program mandates utilization of Homeless Management Information System (HMIS), an electronic data system which tracks and documents homelessness across the United States and in Maine.

Maine’s PATH program mandates utilization of this system for all persons who receive both Outreach/engagement services as well as PATH Enrolled services. Maine’s PATH program is supported by the current administration at a rate of more than 10 times the required federal match—the highest ratio in the country. Maine’s PATH program has been redesigned to focus on the literally, unsheltered, most vulnerable homeless with mental illness and co-occurring substance use disorders first. Maine is committed to ending homelessness, especially among individuals with SMI, with $1.18 million committed in state funding in addition to $300,000 PATH Block Grant Funds.

DHHS lead a paradigm shift from legacy providers and services that often centered on the easiest to serve to new focus on serving the longest, literally, most vulnerable, homeless first. Again borrowing the methodology from Dr. Jeffery Brenner’s ‘Camden Project’ which focuses on the highest utilizers first, we applied this concept to PATH with remarkable results that have earned national recognition:

-25% set aside for persons with lived experience (Peers) to do the actual outreach

-5% set aside to support clinical assessments (this eliminates the provider risk by allowing payment for persons who did not categorically meet Medicaid coverage—those who do meet eligibility requirements receive payment through Medicaid for the assessment.)
HMIS mandate participation of all PATH providers
--Data sharing between all PATH providers (each PATH provider can now 'see' other PATH provider clients)
--Outcome Measures Development
--Housing as a measure for a homeless program, PATH
--Health Care as a measure for PATH
--Behavioral Health (already a measure)

Requirement that PATH provider must be a licensed Community Based Mental Health Agency to ensure and assist in the transition from literally homeless with mental illness to a supportive housing arrangement.

In addition to the PATH program, SAMHS has engaged in a pilot program focused upon serving individuals who are homeless with opioid use and other co-occurring disorders, as this has been identified as a high-risk population for overdose, relapse, and overall poor quality of life. The Medication Assisted Recovery Program (MARP) provides low-barrier access to medication management, substance use and mental health counseling, peer services, and intensive case management. This program is likely to be expanded or duplicated following recent legislation requiring SAMHS to engage in a program that includes all of these facets in addition to a $5m housing fund and intensive outreach to certain target populations (e.g. incarcerated individuals soon to be released). This RFP is scheduled to enter contract beginning 4/1/2020 and will target two locations, one urban and one rural.

Children:
Services to homeless youth include: outreach, drop in, shelter and transitional living programs.
There are currently three providers of homeless services (outreach, drop in, shelter and transitional living services) statewide, one in each region (Portland, Lewiston and Bangor). In addition to the three providers, there are two contracts for outreach only in Dexter and Portland. Youth who have run away or are homeless are eligible for services, and can walk into any youth homeless shelter to receive a meal, shower, laundry facilities and have access to the clothing closet—all free of charge. The outreach providers in each region on Maine know the ‘hot spots’, or where homeless youth congregate in rural Maine, additionally they will travel to any location in Maine to pick up a youth who is homeless and calls for help.

1296 Homeless and Runaway Youth were served in FY19, Per HMIS, Maine Homeless Management Information System.
A RFP for Homeless youth services statewide is about to be published, and new contracts will be in effect on 1/1/2020. Maine will continue to purchase the services previously described.

c. Describe your state’s targeted services to the older adult population.

OADS no longer holds contracts with the MPU’s (Med Psych Units, formally GPU’s). To address the unmet need of older adults with SMI in need of Med Psychiatric Units (MPU), there is an application process for facilities seeking MPU designation that is overseen by the Office of Aging and Disability Services. There are currently 3 MPU’s in Maine (Hawthorn House-Freeport; Mount St Joseph’s-Waterville; and Gorham House-Gorham) serving adults. These MPU beds are designated beds as part of the nursing facility licensure and are monitored by division of licensing and certification.
OADS continues to utilize the Pre-admission Screening and Resident Review (PASRR) as required. The PASRR evaluation process results in care plan development, and recommendation of initial specialized services. PASRR is a required process before any admission to a nursing facility or MPU. Screening is required regardless of the source of payment and whether or not mental illness, intellectual disability or other related condition is known or suspected. 90 days from the completion of the PASRR Level II screening, the Assessing State Agency, Maximus, conducts a 90-day review of the care plan to ensure service implementation. OADS works with Long Term Care Ombudsman and the facilities when a consumer wants or needs to be at a lesser restrictive environment, such as assisted living or other community setting.
If the consumer is in need of PNMI Services as a step down when they no longer meet Nursing Facility (NF), SAMHS is contacted for PNMI referrals and services. If the consumer needs additional community mental health need while in a NF, then the NF arranges that service.
Criterion 5: Management Systems

Describe your state’s management systems.

Financial Resources for the state of Maine mental health services providers consists of a combination of Medicaid, Federal Grants and State General Funds. Maine is experiencing a shortage of workforce for children’s behavioral health services. We are working to enhance the workforce by reaching out to colleges for recruitment activities, and have been working closely with the provider community on enhancing the skill set of behavioral health professionals. Pertaining to Emergency Health Services for individuals with SED/SMI, CBHS has designated staff attending the Maine Disaster Behavioral Health Series--to learn how to respond most effectively in a crisis. The training consists of Psychological First Aid, Critical Response Volunteer Training, and training specific to becoming a disaster volunteer to serve this population effectively in a crisis.

TRAINING INFORMATION: To support Maine’s System of Care, SAMHS has contracted with a training partner, Adcare of Maine, to provide the following trainings to all providers of the Behavioral Healthcare System in SFY19:

- 124 trainings to an estimated 3,038 people in Maine on the following issues: Co-Occurring Disorders, EPBs for adolescents/young adults, Workforce Retention, Working with adolescents, Criminogenic issues, Cultural Competency, Gender Responsiveness, Domestic Violence, Ethics for treatment professionals and supervisor, HIPAA, Prevention and Ethics, CIPPS (Certified Intentional Peer Support), Motivational Interviewing, Training topics for Recovery Coaches, Trauma Informed Care, Telehealth, Pregnancy and Substance Use, Sex and Human Trafficking, Substance Use Disorder and elders, Rural Issues, etc.

- The following Co-Occurring disorder trainings are also available: Prevention approaches to Opiate and Rx misuse, Safe storage & disposal, Opiate Addiction training for veterinarians, Opiate Addiction training for organizations working with veterans, the role of stigma an language in OUD, Opiate Addiction and elders, Using Trauma-Informed prevention to address OUD, Partnering with law enforcement, Maine’s Legal and Regulatory Requirements, and many more.

- In addition, SAMHS has partnered with the Maine Association of Psychiatric Physicians to hold two annual trainings for prescribers to develop further expertise in psychiatric care; an historic difficulty in Maine’s array of services due to a low number of available providers. MAPP also offers ongoing support for physicians who do not have access to psychiatric supervision and seek collaborative consultation with a psychiatric provider regarding care within this domain. This service is offered for free, with psychiatric providers volunteering time to provide assistance throughout the state.

For all providers who have a Mental Health License in Maine, both serving adults and children, the following trainings are required: The agency must have an orientation program that is in place for all new employees that assures that each new employee receives specific information relevant to their duties and the organization.

The agency’s orientation program for new employees that provides training in the following areas:

- Rights of Recipients (Adult and/or Children’s current editions);
- Identification, response and reporting of abuse, neglect, and exploitation;
- Employee’s specific job responsibilities;
- The agency’s mission, philosophy, clinical and other mental health services;
- The agency’s service and therapeutic modalities designed to facilitate health, growth, and recovery;
- The client and family’s right to privacy and confidentiality;
- The physical intervention techniques used, if applicable;
- The determination of the need for training in physical intervention techniques shall be based upon a documented assessment of client’s potential for and history of assaultiveness.

Agencies that do not provide training in physical intervention techniques must be able to document compelling evidence that physical intervention training is unnecessary.

- safety/emergency procedures;
- infection control and prevention;
- the terms of the AMHI Consent Decree, as applicable;
- the perspectives and values of clients of mental health services conducted by a consumer of mental health services.

For children service agencies, the perspectives and values of families are addressed. Children service agencies may also have a family member provide this orientation.

- the individual community support planning process, if applicable;
- the mental health service system;
- the family support services;
- the role state and private psychiatric hospitals play in relation to the agency;
- adverse reactions to psychoactive medications, if applicable;
- child development and children’s educational needs for staff who work with children and/or adolescents;

For staff working with individuals over the age of 60,

- psychogeriatrics and communication techniques with elderly persons; and
- training in the inter-relationship of co-occurring conditions and referral and treatment processes for staff members who work
with individuals with co-occurring conditions.

Additionally, the following requirements must be met for agencies to maintain their Community Mental Health License:

• Each staff member completes orientation within 60 days of hire. New employees shall not be assigned to duties requiring direct involvement with clients until the italicized topics above have been completed.
• The agency must plan for and provide ongoing training and technical assistance to improve staff performance. There must be an agency staff development plan formulated annually which highlights areas for training on issues pertinent to the service(s) offered by the agency.
• There is documented evidence that mental health staff employed 20 or more hours a week participate in at least 20 hours of training annually and/or maintain the number of training hours required by their licensure, whichever is greater.
• There is documented evidence that mental health staff employed fewer than 20 hours per week minimally receive annual training in the following areas: the results of the assessment; and the new agency policies and practices pertinent to the individual's role.

It is up to each individual provider to ensure that their employees are in compliance with the licensing standards/training requirements. Some of these trainings may be provided by Adcare of Maine, while others would have to be provided at the expense of the licensed agency.

OCFS has worked with Disability Rights Maine to create the Children's Rights of Recipient's Training, which was provided to community agencies. Additionally, OCFS partners with Disability Rights about transition called Supported Decision Making. Also, the Children's Behavioral Health Training will continue to be provided to community provider agencies for free. For some contracts with community agencies, OCFS provides in-service training for the staff, this is the same 10-day training that new child welfare workers working for the State of Maine receive.

For FY20-21, SAMHS and OCFS believe that the training resources listed above currently meet the workforce development training needs, as identified by the State and Community. Training plans are developed based on the needs of the State, with input from the community and QIC. As the core training needs as outlined by Maine State Community Mental Health Licensing standards change, OCFS and SAMHS will reassess the need for training enhancements.

Funding is determined by budget allocations and contracts. SAMHS utilizes our workforce development contract to make training available within available resources. SAMHS braids their funding for the workforce development contract in order to support these efforts to greatest extent possible and the changing needs of the behavioral Health environment.
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
   - Yes
   - No

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

**Trauma**[^57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing business as usual? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[^58] paper.

[^57]: Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

[^58]: Ibid

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

1. **Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?**
   - Yes
   - No

2. **Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?**
   - Yes
   - No

3. **Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?**
   - Yes
   - No

4. **Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?**
   - Yes
   - No

5. **Does the state have any activities related to this section that you would like to highlight.**

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

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Footnotes:

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Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.  

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.  

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No

5. Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.

Footnotes:


60 http://csgjusticecenter.org/mental-health/
Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☑ Psychiatric Advance Directives
   c) ☑ Family Engagement
   d) ☑ Safety Planning
   e) ☐ Peer-Operated Warm Lines
   f) ☐ Peer-Run Crisis Respite Programs
   g) ☑ Suicide Prevention

2. Crisis Intervention/Stabilization
   a) ☑ Assessment/Triage (Living Room Model)
   b) ☑ Open Dialogue
   c) ☑ Crisis Residential/Respite
   d) ☑ Crisis Intervention Team/Law Enforcement
   e) ☑ Mobile Crisis Outreach
   f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) ☑ Peer Support/Peer Bridgers
   b) ☑ Follow-up Outreach and Support
   c) ☐ Family-to-Family Engagement
   d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
   e) ☑ Follow-up crisis engagement with families and involved community members

http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427
Recovery community coaches/peer recovery coaches

Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

In 2018, Maine initiated one contract for the statewide crisis toll-free hotline, after years of having each of the 8 Districts being responsible for their own hotline, triage and dispatch. It was a significant adjustment for the entire state crisis system.

In addition to the MaineCrisis Line contract for statewide toll free crisis, each of the 8 districts has one crisis provider contracted to provide both Mobile Response and Crisis Stabilization Units--for both Adults and Children.

The first point of contact for callers is the statewide Maine Crisis Line; callers are triaged and sent to the district mobile providers if their need cannot be resolved telephonically with the Maine Crisis Line.

Once the district team receives the call, the Mobile Crisis provider also attempts to resolve the call on the telephone, but if unable, they dispatch their mobile crisis worker to the community setting of the individual. Contracts are written with statewide providers to encourage them to assess individuals in the emergency room as a last resort--however people are still making their way to Emergency Departments for assessments, and the Mobile Crisis Workers will assess them wherever they are.

Mobile Crisis Workers provide on-site assistance to include de-escalation, stabilization, recovery and follow up services. If needed, Crisis Stabilization/residential services are provided to individuals who cannot safely return home, yet do not require psychiatric hospitalization. Individuals served in CSUs have experienced acute psychiatric episodes, and some are stepping down from psychiatric hospitalization. Contracts are written to ensure that individuals do not have to pay for crisis intervention services, if their insurance does not cover Crisis Intervention, or if they are uninsured.

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

Children Behavioral Health Services is requesting Technical Assistance related to Children’s Crisis intervention.

This is an area that had several recommendations for change in the assessment of Maine’s CBHS (Please see Step 2--Needs/Gaps).

Maine would like to request an expert in crisis intervention come to Maine to meet with State leaders, to bring federal perspective and best practice information, to be used to improve, develop, and increase capacity of crisis intervention for families.

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Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov/.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
5. Does the state have any activities that it would like to highlight?

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?   
   - Yes  
   - No

b) Required peer accreditation or certification?   
   - Yes  
   - No

c) Block grant funding of recovery support services.   
   - Yes  
   - No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?   
   - Yes  
   - No

2. Does the state measure the impact of your consumer and recovery community outreach activity?   
   - Yes  
   - No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Operating from a recovery-oriented framework, services that emphasize support, education/training, rehabilitation, and recovery and services that include natural and community supports and systems that work together to enable consumers to live successfully in their communities. SAMHS strongly supports the Recovery process and has designed our office to specifically include Recovery as one of our pillars. Recovery Supports available and accessible include Recovery Coaching Training and Recovery Coaching. Recovery Peer Support Centers, statewide warm line, recovery telephone support, supported employment, evidence based clubhouses, long-term vocational support, peer support in emergency departments in some hospitals, peer support at Riverview Psychiatric Center, Assertive Community Treatment (ACT) Teams, the Stability Through Engagement Program (STEP) housing program and an Intentional Peer Support Training and Certification Program. Many of these supports are designed to be low-barrier and easily accessible for individuals.

For children with SED, the following recovery supports are available to children and their families: In home supports including Rehabilitative and Community Services, Home Community Treatment, Functional Family Treatment and Multi-Systemic Treatment; Drop In opportunities, Youth Peer Support, Family Peer Support, Warm Lines, Children’s Behavioral Health Planning Process (person centered planning), and Children’s Residential treatment is recovery focused. Both Youth and Families of youth with SED/SMI are eligible to receive Peer Support services. OCFS contracts with two different peer support providers and the services are available in varying intensities and provided statewide. Additionally, through RFP, OCFS will be contracting with homeless youth providers in Maine to ensure that homeless youth receive recovery focused services immediately when they enter the Homeless Continuum of Care.

The Behavioral Health Home model is very focused on recovery, the peer recovery model is integrated into the team approach, and the service is available for both adults and children.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Through the process of MaineCare Rulemaking, the Opioid Health Home was adopted in 2017. The Department adopted this rule pursuant to PL 2017 Ch. 2 Part P Sec. P-1 (“Establishment of Opioid Health Home Program”). On April 11, 2017, the Department adopted an emergency rule which established the Opioid Health Home Service as a MaineCare service. The MaineCare Opioid Health Home (OHH) Services program addresses the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to providing treatment for an individual’s substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. MaineCare members diagnosed with opioid addiction and who have a second chronic condition or are at risk for having a second chronic condition are eligible for these services. The OHH services provide a multi-faceted approach and comprehensive treatment specifically targeted to the opioid dependent population. The program will increase access to treatment options, integrate health and dependency care, and promote stable recovery results. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving.

Peer Run Recovery Centers are Recovery-oriented community services. The focus of these programs has been to primarily provide social, recreational, leisure and some skill building activities from a fixed location to people with Severe Mental Illness (SMI) and co-occurring Substance Use Disorders (SUDs).

The Department seeks to standardize all Recovery-oriented community services by transforming them into Peer Run Recovery Centers. Peer Run Recovery Centers are evidence-based and adjunct to traditional behavioral health care treatment. Peer-run service programs have been evidenced to significantly improve Participants’ wellbeing (hope, empowerment, goal attainment and meaningful life) and to empower Participants by promoting self-efficacy, personal-accountability and self-esteem. The structure, values and provision of this service must be consistent with the Consumer-Operated Service Program (COSP) model. There are currently 9 state-funded Substance Abuse Peer Support Recovery Centers throughout the state, including a recovery hub program, which is tasked with providing technical assistance and training to recovery centers toward quality assurance and improvement. In addition, the state has recently increased support to proliferate peer recovery coaches via training, recruitment, networking, supervision, and outcome measurement, as well as through development of a peer recovery coach certification process for professional credentialing.

5. Does the state have any activities that it would like to highlight?

Over the past 24 months, the state has increased the number of peer centers, including four in counties where there had
previously been none. In addition, the state has increased the level of funding and thereby increased budgets to many existing peer centers, allowing for an increase in number and diversity of peer services. The state has sought to increase the array of services available and involve a novel demographic in peer services with proliferation and support of peer recovery coaching, including putting supportive infrastructure in place for this low-barrier program. Maine’s Certified Intentional Peer Support programs continue to be well attended and receive consistently positive feedback from consumers.

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

Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

**Please respond to the following items**

1. **Does the state's Olmstead plan include:**
   - Housing services provided.
   - Home and community based services.
   - Peer support services.
   - Employment services.

2. **Does the state have a plan to transition individuals from hospital to community settings?**

3. **What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**
   - The Mental Health Rehabilitation Technician / Community Training and Certification processes includes additional emphasis on community inclusion. This certification is required for several community-based services, including Community Integration (Case Management), Behavioral Health Homes, Mental Health Psychosocial Clubhouses, ACT, Crisis Intervention and Community Rehabilitation Services.
   - OCFS utilizes their portion of MHBG funding peer support services; DOC values peer support for the juvenile justice system, and supports it financially.

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment, and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

68. The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  Yes ☐ No ☑
   b) The recovery and resilience of children and youth with SUD?  Yes ☐ No ☑

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare? Yes ☑ No ☐
   b) Juvenile justice? Yes ☑ No ☐
   c) Education? Yes ☑ No ☐

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization? Yes ☑ No ☐
   b) Costs? Yes ☑ No ☐
   c) Outcomes for children and youth services? Yes ☑ No ☐

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes ☑ No ☐
   b) Mental health treatment and recovery services for children/adolescents and their families? Yes ☑ No ☐

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system? Yes ☐ No ☑
   b) for youth in foster care? Yes ☐ No ☑

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

OCFS utilizes the system of care approach to coordinate all services provided to children and families. Behavioral Health Home and Targeted Case Management agencies work diligently to link families to community based services and try to keep youth out of residential settings, when safely possible. The system of care principles are incorporated into all behavioral health contracts, and all efforts are made to support families in their home communities when possible. In addition to treatment such as Outpatient therapy, medication management, Home and Community treatment and Rehabilitation Community Services, Maine recognizes that Youth and Family peer support are services that are critical to support families in their recovery. OCFS is in the process of requesting proposals for statewide Youth and Family peer support providers. In addition to peer support, OCFS offers behavioral health respite, crisis intervention and stabilization units, treatment foster care and will soon offer PRTF services in Maine.

OCFS has maintained strong relationships with other child/young adult-serving state agencies: Department of Corrections-- Juvenile Justice Services, Department of Education, Child Development Services, Office of MaineCare services, Office of Aging and Disability Services and the Office of Substance Abuse and Mental Health Services.

Active collaboration includes monthly meetings with representatives from these teams at a regional level where services are provided to youth and their families; at the policy level where leaders work together to create practice models to support one another; and also at practice level where services to vulnerable populations are shaped, evaluated and promoted, based on outcomes that will improve the well-being of families.

OCFS consists of Child Welfare and Children’s Behavioral Health Services--CBHS is integrated within the Child Welfare offices, and...
the teams operate together very well--ensuring continuity of care for youth involved in Child Protection Services.

7. Does the state have any activities related to this section that you would like to highlight?

Maine's Psychiatric Residential Treatment Facility (PRTF) SPA has been approved by CMS. This is a level of care that Maine has not previously had. Due to the increase in high-level behavioral presentations of youth and need for this higher level of care, we expect that having PRTF in Maine will enable us to bring youth who are currently placed out of state in PRTF back to Maine -- closer to their families and communities, where they can continue to progress toward discharge to community services. There is currently one provider who has expressed interest in becoming a provider in Maine, and OCFS will be meeting with them on September 30, 2019.

General timeline for implementation is January 2020.

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

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  
   - Yes  - No

2. Describe activities intended to reduce incidents of suicide in your state.
   In FY18, the Maine Center for Disease Control and Prevention Suicide Prevention Program (MSPP) trained over 1900 clinicians, educators, and other professionals on evidence-based suicide prevention interventions across the continuum of care, including screening, assessment, treatment, and care coordination for individuals at risk of suicide.

   In 2017, the MSPP received a grant from SAMHSA to implement the National Strategy for Suicide Prevention, with a focus on suicide prevention among adults. Through this grant the MSPP is increasing evidence-based suicide prevention training for medical and behavioral health providers, developing innovative models of outreach and follow-up for individuals at risk of suicide, and working with three behavioral health systems to implement the Zero Suicide model.

   The MSPP promotes awareness and integration of suicide prevention into statewide initiatives and systems.

   The MSPP continues to provide high-quality training and education in suicide prevention to schools, communities, and professional organizations across Maine. In addition to this ongoing work, the MSPP has maximized additional federal funding to develop new strategies and resources, including a web-based Suicide Safer Care Training portal (https://sweetser.academy.reliaslearning.com/). To date, over 600 providers have accessed evidence-based suicide prevention trainings through the Portal.

3. Have you incorporated any strategies supportive of Zero Suicide?  
   - Yes  - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   - Yes  - No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  
   - Yes  - No

   If so, please describe the population targeted.

   Population targeted: Adults 25 years of age or older at increased risk for suicide

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

Footnotes:
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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

• The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

• The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD 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 factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

• The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

• The state public housing agencies which can be critical for the implementation of Olmstead;

• The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

• The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - Yes  
   - No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   - Yes  
   - No

If yes, with whom?

SAMHS has achieved significant growth in development of partnership programs with judicial and corrections systems partners over the past several months. These programs provide treatment and recovery options to individuals with MH and especially SU disorders while engaged in and while transitioning out of these systems. SAMHS has identified this as an area of further growth, as several jurisdictions throughout the state remain isolated either by necessity or choice.

Children:

OCFS has recently been the co-applicant with Department of Education on a SAMHSA grant. The funding supports an initiative called Maine-AWARE (Advancing Wellness and Resiliency in Education), aimed at helping Maine develop a comprehensive framework and infrastructure to support student mental health through effective state and local collaboration between education and health providers.

The project is grounded in a belief that strong implementation of evidence based universal positive behavior and social emotional learning supports coupled with universal behavioral health screening can help schools and communities focus intensive resources on students and families with the greatest need. The project also aims at developing coordinated support services at the school level so that school clinical capacity is maximized and well-articulated with the community’s therapeutic resources.

The framework for building a statewide comprehensive approach to student mental health will be gained through the experiences of an initial implementation with three school administrative units (SAU) which will serve as pilot sites for the initiative: Calais School Department, RSU 10, and RSU 40. They were selected prior to the application submission and are representative of the challenges faced by Maine’s school districts. Factors considered in the selection were geographic location, rate of uninsured children, data from the Maine Integrated Youth Health Survey (mental health and substance use), local employment of a licensed clinical social worker, and existing relationships with community mental health agencies.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality
and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Department of Health and Human Services is moving toward Fee for Service contracts and value based purchasing for services delivered to the public. This ensures a quarterly review of services delivered and maximizes use of dollars spent appropriately. Through the contracting process, performance indicators are established for each contract, that align with both SAMHS and OCFS Strategic Plans. Progress on the performance indicators equals progress toward strategic plan goals and objectives. SAMHS and OCFS are including Office Goals/Objectives in each contract awarded to community agencies.

For all MaineCare billable services, a standard assessment tool is utilized to assess need and measure progress. For SAMHS, the ANSA and LOCUS tools are used to better define acuity and match consumer needs with timely resources; and for OCFS the CANS assessment is used to determine need for TCM and BHH. KEPRO does continued stay reviews to monitor progress in treatment, which forces providers to facilitate discharge planning when level of care is no longer needed.

For OCFS, in addition to the Project AWARE work with DOE, in 2019, Maine Legislature passed a bill "An Act To Promote Social and Emotional Learning and Development for Young Children" This law mandates that "Beginning September 1, 2020, the commissioner shall implement a statewide voluntary early childhood consultation program to provide support, guidance and training to improve the abilities and skills of early care and education teachers and providers working in public elementary schools, child care facilities, family child care settings and Head Start programs serving infants and children who are 8 years of age or younger who are experiencing challenging behaviors that put the infants or children at risk of learning difficulties and removal from early learning and education settings, and to improve the abilities and skills of families and foster parents with infants or children who are 8 years of age or younger in the home who are experiencing challenging behaviors that put the infants or children at risk of learning difficulties and removal from early learning and education settings."

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

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21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The state enables anyone seeking help to be able to access that help. They do this by spending money on the uninsured to make sure they have access to treatment for MH and SA services. The money from the block grant is also used for family, youth and consumer peer services. This helps in the prevention and recovery services.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   Yes ☐ No ☐

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Yes ☐ No ☐

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The council gives feedback to the state on what are the barriers and gaps in MH and SA services. We also held three public forums to gain feedback on the MH and SA services in the state.

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

   none

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.

Footnotes:


70 There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
August 27, 2019

My name is Diane Bouffard and I am the chair of the Quality Improvement Council (QIC) which is Maine’s Mental Health Plaining Council. The QIC was involved in the SAMHSA Block Grant application by soliciting and receiving feedback on the strengths and needs of the Mental Health and Substance Use systems. The QIC held three public forums in the state. The forums were for persons with lived experiences to give feedback on what was going well and what were barriers in the system of care.

There were not many strengths identified other than the convening of the forums which were an opportunity for people to voice concerns in a safe environment free of stigma and shame.

Some of the barriers related to the unavailability of reliable transportation, and many persons with lived experiences live in rural areas where MaineCare transportation is the only option available to them. Another barrier is issues with adults in residential placements and the grievance process; there should be an easy grievance process and it should be independent so there is no chance of fall-back on consumers. There are also 60 children in residential placements outside the State of Maine. This is a massive barrier to families and children in our state. Some other barriers are: the need for MH and SA services at homeless shelters; child abuse due to MH and SA issues; the impact of poverty on persons with lived experiences; need for after-school programming for kids with MH issues; isolation of persons with lived experiences; the need for education of law enforcement about MH and SA issues; teacher training on MH and ACES (adverse childhood experiences); dental health care for adults; and finally, the need for crisis workers to ride with along with law enforcement officers.

One of the biggest barriers that persons with lived experiences are encountering is the long wait lists for services; this is something that then leads the State to spend more money on crisis stabilization services, rather than on direct MH and SA services. We need to build our community supports for persons with lived experiences so they can be healthy and well within our communities.

Diane Bouffard
QIC Chair
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diane Bouffard</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>PO BOX 442 NORRIDGEWOCK ME, 04957 PH: 207-612-8996</td>
<td><a href="mailto:maineqicchair@gmail.com">maineqicchair@gmail.com</a></td>
</tr>
<tr>
<td>Leora Byras</td>
<td>State Employees</td>
<td>education agency</td>
<td>Augusta ME,</td>
<td></td>
</tr>
<tr>
<td>Sue Campbell</td>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td></td>
<td>63 Park St Rockland ME,</td>
<td></td>
</tr>
<tr>
<td>Peter Divine</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>Augusta ME,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genevieve Doughty</td>
<td>Representatives from Federally Recognized Tribes</td>
<td></td>
<td>PO Box 343 Perry ME,</td>
<td></td>
</tr>
<tr>
<td>Victor Dumais</td>
<td>State Employees</td>
<td>MH agency</td>
<td>41 Anthony Ave Augusta ME,</td>
<td></td>
</tr>
<tr>
<td>Karen Evans</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>145 Spring St Apt N Portland ME,</td>
<td></td>
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<tr>
<td>Joel Gilbert</td>
<td>State Employees</td>
<td>Criminal Justice</td>
<td>Augusta ME,</td>
<td></td>
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<tr>
<td>Virgina Jewell</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td>279 Browns Corner Rd Canaan ME,</td>
<td></td>
</tr>
<tr>
<td>Richard Ladd</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>118 Ladd Rd Barnard Twp ME,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vickie McCarthy</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>82 Willow St Apt 3 Augusta ME,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Parks</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>71 Davenport St Augusta ME,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy Pease</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>54 Vermont St Millinocket ME,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Affiliation</td>
<td>Role/Agency</td>
<td>Address</td>
<td></td>
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<tr>
<td>Tara Pelotte</td>
<td>State Employees</td>
<td>Housing agency</td>
<td>41 Anthony Ave, Augusta ME</td>
<td></td>
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<tr>
<td>Andrew Robinson</td>
<td>State Employees</td>
<td>Vocational Rehab Agency</td>
<td>Augusta ME</td>
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</tr>
<tr>
<td>Malory Shaughnessy</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td>295 Water Street, Suite 200, Augusta ME,</td>
<td></td>
</tr>
<tr>
<td>Jeff Tiner</td>
<td>Providers</td>
<td></td>
<td>66 Western Ave, Fairfield ME</td>
<td></td>
</tr>
<tr>
<td>Jessica Wood</td>
<td>State Employees</td>
<td>Social Services Agency</td>
<td>2 Anthony Ave, Augusta ME</td>
<td></td>
</tr>
</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:
## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>14</td>
<td>66.67%</td>
</tr>
<tr>
<td>State Employees</td>
<td>6</td>
<td></td>
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<tr>
<td>Providers</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
<td></td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>7</td>
<td>33.33%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**Footnotes:**

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings? ☐ Yes ☐ No
   b) Posting of the plan on the web for public comment? ☐ Yes ☐ No
      If yes, provide URL:
      In addition to the posting of the most recent application at the link above, the following announcement and fill-in comment form are adjacent to the application that is posted: "The Maine Office of Substance Abuse and Mental Health Services (SAMHS) is seeking input and comment from community stakeholders to guide SAMHS in preparing Maine's applications to the Substance Abuse and Mental Health Administration (SAMHSA)."
   c) Other (e.g. public service announcements, print media) ☐ Yes ☐ No

Footnotes:
The QIC held community Forums in each region of the State to obtain feedback from the public on the State Block Grant Plan. The Forums were advertised to the public and were held in community venues that were not associated with the State Agency (DHHS).
The schedule was as follows: 6/18/19 Augusta (Region II); 6/19/19 Bangor (Region III); 6/27/19 Portland (Region I). A member of the QIC was present at each community forum, and an employee of DHHS attended to take minutes, which were then provided to the QIC as a whole.