Maine

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 01/19/2018 2.51.30 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance
State Information

Plan Year
Start Year 2018
End Year 2019

State DUNS Number
Number 80-904-559
Expiration Date

I. State Agency to be the Grantee for the Block Grant
Agency Name Department of Health and Human Services
Organizational Unit Office of Substance Abuse and Mental Health Services (SAMHS)
Mailing Address 11 SHS, 41 Anthony Ave.
City Augusta
Zip Code 04333-0011

II. Contact Person for the Grantee of the Block Grant
First Name Sheldon
Last Name Wheeler
Agency Name Office of Substance Abuse and Mental Health Services
Mailing Address 11 SHS, 41 Anthony Ave.
City Augusta
Zip Code 04333-0011
Telephone 207-287-2595
Fax 207-287-4334
Email Address Sheldon.Wheeler@maine.gov

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 10/2/2017 3:07:28 PM
Revision Date 1/19/2018 2:50:23 PM

V. Contact Person Responsible for Application Submission
First Name Tara
Last Name Pelotte
Telephone (207) 287-2516
Fax 207-287-4334
Email Address Tara.M.Pelotte@Maine.gov

Footnotes:
# State Information

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

### Fiscal Year 2018

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11988; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
LIST of CERTIFICATIONS

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

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

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee:

Title: _______________________________ Date Signed: _______________________________

If the agreement is signed by an authorized designee, a copy of the designation must be attached.
October 30, 2017

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

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

Dear Ms. Simmons:

This letter is to serve as authorization for Scott Lever, Deputy Commissioner of Health Services, Department of Health and Human Services, to sign for the SAMHSA Substance Abuse Prevention and Treatment 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,

[Signature]
Paul R. LePage
Governor

Cc: Ricker Hamilton, Acting Commissioner, Maine DHHS
Scott Lever, Deputy Commissioner of Health Services, Maine DHHS
Sheldon Wheeler, Director, Office of Substance Abuse and Mental Health Services, Maine DHHS
# State Information

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**Fiscal Year 2018**

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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: Scott Lever

Signature of CEO or Designee: Scott Lever

Title: Deputy Commissioner of Health Services

Date Signed: 12/18/17

mm/dd/yyyy

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

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

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<td>Organization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Footnotes:**
Planning Steps

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

Narrative Question:

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

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

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

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

Maine’s Department of Health and Human Services’ Office of Substance Abuse and Mental Health Services (SAMHS) provides statewide leadership in defining, measuring and improving the quality of services and supports to individuals in need of substance abuse services across the continuum of care: intervention, treatment and recovery. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide a more holistic milieu of services and support to the people of Maine. The new organization consists of the office of the Director and Associate Directors, Treatment and Recovery staff, Quality and Data Team, Special Projects, and Financial and Administrative personnel (see attached organization chart).

The Office of Substance Abuse and Mental Health Services and Maine CDC is centralized in the capital of the state, and contracts with providers statewide to administer necessary services. Through these contracts SAMHS and Maine CDC contribute resources at the public health district level, though unlike other offices, they do not have staff located at the public health district level. SAMHS staff is responsible for contract monitoring, providing technical assistance, and site visits to ensure quality of services being provided.

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

- State of Maine General Fund
- Fund for Healthy Maine (Tobacco Settlement Funds)
- SAMHSA’s Substance Abuse Prevention and Treatment Block Grant
- U.S. Department of Education via MOU with Maine Department of Education (DOE)
- US CDC’s Prescription Drug Overdose: Prevention for States 2015 Grant
- SAMHSA’s Strategic Prevention Framework for Prescription Drugs (SPF Rx) Grant
- SAMSHA’s Maine Youth State Treatment Implementation grant
- SAMSHA’s Opioid State Targeted Response grant

For several years, the state’s substance abuse prevention program was housed under the SSA, the Maine Office of Substance Abuse and Mental Health Services (SAMHS) in Augusta, Maine. In February 2016, the prevention program was moved from SAMHS to the Maine Center for Disease Control and Prevention (Me CDC), to be merged with the tobacco prevention and control program. As a result of this merger, a new program has emerged and is named the Tobacco and Substance Use Prevention and Control Program (TSUPC.) While the new program is still responsible for implementing the 20% set aside of the SAPTBG, they are also responsible for implementing the state’s tobacco prevention and control program. This has provided increased visibility of substance use prevention as a public health issue and has
provided increased opportunities to collaborate with other public health programs. The new TSUPC program has 4 teams that work together with the common goal to reduce substance and tobacco use in Maine and eliminate the consequences of such use. These four teams include the Prevention Team, Clinical Interventions and Data Team, Policy and Communications Team, and Adolescent Health and Injury Prevention Team. In total, there are 12 staff in this program.

While the discussion of how prevention services are delivered in Maine under the Maine CDC will be covered later, there are local and community level prevention providers that are housed across the state. These providers are funded through Maine's federal substance use prevention grants, state funds, and Drug Free Community (DFC) funding.

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

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

In keeping with the requirements of the Substance Abuse Prevention and Treatment Block Grant, all contracted providers are obligated to adhere to the programmatic requirements outlined in their agency contract’s Rider E, which captures the SAPTBG's expectations to prioritize certain populations, such as Pregnant and Parenting Women and IV Drug Users.

PWWDC: Maine has contracts with four agencies for the specific provision of services to pregnant women and women with dependent children from birth through age five. (There are no programs that serve only pregnant women or only women with dependent children, only programs that serve women and families, or block-grant funded contracts where they are prioritized.)
TB: In addition to contractually outlining all the SAPTBG programmatic obligations, the SSA works with the TB Control Officer's Office at the Maine CDC to effectively coordinate services for Persons at Risk for Tuberculosis and a synopsis of the program's efforts is offered below:

The Maine CDC runs a state and federally funded Tuberculosis (TB) Program which serves to eliminate TB by: assuring proper identification and treatment of persons who have active TB disease, preventing the spread of disease to others, finding, screening and treating persons exposed to those with active TB disease, diagnosis and treatment to patients with latent TB infection (LTBI). Federal funds provide program staff to enable surveillance and education of active TB disease. State funds are utilized for diagnosis and treatment efforts for all patients with active TB disease and patients with LTBI who are referred to the program.

Public Health Nursing (PHN) efforts are utilized to support high-risk persons (immunocompromised, substance abuse, homeless, foreign-born, etc.) with LTBI. These patients receive treatment and monthly monitoring through their four- to nine-month course of therapy. They also provide daily directly observed therapy for patients with active TB disease which typically lasts six to nine months, but can be up to twenty-four months. LTBI and active TB disease therapy can be toxic for the liver and is especially dangerous for those with risk factors such as alcohol abuse. PHN uses part of their monthly or daily visits to monitor for medication side-effects to help prevent potentially fatal outcomes.

PWID: The SSA has also further consulted with the Maine CDC, who has oversight of the Needle Exchange Programs, which are “embedded” in their contracted agencies programming, with the understanding that the syringes legally cannot be paid for with federal/State funding (ref. Section 11). All syringes are paid for private funding, such as donations, fundraising, or occasionally “community” grants made by private organizations.

Finally, staff at treatment agencies, schools, health care offices, and social services providers are often from Maine and are sensitive to any economic, educational and/or other healthcare disparities. In addition, the Department’s and provider’s written materials are most often written in “plain language” that is appropriate for people with low literacy skills. Agencies that serve Native Americans have access to culturally appropriate resources and materials, as well as links to the broader Indian communities. Further, the State of Maine adheres to the U.S. Department of Health and Human Service Office of Minority Health regulations regarding the provision of culturally and linguistically appropriate services (CLAS). The State has a strategic plan in place to provide equitable and effective treatment to all those seeking health care. The providers also provide services according to CLAS and are monitored to ensure they are in compliance.

See below for the local and regional entities that provide services funded by the Substance Abuse Prevention and Treatment Block Grant for SFY 2018 and 2019, which are:

**SAMHS Community Substance Abuse Services Block Grant Allocation SFY 2018**

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<thead>
<tr>
<th>Vendor Name</th>
<th>Service</th>
<th>FY2018</th>
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<tbody>
<tr>
<td>Adcare Educational Institute of</td>
<td>Workforce Development And Training</td>
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<td>Organization/Service Provider</td>
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</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------</td>
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<tr>
<td>Maine, Inc.</td>
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<tr>
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<td>Criminogenic Treatment - Hancock</td>
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<tr>
<td></td>
<td>Criminogenic Treatment - Washington</td>
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<td></td>
<td>Intensive Outpatient (SA)</td>
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<td></td>
<td>Residential-ASAM Level 3.5 Other</td>
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<td>Catholic Charities Maine</td>
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<td>Intensive Outpatient (SA) - Portland</td>
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<td>Medication Assisted Treatment (SA)</td>
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<td>Outpatient (SA) - Auburn</td>
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<td>Outpatient (SA) - Portland</td>
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<td>Criminogenic Case Management - Cumberland</td>
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<td>Criminogenic Case Management - Kennebec</td>
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<tr>
<td>Description</td>
<td>City/Native</td>
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<td>Criminogenic Case Management - York</td>
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<td>Day One</td>
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<td>91,062.02</td>
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<td>Adolescent Residential</td>
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<td>Intensive Outpatient (SA)</td>
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<td>FEI.com, Inc</td>
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<td>Support, Maintenance, and Hosting</td>
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<td>Kennebec Valley Mental Health Center dba Kennebec Behavioral Health</td>
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<tr>
<td>Outpatient (SA)</td>
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<tr>
<td>Outpatient-Affected Others</td>
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<td>20,520.00</td>
</tr>
<tr>
<td>Organization</td>
<td>Service Type</td>
<td>Amount</td>
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<tr>
<td>--------------</td>
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<td>MaineGeneral Community Care</td>
<td>Outpatient (SA)</td>
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<td>MaineGeneral Medical Center</td>
<td>Intensive Outpatient (SA)</td>
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<td>Medication Assisted Treatment (SA)</td>
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<td></td>
<td>Overdose Prevention</td>
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<td>Outpatient (SA)</td>
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<td>Mid Coast Hospital - Addiction Resource Center</td>
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<td>Outpatient-Pregnant and Parenting Women</td>
<td>82,080.00</td>
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<td>Milestone Foundation, Inc</td>
<td>Residential-Detox (ASAM 3.7)</td>
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<td>Open Door Recovery Center</td>
<td>Intensive Outpatient (SA)</td>
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<td>Pan Atlantic Research, Inc</td>
<td>Evaluation</td>
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<td>Penobscot Community Health Center, Inc.</td>
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<td>Residential-Shelter</td>
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<td>Rinck Advertising</td>
<td>Preventive Services Media</td>
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<tr>
<td>The Opportunity Alliance</td>
<td>Case Management/Parenting</td>
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<tr>
<td></td>
<td>Case Management-Pregnant and Parenting Women</td>
<td>2,000.00</td>
</tr>
<tr>
<td></td>
<td>Youth engagement &amp; empowerment</td>
<td>112,500.00</td>
</tr>
</tbody>
</table>
Maine continues to have opioids/opiates as high prevalence substances, with an increase in heroin use and overdoses. Maine is attempting to address this and other substance abuse issues through the continued analysis of the data, resources, and capacity of the substance abuse services system at the state and local levels. The allocations of the above funding will shift with the determined need of communities and capacity of service providers to deliver services over this two-year period. This analysis, review, and adjustment process will be ongoing as the state and its partners across all services attempt address substance abuse in Maine.
The role of the SSA is to provide leadership in the realm of the prevention, intervention, treatment and recovery of individuals with addiction, their families and communities. The Office of Substance Abuse and Mental Health Services collaborates with all state agencies and community partners, develops, monitors and improves the lives of those affected by substance use, abuse and addiction across the lifespan.

Intervention Services include: Maine Driver Evaluation and Education Program.

Treatment Services include ASAM – PPC2 Levels of Care as listed in the following:
Detoxification Management, Residential Care, Intensive Outpatient, Outpatient, Co-Occurring Treatment, Medication Assisted Treatment, and Opiate Health Homes. Outpatient and Intensive Outpatient are also being provided through the Drug Court System in Maine.

Recovery Services will include Substance Abuse Peer Recovery Support Centers currently being finalized under the request for proposal review process. These are expected to be located in underserved areas of the state.

Maine has a new structure for the implementation of prevention services in the state. This new system (called Maine Prevention Services) includes 5 domains (Domain 1: Substance Use, Domain 2: Tobacco Prevention, Domain 3: Youth Engagement, Domain 4: Mass Reach Health Communications, and Domain 5: Obesity.) The state of Maine contracts with 5 vendors to provide statewide services under each domain. Each Domain (with the exception of Domain 4) has sub-recipients who provide these services to local communities across Maine. Statewide Substance Use Prevention services are being implemented through a Maine CDC contract with the University of New England (Domain 1 of Maine Prevention Services) who has 21 sub-recipients across Maine who are implementing prevention by using the Strategic Prevention Framework Model (SPF.) They are required to complete an assessment of their communities utilizing data from the SEOW, local level data, and environmental scanning and then determine capacity to implement prevention services. In addition, this assessment includes any special populations within the community to be served and all sub-recipients are required to address any health disparities that may exist. Sub-recipients then develop a work plan based on those assessments after they are provided with a pre-approved list of interventions and activities that they can implement. (See chart below) The sub-recipients then implement the interventions, report on these monthly, and go through a process to evaluate the effectiveness of that intervention for their community.

<table>
<thead>
<tr>
<th>Strategic Approaches (based on CSAP’s strategies)</th>
<th>Must adhere to evidence-based programs and best practice</th>
</tr>
</thead>
</table>
| **Information Dissemination:** This strategy provides awareness and knowledge of the nature and extent of alcohol and other drug use, abuse and addiction and their effects on individuals, families and communities. It also increases knowledge and awareness of available prevention programs and services. This strategy is one-way communication from the source to the audience, with limited interaction. | - Media campaigns  
- Brochures  
- Radio/TV public service announcements  
- Health fairs/health promotion  
- Information line  
- Newsletter Development  
- Social media (e.g. Facebook, Twitter)  
- Web posting (eg. YouTube, pages, blog)  
- Clearinghouse/resource center(s)/directories |
| **Education:** This strategy involves two-way | - Prime For Life program in universal settings |
communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life skills, decision-making, critical analysis, judgment abilities (i.e. Media literacy, classroom - Parenting and family management classes - Peer educators - Education programs for youth groups - Substance Abuse Education Sessions, such as: safe storage, proper disposal of prescription pills, harmful effects of substance abuse - Responsible Beverage Server Seller training)

**Environmental:** This strategy establishes or changes population-based factors* which influence substance use and related problem behaviors.

*Research-based environmental factors are: Access/Availability, Pricing and Promotion, Enforcement of Policy and Laws, Community Norms and Attitudes

- Promoting the establishment or review of alcohol and drug use policies in schools
- Advise and Train regarding enforcement around use and availability of substances such as compliance checks, party patrols, drug take back events, tip lines
- Working with businesses around pricing and advertising strategies for substances
- Promoting Prescription Monitoring Program

**Problem Identification and Referral:** This strategy aims to identify and refer individuals who have illegally used or abused substances. The goal of this strategy is to assess behavior and its impact that can be addressed through education. This strategy is not designed to provide clinical services.

- Promote substance use components of employee and student assistance programs
- Educational intervention/diversion programs for policy/law offenses or incidents (NREPP)

**Community-Based Process:** This strategy builds capacity, readiness and engagement of community stakeholders and target populations in activities that address intervening variables known to impact substance use and abuse.

- Coalition development, stakeholder coordination/collaboration/engagement
- Strategic and sustainability planning
- Youth/adult leadership collaboration
- Data-driven decision making and monitoring

The Prevention system is currently supported at the state level with a variety of funding streams supporting a variety of initiatives. Other services funded through state and/or discretionary grant funds:

- Enforcing Underage Drinking Laws- This is one vendor that coordinates services and distributes funding to sub-recipients (law enforcement agencies) across Maine to implement evidenced based underage drinking enforcement details. This includes funding for details, training for law enforcement, and coordination of a statewide task force.
- Tobacco Compliance (SYNAR)-This is a requirement of the SAPTBG and includes compliance inspections to ensure that tobacco is not being sold to minors in Maine.
- Statewide Clearinghouse of Materials-Housed at the Maine CDC is a statewide clearinghouse of materials that the public can obtain free of charge to disseminate prevention messages, education, and information to youth, young adults, and adults across Maine. This is utilized but UNE sub-recipients as well as several other social service providers across Maine. For more information visit: www.mainepreventionstore.org
- Substance Exposed Infants (SEI) - The Maine Center for Disease Control and Prevention, the Maine Office of Substance Abuse and Mental Health Services, along with the Office of Child and Family Services have joined resources to raise awareness about Substance Exposed Infants and Children across the state of Maine. Over the past several years,
materials and resources such as posters, rack cards, brochures, magnets, and public service announcements have been developed and are now available, free of charge for public dissemination. In addition, the State of Maine has had a Statewide Steering Committee comprised of the above stakeholders as well as an SEI Community Level Task Force with local providers. The goals of both groups are to provide macro and micro services and support to state and community providers in an effort to reduce the number of substance exposed infants in Maine.

- Youth Engagement- The Maine Youth Action Network (MYAN) oversees a statewide network of prevention-focused youth-adult partnerships and youth groups with the overall goals of increasing resilience among youth and reducing youth substance use. This is Domain 3 of Maine Prevention Services. Youth groups include youth policy boards at the district and state level designed to research and implement public health policy change projects, as well as youth groups working more generally on health- and prevention-related efforts. MYAN provides technical assistance to bolster and develop youth-adult partnerships across the state through education and training grounded in positive youth development and social-emotional learning principles.

- Advisory Board-The Tobacco and Substance Use Prevention and Control program in Maine has had an existing Tobacco and Substance Use Prevention Advisory Board that has met bimonthly to provide the program with oversight and consultation in matters related to substance abuse prevention and intervention. It is comprised of state and community-level stakeholders (including Department of Education, Department of Labor, Department of Corrections, community providers, poison center, Child welfare, etc..) with the possibility of the establishment of time-limited subcommittees to tackle specialized tasks and issues as needed. Members of the board serve as advisors and are asked to participate in meetings every other month (for two hours) where the ongoing assessment of the state’s prevention and health promotion infrastructure and state strategic prevention plan occurs.

From the 2013 (5 year) Office of Substance Abuse and Mental Health Services State Prevention Plan, gaps identified in Maine’s prevention system were:
- Need for consistent and adequate funding via the public health infrastructure (Gap: end of SAMHSA Strategic Prevention Framework – State Incentive Grant.) This has been met via Partnership for Success 2015 and SPF-Rx, but the program is looking for continued ways to sustain this work.
- Need for statewide consistent prevention messaging - media.
- Need for support of primary prevention in the schools (Gap: loss of Safe and Drug Free Schools and School Based Health Centers funding and minimal other funding).
- Need for clear education/messaging that increases understanding of perception of harm and costs associated with use.

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

Maine continues to experience an aging workforce and workforce shortages in the behavioral health job sector. Increased focus is being placed on recruitment in the field of addiction services but not at a pace that can stem the tide of the looming workforce shortage. In 2012, SAMHS awarded a Behavioral Health Workforce Development contract to AdCare Educational Institute of Maine, Inc. as the lead agent that is part of the Maine Behavioral Health Workforce Development Collaborative consisting of AdCare ME, the University of Southern Maine – Muskie School of Public Health, and the Co - Occurring Collaborative Serving Maine. This
Collaborative provides Workforce Development Services for substance abuse and mental health services, prevention, intervention, treatment, and recovery providers to maintain a well-trained and credentialed professional and paraprofessional workforce. Each year, the training workplan is developed utilizing strategic need identified by Block Grants as well as training needs identified by SAMHS program administrators and provider input. Recruitment and retention efforts also include a pilot of implementation of an informational program that introduces Maine-based behavioral health career and education paths to high school students, with a focus on juniors and seniors.

We are continuing to work with higher education to infuse addictions related coursework as a requirement in counseling and social work programs, but have repeatedly run up against the college’s accreditation processes and licensing boards (Social workers, clinical counseling). This is an area in which the Maine Behavioral Health Workforce Development Collaborative is partnering with SAMHS to utilize connections of the Collaborative and SAMHS expertise to move this work forward. Progress with Licensing Boards and Academic programs continues to be spotty and slow until changes occur at the national level in terms of accreditation standards and licensing requirements. This contract also supports scholarships to College and University Students in Maine behavioral health programs to the New England School of Additions Studies to engage them early to work within the field.

Additionally, SAMHS is working to build more collaboration with Department of Labor, whose efforts at workforce development have historically focused on physical health care workers. We are exploring opportunities for greater emphasis on behavioral health workforce.

These systems work in tandem to address the needs of diversity in the following ways: Provision within contracts that states there is “no wrong door” when accessing services, assurance of cultural considerations with regard to race, gender and ethnicity via nondiscrimination clause in regulatory and contract language, provision of education and training to increase awareness and appropriate service matching.
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 behavioral health 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 behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data 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, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance 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.

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

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

Through the Healthy People Initiative 1 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.

Footnotes:

Unmet Need within specific Substance Abuse Services for Maine

Maine is geographically expansive and demographically diverse. Service delivery challenges in the more populated, urban areas of south and south-central Maine often differ from those in the other, more rural regions of the state.

The State of Maine Office of Substance Abuse and Mental Health Services use data driven decision making in substance use program planning. Using timely and relevant substance use/risk data enables the Office to ensure substance use prevention and treatment interventions are being implemented statewide, that the intervention is prescriptive/focused, and flexible enough to meet the specific needs of the community. Evaluation of the interventions undertaken is of a high priority, ensuring the intervention has been effective and was an efficient use of allotted funds.

The data sources used to identify the unmet service needs and critical gaps within Maine’s substance abuse prevention, education and treatment system include: Web Infrastructure Treatment System (WITS), National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System (BRFSS), Maine Integrated Youth Health Survey (MIYHS), and Youth Risk Behavioral Surveillance System (YRBSS). To capture variances, unmet need data is compiled by county and/or Public Health District then tabulated statewide. Recent data indicate the following statewide unmet need areas in the 4th quarter SFY17:

Reported Unmet SA Treatment Resource Needs (from WITS)

**May 2017 Wait List**
The following table, from the Kaiser Family Foundation website, demonstrates Maine’s long standing commitment to serving the uninsured. Maine SAMHS uses SAPTBG funds, as well as other State and federal funds, to support only the vulnerable, uninsured populations for overall Intervention, Treatment and Recovery services.

### Health Insurance Coverage of the Total Population, 2016

<table>
<thead>
<tr>
<th>Location</th>
<th>Employer</th>
<th>Non-Group</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Public</th>
<th>Uninsured</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>United States</td>
<td>49%</td>
<td>7%</td>
<td>19%</td>
<td>14%</td>
<td>2%</td>
<td>9%</td>
<td>100%</td>
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<tr>
<td>Maine</td>
<td>49%</td>
<td>5%</td>
<td>21%</td>
<td>16%</td>
<td>1%</td>
<td>7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22%3A%5B%22united-states%22%5D%2C%22wrapups%22%3A%5B%22states%22%5D%2C%22sortModel%22%3A%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%2C%22reverse%22%3Afalse%7D

### Treatment Admissions for IV Drug Users in Maine
The State of Maine has seen a significant increase in treatment admissions for IV Drug Users over the past several years, as evidenced by SAMSHA’s recent preselection of Maine to apply for the Medication Assisted Treatment – Targeted Capacity Expansion funding opportunity. This information was collected and reported through the State of Maine WITS system. The most recent CY16 and C17 admissions data shows promise (but not enough data to reflect a trend), and demonstrates Maine’s serious commitment to pivoting resources where hot-spotting has broadcast the area of greatest need, as well as expanding the availability of treatment and recovery services wherever possible. Maine continues to lead the nation on the topic of substance abuse prevention and treatment, and the efforts seem to be paying dividends as more affected Mainers are able to lead safe, healthy and productive lives.

#### Population:  Total Clients in Service CY 2016 (raw data)
- Pregnant Women: 251
- Women w/children: 2,797
- Co-Occurring: 2,745
- IVDU: 4,687
- Homeless: 2,116

#### Population:  Total Clients in Service CY 2017 (raw data)
- Pregnant Women: 117
- Women w/children: 1,225
- Co-Occurring: 1,265
- IVDU: 2,365
- Homeless: 1,273

The State of Maine does not currently have the ability to accurately track the number of Data 2000 Waived Physicians in our state or the number of patients receiving Buprenorphine Services. As of September 2017 the state of Maine has 10 OTP’s that provide Methadone Maintenance Treatment (MMT). Six (6) of the OTP’s also provide Buprenorphine. Three (3) OTP’s currently provide IOP services to patient’s and seven (7) have recently been approved as Opioid Health Homes; an integrated care delivery model which links primary care with traditional MAT/Behavioral Health therapies and recovery supports. Due to the vast size of the state patients often must travel up to 5 hours a day to access treatment.
Maine IVDU Admissions by Age Group: (chart)

**This information was not available at the time of submission, but is expected to be made available shortly.

IVDU Admissions* by Age at the time of Admission (table)

**This information was not available at the time of submission, but is expected to be made available shortly.

Pregnant Women and Women with Dependent Children
Healthcare providers file reports with the Office of Child and Family Services (OCFS) when infant exposure to illegal substances is suspected, the infant demonstrates withdrawal symptoms or the infant has fetal alcohol spectrum disorder. The data is collected in the Maine Automated Child Welfare Information System (MACWIS). The data shows that the total number of drug affected babies born in the State has steadily increased over a nine year period. The average rate of drug affected babies per 10,000 residents by public health district indicates that the highest rates occur in the State’s more rural districts (Central, Penquis, Downeast, Western and Aroostook) where there are fewer services and challenges to accessing treatment. There are fewer DAB births per 10,000 residents in the higher populated districts (Cumberland, Midcoast, York) where more treatment options and supportive services are available. (Please see the SEOW (State Epidemiological Outcomes Workgroup) Short Report, Drug Affected Babies by County and Public Health District (2006-2014) at:

Also see the CY16 raw data, county-level referral report from MACWIS:
There is no data available specific to women with dependent children in need of substance abuse treatment, however, SAMHS is currently working with providers to provide waitlist information on a monthly basis. Once this is instituted, SAMHS will have the capability to estimate need based on those waiting for services. However, SAMHS’ treatment data for FY12, FY13 and FY14 show that 19% of all clients in treatment are parenting women. In addition, family risk factors identified in child protective assessments give us an indication of the incidence of parental substance use in child protective cases. As reported in Maine’s Child Protective Services Annual Report 2014, alcohol misuse by a parent is a risk factor in 11% of cases (average across three years) and drug misuse by a parent is a risk factor in 19.3% of cases. Mental health problems are also identified as a risk factor in 45% of the assessments. (http://www.maine.gov/dhhs/ocfs/cw/reports/cps_reports.shtml) Services which focus on the priority population of pregnant women and women with dependent children are limited in the State. As discussed in Section 19 there are four programs. One of these programs is a residential treatment, one is a home-based outpatient program and two are women’s substance abuse case management. Only the women’s case management program is statewide. There is a need for more services which provide various levels of treatment and which extend to women in underserved areas of the state.

**Tuberculosis cases in Maine**
SAMHS collaborates with the Maine Center for Disease Control and Prevention to improve outreach to those in substance abuse treatment services to have TB screening and treatment services available to this population. Included in the substance abuse treatment services contracts with agencies is language that these services (screening, testing, counseling, and case management) must be made available to those in Substance Abuse

### CALENDAR YEAR 2016

#### DAB REFERRALS COUNTS BY COUNTY

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>COUNT</th>
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<td>Androscoggin</td>
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<td>Aroostook</td>
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<tr>
<td>Cumberland</td>
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<td>Somerset</td>
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<td>Waldo</td>
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<td>Washington</td>
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<td>York</td>
<td>91</td>
</tr>
<tr>
<td><strong>STATEWIDE TOTAL</strong></td>
<td><strong>1024</strong></td>
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</table>
treatment. All contracted SA treatment agencies must report all active TB cases to the Maine Center for Disease Control and Prevention.

**TB Trend Data:**
The most recently published data comes from the Maine CDC TB/LTBI Registry. Number of positive TB cases reported: SFY 15 there were 9 cases; SFY 14 was 19 cases; SFY 15 had 18 confirmed cases.

(See the full report for more information and subdata):

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**Infectious Disease Epidemiology Report**

**Tuberculosis, 2015**

**Background**

Tuberculosis (TB) is caused by the bacteria *Mycobacterium tuberculosis*. The bacteria are spread through the air by droplets when a person with infectious TB coughs, talks, sings, or sneezes. Tuberculosis is only infectious when the disease is in the lungs (pulmonary) or larynx. Extrapulmonary disease occurs outside of the lungs or larynx and is not infectious. Latent tuberculosis infection (LTBI) occurs when the body's immune system keeps the bacteria under control and inactive, so that disease does not develop. Individuals with LTBI are not symptomatic and not infectious to others.

**Methods**

Two tests are available to screen for tuberculosis. The TB skin test, called the tuberculin skin test (TST), has been used for many years. A newer blood test called interferon gamma release assay (IGRA) is also available. Neither test differentiates between latent or active TB. All positive results require additional evaluation.

Maine monitors the incidence of active TB through mandatory reporting by health care providers, clinical laboratories, and other public health partners. Although not reportable, Maine also monitors LTBI diagnoses.

All TB patients in Maine are evaluated by a healthcare provider in consultation with a TB consultant physician and receive case management services and directly observed therapy (DOT) by a Public Health Nurse (PHN). Maine’s TB Control Program routine reviews case management with PHN and the Medical Epidemiologist. The cases are also reviewed with TB Consultants at quarterly meetings.

A patient with confirmed TB must meet either clinical criteria or be laboratory confirmed with one of the following tests: isolation of *M. tuberculosis*, demonstration of *M. tuberculosis* by polymerase chain reaction (PCR), or demonstration of acid-fast bacilli when a culture has not been or cannot be obtained. Positive cultures for *M. tuberculosis* complex are tested for drug resistance.

**Results**

A total of 18 confirmed cases of TB were reported in 2015 (Figure 1). Of these, one case was resistant to pyrazinamide and one case was extensively drug resistant (XDR).

**Figure 1. Number of Tuberculosis Cases by Year, Maine, 2011-2015**

The incidence rate of TB in Maine in 2015, 1.4 cases per 100,000 persons, was less than the national rate of 3.0 (Figure 2). Nationwide, the case rate increased from 2014 by 3.4%.

**Figure 2. Incidence of Tuberculosis, Maine and United States, 2006-2015**

The median age of TB cases was 46 years (range 1 - 87 years). Cases resided in five counties, Androscoggin (7), Cumberland (8), Piscataquis (1), Somerset (1), and York (1).
Substance Use Prevention Data:
The Maine CDC prevention program relies heavily on the State Epidemiological Outcomes Workgroup (SEOW) to gather and collate data for the program to assist with the identification of strengths, gaps, and needs. The annual State Epidemiological Profile highlights data and progress related to all the prevention priorities identified in the state prevention strategic plan: underage drinking, high-risk drinking among 18-25 year olds, misuse of prescription drugs among 18-25 year olds, marijuana use in 12-25 year olds. The SEOW produces Community Epidemiology Profiles, for each public health district in Maine which mirrors the state-level analysis and includes any data sources that are available and reliable at the sub-state level. Key findings of the reports are highlighted in biannual webinar presentations facilitated by the SEOW Coordinator and in factsheets and briefs regarding Maine data on alcohol use, prescription drug misuse, and marijuana use, as well as mental health. In addition, the SEOW produces factsheets on substance use and mental health among vulnerable populations such as those who are 18 to 25 years old, veterans, and those who identify as LGBTQ (Lesbian, Bisexual, Transgender, Transgender, or Questioning). Factsheets are designed for dissemination among prevention coalitions, parents, community members, stakeholders, and decision-makers and use infographics that are eye catching and easy to read. All SEOW resources are widely distributed on the Maine Prevention field and Maine community coalition listserves and posted on the State of Maine website for prevention professionals to utilize. Within the past two years, an SEOW data dashboard has been developed to make data more accessible to the state, providers, and public in general.

While there are many sources of data utilized by the program, the following outcome data is used most prevalent: Maine Integrated Youth Health Survey (MIYHS), Behavioral Risk Factor and Surveillance Systems (BRFSS), Maine Department of Transportation (MDOT), National Survey on Drug Use and Health (NSDUH), Unified Crime Report (UCR), Maine Health Data Organization (MHOD).

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Data Source(s)</th>
<th>Population</th>
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<tr>
<td>Past 30-day Alcohol Use</td>
<td>MIYHS</td>
<td>Mid School</td>
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<tr>
<td></td>
<td></td>
<td>High School</td>
</tr>
<tr>
<td></td>
<td>NSDUH</td>
<td>12-20</td>
</tr>
<tr>
<td>Binge Alcohol Use (Past 30 day)</td>
<td>MIYHS</td>
<td>Mid School</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High School</td>
</tr>
<tr>
<td></td>
<td>NSDUH</td>
<td>12-20</td>
</tr>
<tr>
<td>Prescription Drug Misuse (Past 30 day, Lifetime use)</td>
<td>MIYHS</td>
<td>Mid School</td>
</tr>
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<td></td>
<td></td>
<td>High School</td>
</tr>
<tr>
<td></td>
<td>NSDUH</td>
<td>18-25</td>
</tr>
<tr>
<td>Marijuana Use (Past 30 day, Lifetime use)</td>
<td>MIYHS</td>
<td>Mid School</td>
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<td>High School</td>
</tr>
<tr>
<td></td>
<td>NSDUH</td>
<td>18-25</td>
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<tr>
<td>Perception of parental disapproval</td>
<td>MIYHS</td>
<td>Mid School</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High School</td>
</tr>
<tr>
<td>Perceived risk of harm</td>
<td>MIYHS</td>
<td>Mid School</td>
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<td>High School</td>
</tr>
<tr>
<td></td>
<td>NSDUH</td>
<td>18-25</td>
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<tr>
<td>Alcohol/drug related car crashes (Annually)</td>
<td>MDOT</td>
<td>16-25</td>
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<td>Alcohol and drug related crime (Annually)</td>
<td>UCR</td>
<td>Under 18</td>
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<td>18+</td>
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<tr>
<td>Family communication around drug use (Annually)</td>
<td>MIYHS</td>
<td>Mid School</td>
</tr>
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<td></td>
<td></td>
<td>High School</td>
</tr>
<tr>
<td>Alcohol and prescription drug-related ER visits</td>
<td>MHDO</td>
<td>Under 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18+</td>
</tr>
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</table>

In 2013, the state received a supplemental grant to expand the work of the SEOW, including the development of a web-based interactive data dashboard system (www.maineseow.com) to track progress in reducing underage and high risk drinking, marijuana use and prescription drug misuse, building on the data structure and content developed for the original SEOW project. This dashboard has been designed with the SEOW...
objectives in mind to provide a snapshot of the current status of a particular substance, show longer-term trends, focus on a particular population or to make special comparisons. To accommodate these diverse needs, the indicators included in this dashboard can be searched in multiple ways: by the substance, target population, or major category (e.g., consumption, consequence). It is the hope of Maine’s SEOW that this dashboard will help communities in building their capacity to address their needs and prevention priorities through data driven decision-making and evaluation. Dashboard Data is updated regularly.

Multiple SEOW resources were produced within the past 12 months (including a state profile, district profile, fact sheets, and webinars) are posted to the Maine SEOW Dashboard [www.maineseow.com](http://www.maineseow.com)

Members of the SEOW are as follows:

**Maine CESN/SEOW Member List**

<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Individual Representative(s)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Caputo, Christina</td>
<td>Viral Hepatitis Coordinator</td>
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<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Birkhimer, Nancy</td>
<td>Director of Performance Improvement</td>
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<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Montagna, Chris</td>
<td>Forensic Chemist Analyst, Health Lab</td>
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<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Damren, Melissa</td>
<td>BRFSS Coordinator, Comprehensive Health Planner</td>
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<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Joel Johnson</td>
<td>Informatician</td>
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<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Robinson, Sara</td>
<td>Epidemiologist, Infectious Disease</td>
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<td>Bosse, Patricia</td>
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<td>DHHS/CDC</td>
<td>Pierce, Steve</td>
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<tr>
<td>DHHS/MaineCare Services</td>
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<td>Director of Change and Data Management</td>
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<tr>
<td>DHHS/Office of Substance Abuse &amp; Mental Health Services</td>
<td>Rogers, Anne</td>
<td>Data and Research Manager</td>
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<td>DHHS/Office of Substance Abuse &amp; Mental Health Services</td>
<td>Johanna Buzzell</td>
<td>Prescription Monitoring Program Coordinator</td>
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<tr>
<td>Department of Education</td>
<td>Jean Zimmerman</td>
<td>HIV Prevention Education Coordinator</td>
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<tr>
<td>Department of Public Safety (DPS), Bureau of Highway Safety</td>
<td>Stewart, Lauren</td>
<td>Highway Safety Manager</td>
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<td>McKinney, Roy</td>
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<td>Powers, Jonathan</td>
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<td>DPS, Maine Information and Analysis Center</td>
<td>Brawn, Rogers</td>
<td>Intelligence Analyst</td>
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<td>DPS, Bureau of Highway Safety</td>
<td>Voisine, Jessica</td>
<td>Highway Safety Coordinator/Fatal Accident Reporting System Analyst</td>
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<td>Brunell, Duane</td>
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<tr>
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<td>University of Maine</td>
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<td>Associate Research Professor</td>
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<tr>
<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Reid Plimpton</td>
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<td>Public Safety/New England HIDTA/Maine Information and Analysis Center</td>
<td>Minkowsky, James</td>
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<td>Johnston, Michael</td>
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<td>Monica St. Clair</td>
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<tr>
<td>DHHS/Center for Disease Control &amp; Prevention</td>
<td>Christine Theriault</td>
<td>Tobacco and Substance Use Prevention and Control Manager</td>
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<td>Maine CDC</td>
<td>Pezzullo, Chris</td>
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<td>Patricia Lech</td>
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<td>Kim Haggan</td>
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<td>Prescription Monitoring Program/SAMHS</td>
<td>Johnson, Bobbie J.</td>
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<td>Cummings, Jessica</td>
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<td>Dept. of Labor</td>
<td>O'leary, Amanda</td>
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<td>Office of Child and Family Services (OCFS),</td>
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<td>DHHS/MCDC ODRVS</td>
<td>Tom Patenaude</td>
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<tr>
<td>CDC</td>
<td>Dyer, Heather</td>
<td>Chemist</td>
</tr>
<tr>
<td>CDC</td>
<td>Pease, Maria</td>
<td>Chemist</td>
</tr>
<tr>
<td>EMS</td>
<td>Nangle, Timothy</td>
<td>Data coordinator</td>
</tr>
<tr>
<td>211 Maine</td>
<td>Banta, Neil</td>
<td>Analyst</td>
</tr>
</tbody>
</table>
Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

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

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

Footnotes:
Quality and Data Collection Readiness

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

   *Providers of substance abuse services must provide client, program, and provider data per state regulation and contractual obligations. The platform for the collection of substance abuse treatment data is WITS. WITS data is transferred at least twice monthly into TEDS.*

   *Maine currently collects the following information on all substance abuse clients treated at a licensed agency and by many private providers: Name or initials, social security number, date of birth, agency and facility treated at, type of service, demographic information, substance use, dates of first call, admission and discharge, living situation, employment, prior service, MH and SA hospital admissions, special population data, payment source and financial status, legal status, if co-occurring, children/dependents, attendance at self-help; most information as required by TEDS.*

   *Maine is currently seeking to upgrade its WITS infrastructure by 1) incorporating data for use by Maine’s drug court system and 2) an upgrade to assist in the interconnectivity with electronic health records (EHR) of large organizations. Currently, those organizations with their own EHR’s have to double enter data to comply with state regulations.*

   *Maine also has a pending TA Tracker request which it expects to submit shortly, which requests federal guidance in navigating 42 cfr in order to implement a proposed, fully-integrated, multi-program, co-occurring supportive, information technology treatment system.*

   *Finally, prior to implementing any new project plan, SAMHS visits the NREPP site, which is SAMSHA’s warehouse of EBPs, and SAMHS also reviews SAMSHA’s other recommendations on EBPs and Best Practice. This is done in order to verify that any data collected is in accordance with documented evidence based or emerging practice.*

   *Substance use prevention services implementation data is collected through an elaborate excel system that is housed with the University of New England (the lead vendor for substance use prevention services.) This system collects data from community level sub-recipients on intervention type, demographics of those served, number of people served/reached, and geographical information of service. The Maine CDC receives these reports monthly. Other prevention services provided utilizing SAPTBG funding report to the State of Maine through monthly reports including similar data sets depending on the service. Prevalence data which is used to assist with program planning as well as identifying areas of strength and improvement is collected typically through the Maine Integrated Youth Health Survey (MIYHS) every other year. This measures consumption, perception of harm, perception of getting caught, and other risk factors. Maine also utilizes BRFSS and NSDUH data for program planning.*
2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.)

The Office of Mental Health and Substance Abuse Services utilizes two systems for the collection of substance abuse and mental health data. As stated in #1, WITS captures all substance abuse data. Kepro Acquisitions, using their Atrezzo platform, is the mental health utilization review provider. This data is transferred into a state-owned system, EIS.

WITS captures all substance abuse data for adolescents and adults. It captures gender, ethnicity, race, special needs, veteran’s status, pregnant/not, HIV status, injection drug user, hep c, and shared needles.

At the time of admission and discharge, payment source is captured.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

Yes.

4. If not, what changes will the state need to make to be able to collect and report on these measures?
Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

| Priority # | 1 |
| Priority Area: | Youth & Young Adults at risk for Substance Abuse |
| Priority Type: | SAP |
| Population(s): | PP |

Goal of the priority area:
Reduce the use, misuse, and abuse of alcohol, marijuana and prescription medications among youth 12-17 years old and young adults aged 18 to 25.

Objective:
Reduce the use, misuse, and abuse of alcohol, marijuana and prescription medications among youth 12-17 years old and young adults aged 18 to 25 by 2.5% annually. Year 1 targets represent a 2.5% reduction from baseline estimates. Year 2 targets represent a 5% reduction from baseline estimates.

Strategies to attain the objective:
1. Engage local public health coalitions to implement evidence-based environmental strategies utilizing the Strategic Prevention Framework Model (SPF) in their service area to reduce use and misuse of alcohol.
2. Support the PMP promotion project with resources to educate health care providers and the public about the misuse of prescription medications.
3. Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices.
4. Create statewide messages and material for use by prevention providers on alcohol, marijuana and prescription medications.
5. Provide Education and Technical Assistance to support the enforcing underage drinking laws environmental strategies statewide.
6. Provide evidence-based universal, indicated and selected population prevention programming throughout the state based on data and evidence of effectiveness.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | 30 Day Alcohol Use of 7th – 8th graders in Maine |
| Baseline Measurement: | SFY15 – 3.9% of 7th – 8th graders in Maine used alcohol in the past 30 days. |
| First-year target/outcome measurement: | SFY18 – 3.8% 7th – 8th graders in Maine/past 30 day alcohol use. |
| Second-year target/outcome measurement: | SFY19 – 3.71% 7th – 8th graders in Maine/past 30 day alcohol use. |
| Data Source: | Maine Integrated Youth Health Survey |

Description of Data:
Past 30 day alcohol use among Maine’s 7th-8th grade population. This is an existing measurement within the survey.

Data issues/caveats that affect outcome measures:
Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.

| Indicator #: | 2 |
| Indicator: | Past 30 day alcohol use among Maine’s 9th to 12th grade population |
| Baseline Measurement: | SFY15 – 23.8% of 9th – 12th graders in Maine used alcohol in the past thirty days. |
| First-year target/outcome measurement: | SFY18 – 23.21% of 9th – 12th graders in Maine/past thirty day alcohol use. |
| Second-year target/outcome measurement: | SFY19 – 22.61% of 9th – 12th graders in Maine/past thirty day alcohol use. |
### Data Source:

Maine Integrated Youth Health Survey (MIYHS)

### Description of Data:

Past 30 day alcohol use among Maine's 9th to 12th grade population. This is an existing measurement within the survey.

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

Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 day alcohol use among Maine's 12 to 20 year olds in Maine</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY15 – 25.7% of 12-20 year olds in Maine used alcohol in the past thirty days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY18 – 25.06% of 12-20 year olds in Maine/past 30 day alcohol use.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY19 – 24.42% of 12-20 year olds in Maine/past 30 day alcohol use.</td>
</tr>
<tr>
<td>Data Source</td>
<td>National Survey on Drug Use and Health (NSDUH)</td>
</tr>
<tr>
<td>Description of Data</td>
<td>Past 30 day alcohol use among Maine’s 12 to 20 year olds in Maine. This is an existing measurement within the survey.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>n/a</td>
</tr>
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</table>

### Data Source:

National Survey on Drug Use and Health (NSDUH)

### Description of Data:

Past 30 day alcohol use among Maine’s 12 to 20 year olds in Maine. This is an existing measurement within the survey.

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

n/a

<table>
<thead>
<tr>
<th>Indicator #</th>
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</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 day alcohol use among Maine’s 18-20 year old population</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY15 – 41.6% of 18-20 year olds in Maine used alcohol in the past thirty days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY18 – 40.56% of 18-20 year olds in Maine/past thirty day alcohol use.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>FY19 – 39.52% of 18-20 year olds in Maine/past thirty day alcohol use.</td>
</tr>
<tr>
<td>Data Source</td>
<td>Behavioral Risk Factor Surveillance Survey, BRFSS</td>
</tr>
<tr>
<td>Description of Data</td>
<td>Past 30 day alcohol use among Maine’s 18 to 20 year olds in Maine. This is an existing measurement within the survey.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>Data is delayed with when it is provided and due to small sample sizes, multiple years need to be combined for achievement of data sets.</td>
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</table>

### Data Source:

Behavioral Risk Factor Surveillance Survey, BRFSS

### Description of Data:

Past 30 day alcohol use among Maine’s 18 to 20 year olds in Maine. This is an existing measurement within the survey.

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

Data is delayed with when it is provided and due to small sample sizes, multiple years need to be combined for achievement of data sets.

<table>
<thead>
<tr>
<th>Indicator #</th>
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</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 day prescription drug misuse among Maine’s 7th-8th grade population.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY15 – 2.2% of 7th – 8th graders in Maine misused prescription drugs in the past thirty days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY18 – 2.15% of 7th – 8th graders in Maine/past thirty day prescription drugs misuse.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY19 – 2.09% of 7th – 8th graders in Maine/past thirty day prescription drug misuse.</td>
</tr>
<tr>
<td>Data Source</td>
<td>Behavioral Risk Factor Surveillance Survey, BRFSS</td>
</tr>
<tr>
<td>Description of Data</td>
<td>Past 30 day prescription drug misuse among Maine’s 7th-8th grade population. This is an existing measurement within the survey.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>Data is delayed with when it is provided and due to small sample sizes, multiple years need to be combined for achievement of data sets.</td>
</tr>
</tbody>
</table>
### Maine Integrated Youth Health Survey

**Description of Data:**
Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.

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

n/a

<table>
<thead>
<tr>
<th>Indicator #</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Past 30 day prescription drug misuse among Maine's 9th to 12th grade population.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>SFY15 – 4.8% of 9th – 12th graders in Maine misused prescription drugs in the past thirty days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>SFY18 – 4.68% of 9th – 12th graders in Maine/past thirty day prescription drug misuse.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>SFY19 – 4.56% of 9th – 12th graders in Maine/past thirty day prescription drug misuse.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Maine Integrated Youth Health Survey (MIYHS)</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Past 30 day prescription drug misuse among Maine's 9th to 12th grade population. This is an existing measurement within the survey.</td>
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<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.</td>
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<tr>
<th>Indicator #</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Lifetime misuse of prescription drugs among Maine's 18-25 year old population.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>SFY15 – 9.4% of 18-25 year old in Maine misused prescription drugs in their lifetime.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>SFY18 – 9.17% of 18-25 year olds in Maine/lifetime misuse of prescription drugs.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Behavioral Risk Factor Surveillance Survey, BRFSS</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Lifetime misuse of prescription drugs among Maine's 18-25 year old population. This is an existing measurement within the survey.</td>
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<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>To ensure reliable/accurate estimates, three years' worth of survey data is combined. Baseline would be for the period of 2013-15. Estimates for 2014-16 are anticipated early 2018.</td>
</tr>
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</table>

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<tr>
<th>Indicator #</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Past 30 day use of Marijuana among Maine's 7th-8th grade population.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>SFY15 – 3.8% of 7th – 8th graders in Maine used marijuana in the past thirty days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>SFY18 – 3.71% of 7th – 8th graders in Maine/past thirty day marijuana use.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>SFY19 – 3.61% of 7th – 8th graders in Maine/past thirty day marijuana use.</td>
</tr>
<tr>
<td>Data Source:</td>
<td></td>
</tr>
</tbody>
</table>
Maine Integrated Youth Health Survey (MIYHS)

Description of Data:
Past 30 day use of Marijuana among Maine’s 7th-8th grade population. This is an existing measurement within the survey.

Data issues/caveats that affect outcome measures:
Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.

Indicator #: 9
Indicator: Past 30 day use of marijuana among Maine’s 9th to 12th grade population.
Baseline Measurement: SFY15 – 19.6% of 9th – 12th graders in Maine used marijuana in the past thirty days.
First-year target/outcome measurement: SFY18 – 19.11% of 9th – 12th graders in Maine/past thirty day marijuana use.
Second-year target/outcome measurement: SFY19 18.62% of 9th – 12th graders in Maine/ past thirty day marijuana use.
Data Source:
Maine Integrated Youth Health Survey (MIYHS)

Description of Data:
Past 30 day marijuana use among Maine’s 9th to 12th grade population. This is an existing measurement within the survey.

Data issues/caveats that affect outcome measures:
Survey is only conducted every two years with 2017 being the next implementation and reporting. The state has no alternative data source for this indicator for this population.

Indicator #: 10
Indicator: Past 30 day use of marijuana among Maine’s 18-25 year old population.
Baseline Measurement: SFY15 – 29.72% of 18-25 year olds in Maine used marijuana in the past thirty days.
First-year target/outcome measurement: SFY18 – 28.98% of 18-25 year olds in Maine/past thirty day use of marijuana.
Data Source:
National Survey on Drug Use and Health (NSDUH)

Description of Data:
Past 30 day use of marijuana among Maine’s 18-25 year old population. This is an existing measurement within the survey.

Data issues/caveats that affect outcome measures:
n/a

Priority #: 2
Priority Area: Improved Outcomes for IV Drug Users
Priority Type: SAT
Population(s): PWID
Goal of the priority area:
To increase positive outcomes for IV Drug Users receiving substance use treatment through timely access and retention of services
Assure timely access, completion of treatment services, and support services to assist and support employment

**Strategies to attain the objective:**

Contract deliverables prioritizing substance abuse treatment to this population with review and non-compliance enforcement.

---

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Retention of Intravenous Drug Using (IVDU) in Outpatient Treatment for at least (4) sessions.</td>
<td>SFY17 – 398 of Intravenous Drug Using (IVDU) in OP Services remained in treatment for (4) or more sessions.</td>
<td>SFY18 – 75% of Intravenous Drug Using (IVDU) in OP Services remained in treatment for (4) or more sessions.</td>
<td>SFY19 – 80% of Intravenous Drug Using (IVDU) in OP Services remained in treatment for (4) or more sessions.</td>
</tr>
<tr>
<td>2</td>
<td>Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for IVDU.</td>
<td>SFY17 – 1,325 of IVDU began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
<td>SFY18 – 90% of IVDU began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
<td>SFY19 – 100% of IVDU began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
</tr>
<tr>
<td>3</td>
<td>Increase employment rate for IVDU’s individuals in Substance Abuse Treatment.</td>
<td>SFY17 Q4 – 48.6% of IVDU’s in substance abuse treatment are employed.</td>
<td>SFY18 – 49% of IVDU’s in substance abuse treatment are employed.</td>
<td>SFY19 – 50% of IVDU’s in substance abuse treatment are employed.</td>
</tr>
</tbody>
</table>

**Data Source:**

SAMHS Treatment Data System

**Description of Data:**

This is an existing measurement within our Treatment Data System.

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

This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.

---

**Data Source:**

SAMHS Treatment Data System

**Description of Data:**

This is an existing measurement within our Treatment Data System

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

Resources available to promote timely access into services include both state and federal funds.
Data Source:
SAMHS Treatment Data System

Description of Data:
This is an existing measurement within our Treatment Data System

Data issues/caveats that affect outcome measures:
Resources to promote employment for substance abuse treatment individuals available via federal and state funds.

Priority #:
3

Priority Area:
Improved Outcomes for Pregnant and Parenting Women

Priority Type:
SAT

Population(s):
PWWDC

Goal of the priority area:
To increase positive outcomes for Pregnant and Parenting Women receiving substance use treatment through timely access and retention of services

Objective:
Assure timely access, completion of treatment services, and support services to assist and support employment

Strategies to attain the objective:
Contract deliverables prioritizing substance abuse treatment to this population with review and non-compliance enforcement.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Retention of Pregnant Women in Outpatient Treatment for at least (4) sessions.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>SFY17 – 16 of Pregnant Women in OP Services remained in treatment for (4) or more sessions.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>SFY18 – 75% of Pregnant Women in OP Services remained in treatment for (4) or more sessions.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>SFY19 – 80% of Pregnant Women in OP Services remained in treatment for (4) or more sessions.</td>
</tr>
</tbody>
</table>

Data Source:
SAMHS Treatment Data System

Description of Data:
This is an existing measurement within our Treatment Data System.

Data issues/caveats that affect outcome measures:
This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for pregnant women.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>SFY17 – 92 of Pregnant Women began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>SFY18 – 90% of Pregnant Women began Intensive OP or Outpatient Services within seven...</td>
</tr>
</tbody>
</table>
Second-year target/outcome measurement: SFY19 – 100% of Pregnant Women began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.

**Data Source:**
SAMHS Treatment Data System

**Description of Data:**
This is an existing measurement within our system.

**Data issues/caveats that affect outcome measures:**
Resources available to promote timely access into services include both state and federal funds.

---

**Indicator #:** 3
**Indicator:** Increase employment rate for pregnant and parenting women in Substance Abuse Treatment.

**Baseline Measurement:** SFY17 Q4 – 60% of pregnant and parenting women in substance abuse treatment are employed.

**First-year target/outcome measurement:** SFY18 – 62% of pregnant and parenting women in substance abuse treatment are employed.

**Second-year target/outcome measurement:** SFY19 – 64% of pregnant and parenting women in substance abuse treatment are employed.

**Data Source:**
SAMHS Treatment Data System

**Description of Data:**
This is an existing measurement within our system.

**Data issues/caveats that affect outcome measures:**
Resources to promote employment for substance abuse treatment individuals available via federal and state funds.
Indicator #: 1
Indicator: Retention of all individuals in Outpatient Treatment for at least (4) sessions.
Baseline Measurement: SFY17 – 1,190 of Individuals in OP Services remained in treatment for (4) or more sessions.
First-year target/outcome measurement: SFY18 – 75% of Individuals in OP Services remained in treatment for (4) or more sessions.
Second-year target/outcome measurement: SFY19 – 80% of Individuals in OP Services remained in treatment for (4) or more sessions.
Data Source: SAMHS WITS (Treatment) Data System
Description of Data: This is an existing measurement within our Treatment Data System.
Data issues/caveats that affect outcome measures:
This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.

Indicator #: 2
Indicator: Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for MaineCare or Grant-Funded (at admission) individuals.
Baseline Measurement: SFY17 – 3,970 of MaineCare or Grant-Funded (at admission) individuals began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.
First-year target/outcome measurement: SFY18 – 90% of MaineCare or Grant-Funded (at admission) individuals began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.
Second-year target/outcome measurement: SFY19 – 100% of MaineCare or Grant-Funded (at admission) individuals began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.
Data Source: SAMHS Treatment Data System
Description of Data: This is an existing measurement within our system.
Data issues/caveats that affect outcome measures:
Resources available to promote timely access into services include both state and federal funds.

Indicator #: 3
Indicator: Increase employment rate for individuals in Substance Abuse Treatment.
Baseline Measurement: SFY17 Q4 – 47% of individuals in substance abuse treatment are employed.
First-year target/outcome measurement: SFY18 – 49% of individuals in substance abuse treatment are employed.
Second-year target/outcome measurement: SFY19 – 50% of individuals in substance abuse treatment are employed.
Data Source: SAMHS WITS Data System
Description of Data: This is an existing measurement within our system.
Data issues/caveats that affect outcome measures:
Resources to promote employment for substance abuse treatment individuals available via federal and state funds.
Priority #: 5
Priority Area: TB Services for persons in substance abuse treatment services
Priority Type: SAT
Population(s): TB

Goal of the priority area:
To ensure availability of TB services for persons in substance abuse treatment services.

Objective:
To increase positive outcomes for Persons at Risk for TB receiving substance use treatment through referrals and timely access to appropriate medical and support services provided by the Maine CDC or equally qualified private provider.

Strategies to attain the objective:
Collaborate with the Maine CDC to improve outreach to those in substance abuse treatment services to have TB screening and treatment services available to this population. Include in substance abuse treatment contracts with agencies language that these services (screening, testing, counseling and case management) must be made available to those in substance abuse treatment. The SSA also includes in all treatment contracts that the agencies must report all active TB cases to the Maine CDC.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Increase Substance Abuse provider referrals for TB screening and other appropriate services |
| Baseline Measurement: | SFY17 - 3% of Substance Abuse providers will refer for TB screening and services within (7) days |
| First-year target/outcome measurement: | SFY18 - 4% of Substance Abuse providers will refer for TB screening and services within (7) days |
| Second-year target/outcome measurement: | SFY19 - 95% of Substance Abuse providers will refer for TB screening and services within (7) days |

Data Source:
Contract Performance Measures Reports (Quarterly).

Description of Data:
SAMHS' Contracted Substance Abuse providers will refer for TB screening and services within (7) days of admission to the Maine CDC Public Health Nursing/TB Control Program or an equally qualified provider.

Data issues/caveats that affect outcome measures:
The new Contract Performance Measures will not go into effect for SFY19 unless there is an amendment before 7/18. Also, this data is only reflective of the uninsured/grant-funded.

Footnotes:
### Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017  Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</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>$5,076,792</td>
<td></td>
<td>$18,883,227</td>
<td>$2,545,516</td>
<td>$12,969,652</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td></td>
<td>$380,714</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$4,696,078</td>
<td></td>
<td>$18,883,227</td>
<td>$2,545,516</td>
<td>$12,348,488</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$1,529,992</td>
<td></td>
<td></td>
<td></td>
<td>$6,698,297</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Administration (Excluding Program and Provider Level)</td>
<td>$347,725</td>
<td></td>
<td>$762,875</td>
<td>$3,244,301</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>11. SABG Total (Row 1, 2, 3, 4 and 10)</td>
<td>$6,954,509</td>
<td>$0</td>
<td>$18,883,227</td>
<td>$5,956,927</td>
<td>$22,912,250</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

---

**Footnotes:**

Recently passed Medicaid Expansion will most likely impact this Medicaid number going forward however, there is no way to forecast what this number may look like.
Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>0</td>
<td>1225</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>0</td>
<td>1265</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>0</td>
<td>2365</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>0</td>
<td>1273</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the stats does not have a data source.
SAMHS is currently working with providers to provide waitlist information on a monthly basis. Once this is instituted, SAMHS will have the capability to estimate need based on those waiting for services.

Footnotes:
**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$5,076,792</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$1,529,992</td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td></td>
</tr>
<tr>
<td>4. Early Intervention Services for HIV *</td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$347,725</td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$6,954,509</strong></td>
</tr>
</tbody>
</table>

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.
### Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2017  
Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td>Information Dissemination</td>
<td>Selective</td>
<td>$64,689</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$43,126</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$21,563</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$258,757</strong></td>
</tr>
<tr>
<td>Education</td>
<td>Universal</td>
<td>$28,634</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$14,317</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$14,317</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$57,268</strong></td>
</tr>
<tr>
<td>Alternatives</td>
<td>Universal</td>
<td>$12,713</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$12,713</strong></td>
</tr>
<tr>
<td>Problem Identification and Referral</td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$21,502</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$21,502</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$43,004</strong></td>
</tr>
<tr>
<td>Category</td>
<td>Universal</td>
<td>Selective</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Community-Based Process</td>
<td>$162,646</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>$256,359</td>
<td></td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$37,228</td>
<td></td>
</tr>
<tr>
<td><strong>Total Prevention Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017  
Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$675,404</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$225,135</td>
</tr>
<tr>
<td>Selective</td>
<td>$100,508</td>
</tr>
<tr>
<td>Indicated</td>
<td>$78,945</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,079,992</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$6,954,509</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>15.53 %</strong></td>
</tr>
</tbody>
</table>

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

**Footnotes:**
# Planning Tables

## Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017       Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBT</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>

## Footnotes:
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## Planning Tables

### Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017  
Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td>$36,000</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td>$34,000</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td>$189,000</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td>$38,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td>$408,500</td>
<td>$117,000</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td>$20,000</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td>$503,500</td>
<td>$54,000</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td>$0</td>
<td>$950,000</td>
<td>$450,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**
Environmental Factors and Plan

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

Narrative Question
1. The Health Care System, Parity and Integration

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. Roughly 30 percent of persons who are dually eligible for Medicare and Medicaid 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 are dually eligible for Medicare and Medicaid.

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 receiving 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 behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care. SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental 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 behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between 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 behavioral health 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 behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with 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 behavioral health 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 behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should 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 behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. 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 include 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.

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29 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 disorder settings.

   Individuals with M/SUD's have a complex set of needs that are best addressed through an integrated approach to treatment that includes assessment, diagnosis, treatment planning, psychosocial treatment, medication monitoring, referrals and on-going recovery supports which are offered through the Opioid Health Home model in Maine. Specifically, our uninsured have access to Opiate Health Home levels of care which have been designed from the ground up to integrate primary care with behavioral health care. The wrap-around, team based approach to care concepts are embedded into MaineCare/Medicaid rule for both the Health Home models and are designed with the expectation of a comprehensive care management system that pro-actively links recipients of care to both Primary and Behavioral health treatments. In addition to the explicit incorporation of Peer supports in the Opioid model, it also identifies and values shared decision making, health promotion, individual and family support, and referrals to community and natural supports.

2. Describe how the state provides 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.

   See above and http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html

These innovative Health Home models are already formally established in MaineCare/Medicaid rule that has been developed jointly with the Office of MaineCare Services and the Office of Substance Abuse and Mental Health Services. Both the Behavioral and Opioid Health Home models provide a fully integrated, evidence based approach in response to earlier studies in Maine and across the nation indicating that persons with mental illness and substance use disorders are dying 25 years younger than their socioeconomic peers. Access to a proactively linked behavioral health and primary care setting for our targeted population groups is an imperative in improving health outcomes for all Mainers including the uninsured. All contractual reimbursement for the...
uninsured participating in these models is identical to the MaineCare reimbursement models embedded in existing rule so that consumers can receive the same high quality, level of care.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  ○ Yes  ○ No
and Medicaid?  ○ Yes  ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?  ○ Yes  ○ No

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  ○ Yes  ○ No

6. Do the behavioral health providers screen and refer for:
   a) Prevention and wellness education  ○ Yes  ○ No
   b) Health risks such as
      i) heart disease  ○ Yes  ○ No
      ii) hypertension  ○ Yes  ○ No
      viii) high cholesterol  ○ Yes  ○ No
      ix) diabetes  ○ Yes  ○ No
   c) Recovery supports  ○ Yes  ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  ○ Yes  ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  ○ Yes  ○ No

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

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\textsuperscript{45}, Healthy People, 2020\textsuperscript{46}, National Stakeholder Strategy for Achieving Health Equity\textsuperscript{47}, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, 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)\textsuperscript{48}.

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.”\textsuperscript{49}

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\textsuperscript{50}. 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\textsuperscript{51}. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the 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.

\textsuperscript{45} http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
\textsuperscript{46} http://www.healthypeople.gov/2020/default.aspx
\textsuperscript{47} http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf
\textsuperscript{48} http://www.thinkculturalhealth.hhs.gov
\textsuperscript{49} http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
\textsuperscript{50} http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208
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, LGBT, 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 behavioral health 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) standard? ☐ Yes ☐ No

6. Does the state have a budget item allocated to identifying and remedying disparities in behavioral health care? ☐ Yes ☐ No

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

   Office of Multicultural Affairs
   On November 6, 2012, Maine citizens were among the first in the country in voting to approve Marriage Equality for all. This substantial support and recognition of diversity in our state is further demonstrated by Maine’s Department of Health and Human Services’ Office of Multicultural Affairs. In order to improve services to racial, ethnic, linguistic minorities, and specific cultural subpopulations in Maine, DHHS with the support of the Governor’s Office, strategically established the Office of Multicultural Affairs (OMA). The office provides support to state agencies, non-governmental organizations, and community partners in order to develop sustainable projects and initiatives that will address the needs of the above mentioned multicultural communities. SAMHS implements the recommendations of OMA Sub-Cabinet, acknowledging the importance and need to provide strategic planning, policy development and program implementation of services to Maine residents who belong to racial, ethnic, linguistic, and specific cultural subpopulation minorities. These services assist recipients in the achieving educational, financial, and social self-sufficiency. SAMHS promotes mutual cooperation, exchange, and understanding among the various populations served which is vital to the provision of meaningful and effective service delivery. SAMHS also requires via the Substance Abuse and Mental Health Services contracts Language Access that includes Interpretation Services (Communication Access), Accessibility for the Deaf and Hard of Hearing, and provider responsibilities for the Deaf and/or Severely Hard of Hearing and/or nonverbal. Providers conduct bio-social-psychological assessments upon intake with clients that include a domain related to physical health and mental health. They are also required to screen for TB and HIV and refer out for services (if they do not provide them). As part of the treatment plan they discuss wellness and prevention skills.

   Office of Health Equity In addition, Maine DHHS’s Center for Disease Control and Prevention’s Office of Health Equity was established in 2006, with the goal of achieving the highest level of health for all people regardless of differences in social, economic or environmental conditions. The Office of Health Equity is comprised of four separate groups that focus on a specific area in the public health domain:
   • Maine Families Home Visiting
   • Women, Infants and Children (WIC)
   • Minority Health & Special Populations
   • Women’s Health

   Maine’s Office of Health Equity program addresses disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care. The office also:
   1. Promotes the collection of health data by racial, ethnic, gender, LGBT, age, and primary language categories and strengthening infrastructure for data collection, reporting, and sharing;
   2. Works to increase awareness of the major health problems of racial and ethnic minorities and factors that influence health;
   3. Establishes and strengthens networks, coalitions, and partnerships to identify and solve health problems; develops and promotes policies, programs, and practices to eliminate health disparities and achieve health equality; and
   4. Provides technical assistance, training, and seminars.
In order to accomplish the goals of this Office, the overall approach is to effect system changes within the Maine Center for Disease Control & Prevention (Maine CDC), the Department of Health and Human Services (DHHS), grantee agencies, and community partners. The primary strategies are leadership engagement and community collaboration. We work with, and fully engage with communities to address health inequities for its vulnerable populations; taking the knowledge and information obtained through our engagement with the communities back to the legislature and policy makers.

Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the 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 = Q ? C)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, and the NQF. 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 behavioral health 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. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private 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 behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

\[ \text{Health Care Value} = \text{Quality} \times \text{Cost} \]
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.

56 http://psychiatryonline.org/
57 http://store.samhsa.gov
58 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.

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

The re-organization of SAMHS and OCFs was centered on more efficiently and effectively delivering necessary and accountable services to persons in need. Specifically, SAMHS has designed the new office along three teams: 1) Prevention and Intervention; 2) Recovery and Treatment; and 3) Data, Quality Management, and Resource Development. These three teams have representation at the leadership level and work in an integrated manner, both at the inter and intra office functional levels. Implementation of Evidence Based Practices and linkages to Medicaid, the single largest funding source, are very strong and consistent. This includes formal development and joint implementation and of performance measures and contracting, as well as implementation of these performance measures into formal Rule Making. Monitoring of success occurs at multiple levels: and within SAMHS's own team – Data, Quality Management, and Resource Development. These Offices work closely together in the design, development, implementation, review, and monitoring of the performance measures referenced above.

Value Based Purchasing: In the fall of 2011, former Commissioner Mayhew released a memo which announced the intention of the Department of Health and Human Services and Office of MaineCare Services to pursue a Value-Based Purchasing (VBP) strategy in order to improve the quality and cost of care for MaineCare members. The Department stated that they would strengthen the state's collaboration with providers, leverage current programs, and take advantage of emerging federal opportunities. Three major initiatives were later unveiled under this VBP strategy; Health Homes, Behavioral Health Homes, and Accountable Communities. There are over 50,000 MaineCare members currently being served by these programs. The Department has also recently jointly released the Opioid Health Home, another model which links behavioral health therapy with primary care, which allows for more information sharing and a comprehensive plan of care for each unique individual. More information for each program can be found on their individual pages.

The Department of Health and Human Services then demonstrated a commitment to improving the quality and cost of healthcare for all of Maine by applying for, and winning, a State Innovation Model (SIM) Testing grant from Centers for Medicare and
Medicaid Services (CMS). In October of 2013, Maine received grant funds totaling $33 Million from CMS over the next three years to help Maine achieve the Triple Aim: Improving population health, improving patient experience, and lower the cost of care by 2016. This is an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and Maine consumers.

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

Information technology/infrastructure support would help Maine’s overall integration to support uninsured populations. The prohibition of information sharing as a result of 42 C.F.R. Part 2 is a barrier to service delivery; any assistance offered pertaining to this challenge would be appreciated.

**Footnotes:**
Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or “participant” controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual’s service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual’s traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction’s impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?      Yes ☐ No ☐

2. Are there any concretely planned initiatives in our state specific to self-direction? ☐ Yes ☐ No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:
   
   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

Under SAMHS Housing Programs, to the greatest extent practicable, SAMHS empower consumers with tenant-based housing vouchers which enhance individual choice, independence, and control over where a person lives and what services (if any) such a person decides to receive. Independent housing vouchers represent a foundation of recovery and hope. Systems of care are recognizing that access to safe, decent, and affordable housing is a medical necessity for many persons with disabilities.

Independent housing vouchers: deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care. Such vouchers can be used in either the community or group settings—at the consumer’s discretion. These vouchers are a logical extension of the concept, Money Follows the Person in which the consumer directs their own care and in this case, their housing as well.

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

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

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard?  
   Yes ☐ No ☐

3. Does the state have any activites related to this section that you would like to highlight?  
   SAMHSA’s SABG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental health disorders, substance use disorders, and associated problems. The goals of the Block Grant programs are consistent with SAMHSA’s vision for a high-quality, self-directed, and satisfying life. The components of a healthy life are the four dimensions of recovery. Additional aims of the Block Grant programs reflect SAMHSA’s role as a public health agency: 1) Increase prevention and wellness activities, 2) increase access to evidence based mental health services, and 3) improve the use of data through surveillance activities, analysis, and continuous quality improvement to inform service planning and decision making.

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

1. Increase Prevention and Wellness activities at the DHHS and Provider level.

   Further promote linkages by and between the Office of Substance Abuse and Mental
Health Services and the office of Child and Family Services to include enhanced coordination with the Substance Abuse Prevention and Treatment Block Grant. Carry forward and support with Block Grant and other resources Prevention and Wellness activities in the provider and consumer communities.

2. Increase utilization and Evidence-Based Practices. Fund and support both promising and evidence-based practices using Block Grant and other resources.

3. Increase Access and Capacity. Fund and support specific and necessary services targeting uninsured individuals supported by Block Grant and other resources.

Please indicate areas of technical assistance needed to this section

Footnotes:
Environmental Factors and Plan

8. 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\(^\text{59}\) 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.

\(^\text{59}\) http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

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

2. What specific concerns were raised during the consultation session(s) noted above?
   See Activities
   Does the state have any activities related to this section that you would like to highlight?

   The State of Maine, through the Department of Health and Human Services, Maine Center of Disease Control and Prevention has created a Public Health Infrastructure in the state of Maine consisting of 8 geographical Public Health Districts encompassing the entire state, and one Tribal Health District encompassing all of the Tribes in Maine. Through this Public Health Infrastructure, the state is able to dispense funds and funding opportunities to deliver services; Substance Abuse Prevention Services being one. The tribes in Maine have had representation on a variety of SAMHS workgroup and through this effort, partnering with the tribes through the work done through the Tribal Public Health District; SAMHS continues to have conversations, discussions, and providing support to the tribes to address substance abuse issues within the tribal communities and with its people. In the area of Prevention, SAMHS has historically provided funding to the 5 tribal communities that exist in Maine for substance abuse prevention services through the Tribal Public Health District. With that, there are representatives from the tribes that serve on several of SAMHS workgroups including Prevention Advisory Board and Marijuana Workgroup. SAMHS has no technical assistance needs with regards to prevention services with the tribes.

   SAMHS is working with internally established liaisons for collaboration and input from the tribes on both our Mental Health and Substance Abuse Prevention and Treatment Block Grants. Staff within our office is already sharing information and ideas regarding improving linkages with the Tribal communities in Maine. The consumer run, Quality Improvement Council has also reach out to the Maine Tribal community for their representation and membership on the QIC. More work needs to be done in
this arena and both the QIC and SAMHS continue to proactively conduct outreach to Maine’s tribal communities. There are four Native federally recognized Indian tribes in Maine: Maliseet, Passamaquoddy, Penobscot and Micmac, collectively known as the Wabanaki. Most of the native population of Maine resides on tribal land, although there are others who live in Maine’s towns and cities. Each tribe maintains their own government, land, resources, schools, and cultural centers. Three of them have their own health centers.

Two of the tribes (three facilities) are licensed by the State of Maine to provide substance abuse treatment services. SAMHS has a substance abuse treatment contract with the Passamaquoddy Tribe of Indian Township. The contract, in the amount $50,000, is funded by State General Funds and Substance Abuse Block Grant funds. Outpatient substance abuse treatment services are provided at the Passamaquoddy Health Center (PHC) located at Indian Township, Princeton, Maine. SAMHS conducts an annual site review of this contract, the most recent one completed on 9/20/17. Compliance with contract requirements was reviewed at that time and SABG requirements were discussed in detail with clinical and executive staffs. Additionally, SAMHS staff remains in close email and phone contact with the Passamaquoddy Health Center treatment staff throughout the year. The issue of confidentiality and historic trauma was raised by the executive director during the recent site review. This issue has been referred to the SAMHS director for discussion. SAMHS is considering a training regarding cultural issues and working with the tribes. Technical assistance in this Treatment area would be welcome.

Please indicate areas of technical assistance needed to this section

See Activities

Footnotes:
Environmental Factors and Plan

9. Primary Prevention - Required SABG

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   - Yes
   - No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - Yes
   - No
   - Data on consequences of substance using behaviors
   - Substance-using behaviors
   - Intervening variables (including risk and protective factors)
   - Others (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)

☐ Archival indicators (Please list)

☑ National survey on Drug Use and Health (NSDUH)

☑ Behavioral Risk Factor Surveillance System (BRFSS)

☐ Youth Risk Behavioral Surveillance System (YRBS)

☐ Monitoring the Future

☐ Communities that Care

☐ State - developed survey instrument

☐ Others (please list)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?

☐ Yes ☐ No

If yes, (please explain)

Data is reviewed to determine if there are any gaps in rates of use as well as services provided. Once reviewing consumption rates, we review what we are implementing for services and make modifications to our program planning based on that. This is done through an annual team strategic planning process. At the state and local level, the Strategic Prevention Framework model is used to select strategies and determine programming.

If no, (please explain) how SABG funds are allocated:

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
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking;

- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Capacity Building

1. **Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?**
   - Yes ☐ No ☐
   
   If yes, please describe
   
   In 2014 the Maine Prevention Certification Board was created and implementation of prevention certification began in 2015. Please visit www.MainePreventionCertification.org for more information.

2. **Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?**
   - Yes ☐ No ☐
   
   If yes, please describe mechanism used
   
   Through a workforce development contract that was established through a competitive RFP process, workforce development services are being implemented for prevention, intervention, treatment, and recovery.

3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**
   - Yes ☐ No ☐
   
   If yes, please describe mechanism used
   
   Each community provider receiving funding from the State of Maine is required to do an assessment of their local community to assess for needs, assets, gaps in service, data trends, etc. They follow the SPF model to then make selections of their activities in order to address unmet community prevention needs. A guide was created for community providers to assist with this process. To view, visit: http://www.maine.gov/dhhs/mecdc/population-health/prevention/provider/index.htm

   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
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

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- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.  

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   - [ ] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - [ ] Timelines
   - [ ] Roles and responsibilities
   - [ ] Process indicators
   - [ ] Outcome indicators
   - [ ] Cultural competence component
   - [ ] Sustainability component
   - [ ] Other (please list):

   - [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   - Yes  
   - No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

   A series of criteria was developed for the Evidence-based workgroup and can be made available upon request. The group meets to review the criteria including data, outcomes, and the like.

   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.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) □ SSA staff directly implements primary prevention programs and strategies.

   b) □ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) □ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) □ The SSA funds regional entities that provide training and technical assistance.

   e) □ The SSA funds regional entities to provide prevention services.

   f) □ The SSA funds county, city, or tribal governments to provide prevention services.

   g) □ The SSA funds community coalitions to provide prevention services.

   h) □ The SSA funds individual programs that are not part of a larger community effort.

   i) □ The SSA directly funds other state agency prevention programs.

   j) □ Other (please describe)

   The State of Maine funds one vendor (University of New England) to implement substance use prevention strategies across the state through distribution of the funding to community prevention coalitions. These coalitions then implement approved strategies through a workplan approved by the Department.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) **Information Dissemination:**

      - Public Service announcements, community presentations, brochures/printed materials, media campaigns, social media.

   b) **Education:**

      - Prime for Life curriculum, online education programs, classroom education, education sessions for groups,

   c) **Alternatives:**

      - Youth engagement and empowerment services, youth councils/advisory groups.

   d) **Problem Identification and Referral:**

      - Student Intervention and Reintegration Program (using the Prime for Life curriculum with students who have violated school substance use policies), student/employee assistance programs.

   e) **Community-Based Processes:**
Strategic planning, resource sharing, multi-agency collaboration, community training.

f) Environmental:
Prescription drug take back events, safe storage and disposal of medications, PMP promotion, public policy efforts, retailer education, pricing/promotion, social norms campaigns.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  
   ☑ Yes ☐ No

   If yes, please describe
   The Tobacco and Substance Use Prevention and Control Program with the Maine CDC manages all state and federal prevention services throughout the state of Maine with the exception of DFC funded communities.

   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.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

• **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

• **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

• **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

• **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

• **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

• **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  - No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - Includes evaluation information from sub-recipients
   - Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - Establishes a process for providing timely evaluation information to stakeholders
   - Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - Other (please list:)
   - Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - Numbers served
   - Implementation fidelity
   - Participant satisfaction
   - Number of evidence based programs/practices/policies implemented
   - Attendance
   - Demographic information
   - Other (please describe:)

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - 30-day use of alcohol, tobacco, prescription drugs, etc
   - Heavy use
   - Binge use
c) Perception of harm
   ✔

Disapproval of use

Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

Other (please describe):
# Environmental Factors and Plan

## 11. Substance Use Disorder Treatment - Required SABG

### Narrative Question

**Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs**

### Criterion 1

**Improving access to treatment services**

1. Does your state provide:

   a) A full continuum of services

      i) Screening  
         - Yes ☑ No
      ii) Education  
         - Yes ☑ No
      iii) Brief Intervention  
         - Yes ☑ No
      iv) Assessment  
         - Yes ☑ No
      v) Detox (inpatient/social)  
         - Yes ☑ No
      vi) Outpatient  
         - Yes ☑ No
      vii) Intensive Outpatient  
         - Yes ☑ No
      viii) Inpatient/Residential  
         - Yes ☑ No
      ix) Aftercare; Recovery support  
         - Yes ☑ No

   b) Are you considering any of the following:

      Targeted services for veterans  
      - Yes ☑ No

   c) Expansion of services for:

      (1) Adolescents  
      - Yes ☑ No
      (2) Other Adults  
      - Yes ☑ No
      (3) Medication-Assisted Treatment (MAT)  
      - Yes ☑ No
Narrative Question

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes  
   - No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWDDC receiving services?  
   - Yes  
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes  
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes  
   - No

5. Are you considering any of the following:  
   a) Open assessment and intake scheduling  
      - Yes  
      - No
   b) Establishment of an electronic system to identify available treatment slots  
      - Yes  
      - No
   c) Expanded community network for supportive services and healthcare  
      - Yes  
      - No
   d) Inclusion of recovery support services  
      - Yes  
      - No
   e) Health navigators to assist clients with community linkages  
      - Yes  
      - No
   f) Expanded capability for family services, relationship restoration, custody issue  
      - Yes  
      - No
   g) Providing employment assistance  
      - Yes  
      - No
   h) Providing transportation to and from services  
      - Yes  
      - No
   i) Educational assistance  
      - Yes  
      - No

6. States are required to monitor program compliance related to activities and services for PWDDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Maine Women's Services Network (WSN) representative is responsible for overseeing PWDDC services and monitoring contract compliance. A comprehensive on-site review of each PWDDC program is conducted annually and includes a review of policies and procedures, compliance with contract requirements, compliance with all applicable Federal and State regulations (including SABG requirements), and a review of client records. The provider receives a summary report with corrective actions if warranted. In addition to the annual review, the WSN maintains phone and email contact with the PWDDC providers throughout the agreement period. The waitlist is monitored monthly.

   SAMHS' Quality Team has been working on improving quality management of contract providers and has developed monitoring procedures with the goal of implementing these in FY18. One of the procedures that is now operational is the implementation of quarterly reporting of progress toward outcome measures. (This is in addition to the data already captured in SAMHS data system - WITS.) The reports submitted by PWDDC providers will be reviewed by the WSN and a follow-up discussion with ensue.
Narrative Question
Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

**Criterion 4,5&6**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement  
   b) 14-120 day performance requirement with provision of interim services  
   c) Outreach activities  
   d) Syringe services programs  
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  

2. Are you considering any of the following:
   a) Electronic system with alert when 90 percent capacity is reached  
   b) Automatic reminder system associated with 14-120 day performance requirement  
   c) Use of peer recovery supports to maintain contact and support  
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Program Managers, including the State Opioid Treatment Authority (SOTA) are responsible for overseeing and monitoring compliance of programs which provide detoxification, medication assisted treatment (MAT), opioid treatment programs (OTP), outpatient, intensive outpatient, and residential services. A comprehensive on-site review of each program is conducted annually and includes a review of policies and procedures, compliance with contract requirements, compliance with all applicable Federal and State regulations (including SABG requirements for PWID), and a review of client records. The provider receives a summary report with corrective actions if warranted. In addition to the annual review, Program Managers maintain phone and email contact with the PWWDC providers throughout the agreement period. The SOTA provides additional support the MAT and OTP programs. Waitlists are monitored monthly.

SAMHS’ Quality Team has been working on improving quality management of contract providers and has developed monitoring procedures with the goal of implementing these in FY18. One of the procedures that is now operational is the implementation of quarterly reporting of progress toward outcome measures. (This is in addition to the data already captured in SAMHS data system - WITS.) The reports submitted by PWID providers will be reviewed by Program Managers and SOTA and a follow-up discussion with ensue.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Are you considering any of the following:
   a) Business agreement/MOU with primary healthcare providers  
   b) Cooperative agreement/MOU with public health entity for testing and treatment  
   c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The State of Maine SSA currently uses block grant funding for most of its treatment provider contracts (see allocations in Step 1) in order to ensure that agreements for tuberculosis services will be made available to individuals receiving SUD treatment. Maine SSA program staff discuss the tuberculosis services requirement at least annually at site review with the treatment providers, as well as discuss any need for Training and Technical Assistance that might result at that time.
At the time of writing this block grant application, Maine SSA staff have recently met with the Maine CDC’s TB Control Officer to collaborate on the F18/F19 year plan; current treatment providers were discussed at that time, as well as aligning data collection as well as prevention efforts. Additional TB Training and Technical Assistance and collaboration discussions are expected to be scheduled throughout the program year as the need arises.

**Early Intervention Services for HIV (for “Designated States” Only)**

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes ☐ No ☑

2. Are you considering any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas Yes ☐ No ☑
   b) Establishment or expansion of tele-health and social media support services Yes ☐ No ☑
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes ☐ No ☑

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes (42 U.S.C § 300x-31(a)(1)(F))? Yes ☐ No ☑

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes ☐ No ☑

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes ☐ No ☑

If yes, please provide a brief description of the elements and the arrangement.
Criterion 8,9&10

Service System Needs
1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement ❘ Yes ❘ No
2. Are you considering any of the following:
   a) Workforce development efforts to expand service access ❘ Yes ❘ No
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services ❘ Yes ❘ No
   c) Establish a peer recovery support network to assist in filling the gaps ❘ Yes ❘ No
e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations ❘ Yes ❘ No
   f) Explore expansion of service for:
      i) MAT ❘ Yes ❘ No
      ii) Tele-Health ❘ Yes ❘ No
      iii) Social Media Outreach ❘ Yes ❘ No

Service Coordination
1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? ❘ Yes ❘ No
2. Are you considering any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ❘ Yes ❘ No
   b) Establish a program to provide trauma-informed care ❘ Yes ❘ No
   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education ❘ Yes ❘ No

Charitable Choice
1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 ($54.8(b) and $54.8(c)(4)) and 68 FR 56430-56449) ❘ Yes ❘ No
2. Are you considering any of the following:
   a) Notice to Program Beneficiaries ❘ Yes ❘ No
   b) Develop an organized referral system to identify alternative providers ❘ Yes ❘ No

Referrals
1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ❘ Yes ❘ No
2. Are you considering any of the following:
   a) Review and update of screening and assessment instruments ❘ Yes ❘ No
   b) Review of current levels of care to determine changes or additions ❘ Yes ❘ No
   c) Identify workforce needs to expand service capabilities ❘ Yes ❘ No
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  
   ☐ Yes ☐ No

Patient Records
1. Does your state have an agreement to ensure the protection of client records?  
   ☐ Yes ☐ No
2. Are you considering any of the following:
   a) Training staff and community partners on confidentiality requirements  
      ☐ Yes ☐ No
   b) Training on responding to requests asking for acknowledgement of the presence of clients  
      ☐ Yes ☐ No
   c) Updating written procedures which regulate and control access to records  
      ☐ Yes ☐ No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  
      ☐ Yes ☐ No

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  
   ☐ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   At least 5% of direct-service, treatment provider sub-recipients are estimated to be reviewed by independent peers in F2018 and F2019.

   SAMSHA has suggested that ME SAMHS submit a TA request in this area, which will be taken under consideration.
3. Are you considering any of the following:
   a) Development of a quality improvement plan  
      ☐ Yes ☐ No
   b) Establishment of policies and procedures related to independent peer review  
      ☐ Yes ☐ No
   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations  
      ☐ Yes ☐ No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  
   ☐ Yes ☐ No

If YES, please identify the accreditation organization(s)
   i) ☐ Commission on the Accreditation of Rehabilitation Facilities
   ii) ☐ The Joint Commission
   iii) ☐ Other (please specify)
## Criterion 7 & 11

### Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes  
   - No

2. Are you considering any of the following:
   - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
     - Yes  
     - No
   - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
     - Yes  
     - No

### Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   - a) Recent trends in substance use disorders in the state  
     - Yes  
     - No
   - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
     - Yes  
     - No
   - c) Performance-based accountability  
     - Yes  
     - No
   - d) Data collection and reporting requirements  
     - Yes  
     - No

2. Are you considering any of the following:
   - a) A comprehensive review of the current training schedule and identification of additional training needs  
     - Yes  
     - No
   - b) Addition of training sessions designed to increase employee understanding of recovery support services  
     - Yes  
     - No
   - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  
     - Yes  
     - No
   - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
     - Yes  
     - No

### Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   - a) Allocations regarding women  
     - Yes  
     - No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes  
      - No
   b) Early Intervention Services Regarding HIV  
      - Yes  
      - No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes  
      - No
   b) Professional Development  
      - Yes  
      - No
   c) Coordination of Various Activities and Services  
      - Yes  
      - No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

https://www1.maine.gov/sos/cec/rules/10/chaps10.htm
Environmental Factors and Plan

12. 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 2016-FFY 2017?  
   - Yes  
   - No

Does the state have any activities related to this section that you would like to highlight?
Since the merger of our former legacy offices, SAMHS created a revised and updated CQI/TQM plan that integrates Mental Health and Substance Abuse measures and included in the F16/F17 Substance Abuse Block Grant application. That CQI/TQM plan expires this fiscal year, and is currently under revision. A current CQI/TQM plan will be submitted as soon as it is available for release.

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

Footnotes:
Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma 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 behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. 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 behavioral health 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 paper.

60 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.  
61 ibid

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers?  
   - Yes ☐ No ☒

3. Does the state have a plan to build the capacity of behavioral health 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.

History

In 1984, the Federal Child and Adolescent Service System became the first to systematically address children’s mental health in collaboration with family members, advocates, policy makers, service and technical assistance providers, agency administrators, and cultural brokers. This group conceived the “system of care” concept, which was defined two years later, and again in 2010.

In 1992 the Comprehensive Community Mental Health Services for Children and Their Families Program began funding “systems of care” in states, communities, territories and tribal organizations. The aim was to galvanize collaborative, comprehensive “systems,” including community-based organizations, to focus their support of young people’s recovery on resiliency and skills building through family-driven, youth-guided and culturally and linguistically competent services, supports, planning and treatment.
The THRIVE Initiative (2005-2011) was Maine’s third System of Care grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). As a result of THRIVE’s work with Maine’s Office of Child and Family Services, all state contracted mental health agencies were required to be trauma-informed.

In 2005, Maine DHHS/OCFS and Tri-County Mental Health Services was awarded a SAMHSA System of Care grant; the THRIVE Initiative was specifically created within TCMHS to provide System of Care core values and practices through training, education and technical assistance. These System of Care values are as follows:

- Family driven and youth guided, with the strengths and needs of the youth and family determining the types and mix of services and supports.
- Community based, with the services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

In addition to the above, THRIVE adopted trauma-informed as the fourth system of care value which means that all staff and community members are aware of the impact that trauma and violence have on individuals, families, and communities. This value promotes growth and resiliency and changes the traditional “problem” statement of “what is wrong with you?” into “what has happened to you?”

Through the DHHS/CBHS System of Care (SOC) grant, THRIVE successfully:
- Changed Maine DHHS/OCFS state contract language to require that child serving mental/behavioral health agencies be trauma-informed and practice system of care principles (Trauma-Informed Care: The Provider shall have a plan for providing trauma-informed care based on principles of trauma-informed care and generally recognized bases of trauma-specific interventions, both as outlined by the Substance Abuse and Mental Health Services Administration at: http://www.samhsa.gov/ntic/trauma-interventions),
- Created and implemented the Trauma-Informed System of Care Agency Assessment Tool (TIAA),
- Provided technical assistance and continuous quality improvement planning with agencies,
- Partnered with family organizations in Maine to further family voice and choice,
- Developed a statewide youth advocacy organization,
- Created a trauma-informed culture in Maine state systems,
- Implemented and sustained trauma specific treatments,
- Created a train the trainer model for trauma-informed care, and
- Consulted and provided training and TA to other states on Trauma-Informed change.

In October 2011 Maine was one of 24 states, tribal communities and territories to receive a one-year SAMHSA expansion grant, under which three work groups oversee a THRIVE-facilitated Statewide Leadership Team: developed continuous quality improvement standards for mental health agencies; planned for implementation of trauma-informed principles, practices and assessments in juvenile justice services; and developed and distributed a military family-driven mental health services satisfaction survey.

In October 2012, THRIVE became the training and technical assistance partner for Maine’s Department of Corrections Division of Juvenile Services’ four-year SAMHSA grant, Expanding Trauma-Informed System of Care Practices in Maine. THRIVE continues to have 5 Free Trauma-Informed webinars on their website, available to both educators and providers.

THRIVE is partnering with community providers to develop a Trauma-Informed and Resilience Based System of Care in Maine. They are holding focus groups with stakeholders, providers, medical community, and law enforcement, to see what is working well, what needs work, etc. They ask participants if they know what ACES are, what resiliency is, what trauma-informed means, how they learned about it, how it is used in their work, challenges, successes, gaps.

In 2017, THRIVE/Youth Move Maine began working in partnership with MMC/PIER FEP program to provide youth peer support to the youth participating in the First Episode Psychosis treatment at Maine Medical Center’s PIER program. MHBG funding has funded the addition of youth with lived experience to the FEP Program to: integrate youth voice, experience and expertise in interventions),

Maine’s PATH program has a 20% contractual set-aside for PATH Peer Navigators. A PATH Peer Navigator is an individual that has: 1) identified as experiencing homelessness; 2) at some time been diagnosed with a Serious Mental Illness (SMI) or a co-occurring SMI and Substance Use Disorders (SUD); and completed the Intentional Peer Support (IPS) Specialists Training Program within one (1) year of being hired by the Provider. Peer Navigator duties include, but are not limited to, Outreach and Engagement with Literally Homeless individuals through multiple contacts and interactions, and referring them into housing and/or Mental Health Services.

State of Maine’s contracts incorporates the following expectations, to insure the availability of access to opportunities for
consumer input and involvement: "the Provider shall give all new clients information regarding organized opportunities within
the agency for consumer voice and input into policies, development and implementation of mental health services such as a
consumer advisory group. The Provider shall give all new clients and make available to existing clients, information about the
Consumer Council System of Maine (CCSM) and opportunities for participation in local councils of the CCSM. Printed information
will be made available through the CCSM."

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

Footnotes:
Environmental Factors and Plan

14. 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.62

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.63

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 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.

63 http://csgjusticecenter.org/mental-health/

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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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?

   Question 1 - Currently in Maine, there are six Adult Drug Treatment courts, three Family Treatment Drug Courts (a person participating in this court does not need to have criminal charges/history), one Co-occurring Drug Court, and one Co-occurring Veterans Drug Court all adhering to the National Association of Drug Court Professionals best practice standards. Each court has a treatment team to include treatment providers, clinical case managers, Dept. of Corrections, attorneys, and a specialty trained judge. Prior to acceptance in the court, each client is screened and assessed. A treatment plan is developed to address substance use disorders, mental health disorders in conjunction with a service plan developed by the clinical case manager. Goals include abstinence from substances and alcohol while integrating back into the community.

   Question 2 - Refer to Crisis Services section for additional detail on State strategies.

   Question 3 - SAMHS will provide MAT training to Judges, attorneys, jail staff and other court officials as a best-practice practice in treating individuals involved with the criminal justice system in April 2018. The goal is to increase awareness of the effectiveness of MAT treatment in reducing relapses and recidivism.
Question 4- Maine has two interagency coordinating committees that include the SMHA/SSA, the Maine Justice Assistance Council and the Maine Opiate Collaborative. SAMHS Prevention Team has a representative attend the Maine Department of Corrections Juvenile Justice Advisory Group (JJAG). The mission of the Maine Juvenile Justice Advisory Group is to advise and make recommendations to state policy makers and to promote effective system level responses that further the goals of the Juvenile Justice and Delinquency Prevention Act.

Question 5- SAMHS has a contract with Day One, Inc. for the provision of outpatient services at the, Long Creek Youth Detention Center, located in South Portland, Maine. All committed youth ages 13 to 18 are located at this facility. Youthful offenders (19 through 25) as well as adults (26 and up) receive outpatient services at Mountain View Correctional Facility, located in Charleston, Maine. The total contract amount is $810,694, $308,063 of which are SAPTBG funds. The balance of $502,630 is from State General Funds.

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<th>Number Served FY16</th>
<th>Number Served FY17</th>
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<tr>
<td>Mountain View (ages 19 – 25)</td>
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</tbody>
</table>

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

Footnotes:
Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes □ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ○ Yes □ No
3. Does the state purchase any of the following medication with block grant funds? ○ Yes □ No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ○ Yes □ No
5. Does the state have any activities related to this section that you would like to highlight?

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Please indicate areas of technical assistance needed to this section.

Resources for Medication Assisted Treatment in the state of Maine are limited. Maine has experienced an increase in treatment admissions for individuals addicted to opioids since 2005, and was recently selected by SAMSHA to apply for the Medication Assisted Treatment – Targeted Capacity Expansion funding opportunity based on its rate of treatment admissions. Opioid overdoses have increased over the past 5 years. Additional funding would support the expansion of MAT and other evidenced based treatments throughout the state, specifically in rural areas. Funding would also provide supports for non-Medicaid eligible individuals who are opioid dependent and at risk of relapse.

Funding for programs that provide evidence-based MAT treatment utilizing the FDA approved medications to individuals diagnosed with opioid dependence throughout the state would ensure that affordable and sustainable treatment is available and accessible to all individuals throughout the state.

Additional funds could be used to promote education to local communities on the effectiveness of utilizing MAT treatments and the effectiveness of recovery oriented treatment services.

Funding could be utilized to provide technical assistance for local programs addressing the utilization of MAT, increase opportunities for provider training addressing safe prescribing practices, and diversion control planning as well as assist in identifying programs that consistently operate within the established best practices.
Environmental Factors and Plan

16. 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 behavioral health 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 behavioral health 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 behavioral health 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:

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**Please respond to the following items:**

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) WRAP Post-Crisis
   b) Peer Support/Peer Bridgers
   c) Follow-up Outreach and Support
   d) Family-to-Family Engagement

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e) Connection to care coordination and follow-up clinical care for individuals in crisis
f) Follow-up crisis engagement with families and involved community members
g) Recovery community coaches/peer recovery coaches
h) Recovery community organization

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

SAMHS’ contracts with statewide provider agencies to administer the Maine 24 hour Crisis Hot line. In addition, Crisis Mobile Response services are immediate, crisis-oriented, on-scene services positioned toward stabilization of an acute, emotional disturbance to ensure the safety of a consumer, and the community, in the least restrictive setting. 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 as clinically appropriate. The provider shall abide by the Rights of Recipients of Mental Health Services when providing services to Maine residents. See: http://www.maine.gov/dhhs/samhs/mentalhealth/rights-legal/index.html

Crisis Services is provided to consumer(s) of all ages who exhibit disturbed thought patterns or behavioral and/or emotional disturbances. 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 as appropriate. 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 a day in order to provide face-to-face crisis assessments. Crisis Assessments, telephone service which is the point of entry for crisis intervention services, and Memorandums of Understanding (MOU) with all providers and hospitals in the area exist between and amongst the parties to ensure the minimum Crisis Service System requirements are achieved.

This Service is supported with both MaineCare and State general funding with cross collaboration between SAMHS, Office of Child and Family Services, and Office of Aging and Disabilities all under DHHS.

Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

17. Recovery - Required

Narrative Question

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Peer-run respite services
- Whole Health Action Management (WHAM)
- Peer-run crisis diversion services
- Shared decision making
- Drop-in centers
- Telephone recovery checkups
- Person-centered planning
- Recovery community centers
- Warm lines
- Self-care and wellness approaches
- Peer specialist
- Supportive housing models
- Peer recovery coaching
- Self-directed care
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Peer wellness coaching
- Evidenced-based supported employment
- Room and board when receiving treatment
- Peer health navigators
- Wellness Recovery Action Planning (WRAP)
- Family navigators/parent support partners/providers
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Peer-delivered motivational interviewing
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:

   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

   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 abuse services. The QIC reviews, monitors and advises the state mental health and substance abuse system in a variety of areas. Our main focus is the SAMHSA Block Grant allocations which include behavioral, developmental and substance abuse issues for children, youth, family, young adults and adults.

   Our purpose is to foster accountability through our working relationships with state entities involved with the provision of behavioral health services. We aim to create a platform for children, youth, family, young adult and adult voices to give their perspectives on policy and funding issues.

   QIC Mission: Our mission is to improve the state system of mental health and substance abuse disorder services by magnifying the voice of the Mainer’s with lived experiences and their families by making specific recommendations for improvements.

   QIC Vision: The QIC wants every individual served by the Maine Department of Health and Human Services be provided with the highest standards of quality mental health and substance abuse services in an environment of respect and empowerment.

   The Consumer Council System of Maine (CCSM) is an independent, public instrumentality established by Maine law (Title 34-B, §3611). The CCSM is responsible for providing an independent and effective consumer voice into mental health public policy, services, and funding decisions. The CCSM consists entirely of past/present recipients of mental health services (consumer/peers), including all Statewide Consumer Council representatives and paid staff. CCSM welcomes and needs the participation of all mental health consumers/peers from all over Maine.

   CCSM Mission Statement: The Consumer Council System of Maine represents fellow consumers with an effective, organized voice in shaping public policy and mental health services. We hold as essential the participation of all consumers and look to collaborate with allies to find realistic solutions to local and statewide issues and to advance recovery-oriented, consumer-driven mental health care and peer-run recovery opportunities.

   CCSM Vision Statement: The Consumer Council System of Maine leads the way as a well-established cornerstone of a recovery-oriented system of mental health care, moving forward with courage and creativity, directed by an informed, diverse grassroots consumer network.

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-orientated 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, a peer crisis respite program, supported employment, evidence based clubhouses, long-term vocational support, peer support in emergency departments in some hospitals, peer support at Riverview Psychiatric Center, the Stability Through Engagement Program (STEP) housing program and an Intentional Peer Support Training and Certification Program. Many of these supports are designed to be low-barrier and easily accessible for individuals.

   For children with SED, the following recovery supports are available to children and their families: In home supports including Home Community Treatment, Functional Family Treatment and Multi-Systemic Treatment; Drop In opportunities, Peer Specialists, Youth Peer Support, Parent 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.

The Department has submitted a State Plan Amendment (SPA) request to CMS for approval, and anticipates that CMS will approve the Opioid Health Home SPA. Pending CMS approval, covered services will be provided as described in this rule.

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.

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

Through the State of Maine Request for Proposals (RFP), Mental Health Block Grant funds were utilized to support a Recovery Based Training Program designed to utilize the Peers in the delivery of Recovery Based training curriculum in January 2017. Sweeter is located in Brunswick and is a community based Mental Health provider. Sweeter will provide a Recovery Based Training program This also includes ensuring that all Recovery Based training’s are accessible and available Statewide, including rural and underserved areas of Maine. Trained Peers will then become facilitators, who introduce the evidenced informed recovery curriculum and ongoing skill development to other Peers employed or volunteering in Behavioral Health Setting HH services setting such as Behavioral Health homes, assertiveness community treatment programs, Club Houses and Peer run recovery centers. The curriculum provides skills to support individuals in Recovery from behavioral health issues, aligns with their efforts with the principals of Intentional Peer Support, and promotes evidence based or promising practices. Peers with lived experiences have critical roles in caring for themselves and each other, whether informally through self-help or more formally through Peer Support Services. Their involvement with Recovery Based Training will strengthen the program and assist in achieving desirable outcomes.

In 2017, SAMHS sponsored a training titled: "A Day of Dialogue: Peer Role on Behavioral Health Home Teams". It was facilitated by SAMHS Lead CIPSS trainer, with special keynote guest Chris Hansen, who worked in mental health user/survivor politics and peer groups in New Zealand and Internationally for ten years. One of the missions of IPS in Maine is to influence traditional practice so that it is more consumer friendly. Peer workers can help make that change and both SAMHS and OCFS have contracts for peer support.

OCFS has dedicated their MHBG funding, as recommended by the QIC, to Peer Support for both youth and parents of youth with SED/SMI. This evidence based practice is not covered by Maine’s State Medicaid Plan, yet the results of this support are immeasurable.

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

Footnotes:
Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office 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.

Please respond to the following items

1. Does the state’s Olmstead plan include:
   - housing services provided. [Yes / No]
   - home and community based services. [Yes / No]
   - peer support services. [Yes / No]
   - employment services. [Yes / No]

2. Does the state have a plan to transition individuals from hospital to community settings? [Yes / No]

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?
   - SAMHS is implementing a redesign of our Mental Health Rehabilitation Technician / Community Training and Certification processes that 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 and Community Rehabilitation Services.
   - MHBG funding is being utilized for peer services and also the Peer Recovery Training Program has been added, this provides training for WRAP Facilitators.
   - 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:
Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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 behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (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).


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 behavioral health 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 behavioral health 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.)

The Office of Child and Family Services, Children’s Behavioral Health Services (CBHS) is the authority in Maine regarding behavioral health treatment and services for children from birth up to their 21st birthday. 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), and the Office of Substance Abuse and Mental Health Services (SAMHS).

These relationships are nurtured and strengthened through active collaboration within the system of care. Collaboration and partnerships are developed at the regional level where services are delivered to children and their families, at the policy level where strategies are formulated and values are supported, and at the practice level where behavioral health services are shaped, evaluated, and promoted, based on outcomes beneficial to children and their families. Substance Abuse treatment for adolescents falls under SAMHS purview.

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

SAMHS FY18 contracts for adolescent treatment services total $1,036,682. $372,139 of the total is from block grant funds and the remaining $664,543 from State General Funds (including Funds for Healthy Maine.) Services provided include Outpatient, Intensive Outpatient (IOP), Residential and school based (excluding juvenile detention services discussed above and SYT-I described below)
and are targeted to youth with a substance use disorder or a substance use disorder with a co-occurring mental health condition. Most adolescent services are located in the central and southern parts of the state. Treatment providers located in other geographic areas and may serve adolescents on an incidental basis.  

In 2015, Maine applied for and was awarded $800,000 for three years through SAMHSA’s State Youth Treatment-Implementation (SYT-I) cooperative agreement to build upon infrastructure achieved during the implementation of the SAMHSA State Adolescent Treatment Enhancement and Dissemination (SATED) cooperative agreement. SYT-I funds have been used to improve the State’s capacity to increase access to evidence-based assessment, treatment, and recovery supports for youth with substance use disorders, mental illness or co-occurring disorders; to improve the quality of evidence-based treatment and recovery supports for adolescents (age 12-18) and youth in transition (ages 16-25); and to improve access to services for families and primary caregivers. 

Two agencies Day One, Inc. and Sequel Care were selected through a Request for Proposals process to implement the Adolescent Community Reinforcement Approach with the younger youth and their families in the southern and Midcoast areas of the State. Medication Assisted Treatment was to be made available to transitional age youth through SYT-I. However, The need for adolescent treatment services in the rural area of the State far exceeds the available resources. Please indicate areas of technical assistance needed related to this section. 

A particular area of need is for residential services for transitional age youth (19 through 25). These transitional age youth are faced with entering the adult treatment system which is not geared to addressing their specific developmental needs. If they participate in residential treatment at all, they have to enter facilities with older adults who are further along the continuum of substance abuse and accompanying criminal behavior.

There is currently one agency in the state, Day One, that is partially addressing this need by extending the age range of youth served from thirteen to eighteen (13-18) to thirteen to twenty (13 – 20). Day One has three residential treatment facilities which meet the American Society of Addiction Medicine’s (ASAM) level 3.5, adolescent criteria. They are located in York and Somerset Counties. There are a total of 27 beds, six of which are for females.

**Footnotes:**
### Behavioral Health Advisory Council Members

**Start Year:** 2018  
**End Year:** 2019

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<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
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<tr>
<td>Diane Bouffard</td>
<td>Parents of children with SED</td>
<td>GEAR Parent Net/Kennebec CR/THRIVE EvalCmte/CAAN/MaineYouth Suicide</td>
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<tr>
<td>Samuel Chamberlain</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
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<td>Genevieve Doughty</td>
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<td>Dept of Labor Vocational Rehabilitation</td>
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<td>Dan Herndal</td>
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<td>DHHS Office of Substance Abuse and Mental Health Services</td>
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<td>Jessica Wood</td>
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Footnotes:
Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018  End Year: 2019

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<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>14</td>
<td>56.00%</td>
</tr>
<tr>
<td>State Employees</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>11</td>
<td>44.00%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>**Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>abuse services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federally Recognized Tribe Representatives</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>people)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

We do have someone from the LGBTQ population but there is not a drop down box for that. We are continually looking for more members from the diverse racial and ethnic population the council was very involved in the application process. There is great communication between the state and the council.

Footnotes:
Environmental Factors and Plan

23. 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:

   The Office of Substance Abuse and Mental Health Services placed the following information on a web page on the SAMHS website at:
   This information was then sent out through the various listservs that the Office of Substance Abuse and Mental Health Services has as well as its partners that cover the Substance Abuse and Mental Health Prevention, Intervention, Treatment, and Recovery services and consumers in Maine, as well as the general public through social media links through the provider networks. This information was also shared with state level partners and stakeholders. Individuals were able to complete the online form below or call into our office to provide comments.

   Office of Substance Abuse and Mental Health Services The Maine Office of Substance Abuse and Mental Health Services (SAMHS) is in the process of developing FY 18/19 Grant Applications to Substance Abuse and Mental Health Administration (SAMHSA) for the “Community Mental Health Services Plan and Report and the “Substance Abuse Prevention and Treatment Plan and Report”. SAMHS is seeking input from the community and stakeholders to guide SAMHS in preparing and submitting two (2) separate applications to address Maine’s Mental Health and Substance Abuse systems of care and service delivery.

   View SAMHS' Grant Application site (http://www.maine.gov/dhhs/samhs/grants/index.shtml):
   The comment Form had the following information fields: Name, Organization, Phone, Email, and Comment. Comments were received, reviewed, and taken into consideration when drafting the SAPT Block Grant Behavioral Health Assessment and Plan 2018-2019.
   c) Other (e.g. public service announcements, print media) ☐ Yes ☐ No

Footnotes:
Maine

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 10/16/2018 4.14.33 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance
State Information

Plan Year
Start Year 2018
End Year 2019

State DUNS Number
Number 80-904-559
Expiration Date

I. State Agency to be the Grantee for the Block Grant
Agency Name Department of Health and Human Services
Organizational Unit Office of Substance Abuse and Mental Health Services (SAMHS)
Mailing Address 11 SHS, 41 Anthony Ave
    City Augusta
    Zip Code 04333-0011

II. Contact Person for the Grantee of the Block Grant
First Name Sheldon
Last Name Wheeler
Agency Name Office of Substance Abuse and Mental Health Services
Mailing Address 11 SHS, 41 Anthony Ave
    City Augusta
    Zip Code 04572
Telephone 207-287-2595
Fax 207-287-4334
Email Address Sheldon.Wheeler@Maine.gov

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 9/28/2018 3:37:34 PM
Revision Date 10/16/2018 4:14:09 PM

V. Contact Person Responsible for Application Submission
First Name Tara
Last Name Pelotte
Telephone 2072872516
Fax
Email Address Tara.M.Pelotte@Maine.gov

Footnotes:
# State Information

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

### Fiscal Year 2019

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

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

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<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
<td>42 USC § 300x-26</td>
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<td>Section 1927</td>
<td>Treatment Services for Pregnant Women</td>
<td>42 USC § 300x-27</td>
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<td>Section 1928</td>
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<td>Maintenance of Effort Regarding State Expenditures</td>
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<td>42 USC § 300x-31</td>
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<td>Application for Grant; Approval of State Plan</td>
<td>42 USC § 300x-32</td>
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<tr>
<td>Section 1935</td>
<td>Core Data Set</td>
<td>42 USC § 300x-35</td>
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## Title XIX, Part B, Subpart III of the Public Health Service Act

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<td>42 USC § 300x-52</td>
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<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
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<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
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<td>42 USC § 300x-57</td>
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<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
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<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
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<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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 other Certifications summarized above.

State: ______________________________________________________________________

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

Signature of CEO or Designee¹: ______________________________________________________________________

Title: ______________________________________________________________________ Date Signed: ______________________________________________________________________

mm/dd/yyyy

Footnotes:

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

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

Fiscal Year 2019

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
<td>42 USC § 300x-26</td>
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<tr>
<td>Section 1927</td>
<td>Treatment Services for Pregnant Women</td>
<td>42 USC § 300x-27</td>
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<tr>
<td>Section 1928</td>
<td>Additional Agreements</td>
<td>42 USC § 300x-28</td>
</tr>
<tr>
<td>Section 1929</td>
<td>Submission to Secretary of Statewide Assessment of Needs</td>
<td>42 USC § 300x-29</td>
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<tr>
<td>Section 1930</td>
<td>Maintenance of Effort Regarding State Expenditures</td>
<td>42 USC § 300x-30</td>
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<td>Section 1931</td>
<td>Restrictions on Expenditure of Grant</td>
<td>42 USC § 300x-31</td>
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<tr>
<td>Section 1932</td>
<td>Application for Grant; Approval of State Plan</td>
<td>42 USC § 300x-32</td>
</tr>
<tr>
<td>Section 1935</td>
<td>Core Data Set</td>
<td>42 USC § 300x-35</td>
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Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
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<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
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<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
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<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
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<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
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<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
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<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
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<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
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<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
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</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§229d-dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violation pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions
to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1970, 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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential
components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as
amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic

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 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,”
Printed: 8/3/2018 3:25 PM - Maine
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 other Certifications summarized above.

State: Maine  

Name of Chief Executive Officer (CEO) or Designee: Scott T. Lever, Esq.

Signature of CEO or Designee: Scott T. Leve

Title: Deputy Commissioner  

Health Services  

Date Signed: 8-7-18

Footnotes:

1 If the agreement is signed by an authorized designee, a copy of the designation must be attached.
October 30, 2017

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

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

Dear Ms. Simmons:

This letter is to serve as authorization for Scott Lever, Deputy Commissioner of Health Services,
Department of Health and Human Services, to sign for the SAMHSA Substance Abuse
Prevention and Treatment 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,

[Signature]
Paul R. LePage
Governor

Cc: Ricker Hamilton, Acting Commissioner, Maine DHHS
Scott Lever, Deputy Commissioner of Health Services, Maine DHHS
Sheldon Wheeler, Director, 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>
<tr>
<th>Name</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td></td>
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</table>

**Signature:**

**Date:**

**Footnotes:**
### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2018  Planning Period End Date: 9/30/2020

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FY 2018 SA Block Grant Award</th>
<th>FY 2019 SA Block Grant Award</th>
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<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$5,090,813</td>
<td>$5,090,079</td>
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<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$1,529,992</td>
<td>$1,529,992</td>
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<tr>
<td>3. Tuberculosis Services</td>
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<tr>
<td>4. Early Intervention Services for HIV *</td>
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<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$347,725</td>
<td>$347,725</td>
</tr>
<tr>
<td>6. Total</td>
<td>$6,968,530</td>
<td>$6,967,796</td>
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</table>

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.
### Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2018  Planning Period End Date: 9/30/2020

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2018 SA Block Grant Award</th>
<th>FY 2019 SA Block Grant Award</th>
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<tbody>
<tr>
<td><strong>Information Dissemination</strong></td>
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<td></td>
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<td><strong>Alternatives</strong></td>
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<td>Community-Based Process</td>
<td>$162,646</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Prevention Expenditures</strong></td>
<td><strong>$1,079,992</strong></td>
<td><strong>$1,079,992</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$6,968,530</strong></td>
<td><strong>$6,967,796</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>15.50 %</strong></td>
<td><strong>15.50 %</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures*
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2018    Planning Period End Date: 9/30/2020

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
<th>FY 2019 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$675,404</td>
<td>$675,404</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$225,135</td>
<td>$225,135</td>
</tr>
<tr>
<td>Selective</td>
<td>$100,508</td>
<td>$100,508</td>
</tr>
<tr>
<td>Indicated</td>
<td>$78,945</td>
<td>$78,945</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,079,992</strong></td>
<td><strong>$1,079,992</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$6,968,530</strong></td>
<td><strong>$6,967,796</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>15.50 %</strong></td>
<td><strong>15.50 %</strong></td>
</tr>
</tbody>
</table>

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

**Footnotes:**
### Planning Tables

#### Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2018       Planning Period End Date: 9/30/2020

<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>✓</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✓</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✓</td>
</tr>
<tr>
<td>Cocaine</td>
<td>✓</td>
</tr>
<tr>
<td>Heroin</td>
<td>✓</td>
</tr>
<tr>
<td>Inhalants</td>
<td>✓</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>✓</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>✓</td>
</tr>
<tr>
<td>Military Families</td>
<td>✓</td>
</tr>
<tr>
<td>LGBT</td>
<td>✓</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✓</td>
</tr>
<tr>
<td>African American</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>✓</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>✓</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td></td>
</tr>
</tbody>
</table>
### Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
<th>FY 2019 A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td>$189,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$189,000</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$38,000</td>
<td>$0</td>
<td></td>
<td>$38,000</td>
<td>$0</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$408,500</td>
<td>$117,000</td>
<td></td>
<td>$408,500</td>
<td>$117,000</td>
<td></td>
<td></td>
<td>$117,000</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td>$20,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$20,000</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$503,500</td>
<td>$54,000</td>
<td></td>
<td>$503,500</td>
<td>$54,000</td>
<td></td>
<td></td>
<td>$54,000</td>
</tr>
<tr>
<td>8. Total</td>
<td>$0</td>
<td>$950,000</td>
<td>$450,000</td>
<td>$0</td>
<td>$0</td>
<td>$950,000</td>
<td>$450,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**

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Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the Consolidated Appropriations Act, 2016 (P.L. 114-113) signed by President Obama on December 18, 2015.

Section 520. Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification from the State Project Officer. Please note that the term used in the SABG statute and regulation, intravenous drug user (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, persons who inject drugs (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when modifying the Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016 the federal government released three guidance documents regarding SSPs: These documents can be found on the Hiv.gov website: https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs,


3. The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf,

Please refer to the guidance documents above when requesting a modification to the state’s 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017 funds and support an existing SSP or establish a new SSP
- Include proposed protocols, timeline for implementation, and overall budget
• Submit planned expenditures and agency information on Table A listed below

• Obtain State Project Officer Approval

• Collect all SSP information on Table B listed below to be reported in the FFY 2019 SABG report due December 1, 2018

End Notes

1 Section 1923(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-23(b)) and 45 CFR ? 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2016 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 SABG funds only and is consistent with guidance issued by SAMHSA.

2 Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. ? 300x-31(a)(1)(F)) and 45 CFR ? 96.135(a)(6) explicitly prohibits the use of SABG funds to provide persons who inject drugs (PWID) with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

3 Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2016 (P.L. 114-113)

4 Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(a)) and 45 CFR ? 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(b)) and 45 CFR 96.128 requires ?designated states? as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

5 Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016 describes a SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all of the following services:

• Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;

• HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;

• Provision of naloxone (Narcan?) to reverse opiate overdoses;

• Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;

• Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and

• Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of a SSP that can be supported with federal funds.

• Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);

• Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;

• Testing kits for HCV and HIV;

• Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
• Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

• Provision of naloxone to reverse opioid overdoses

• Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;

• Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;

• Communication and outreach activities; and

• Planning and non-research evaluation activities.

Footnotes:
Maine has no plans at this time to modify the FY2018-2019 SABG Behavioral Health Assessment and Plan based on The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction 1,2 on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)), which was modified by the Consolidated Appropriations Act, 2016 (P.L. 114-113) signed by President Obama on December 18, 20153.
### Syringe Services (SSP) Program Information-Table A

<table>
<thead>
<tr>
<th>Syringe Services Program SSP Agency Name</th>
<th>Main Address of SSP</th>
<th>Dollar Amount of SABG funds used for SSP</th>
<th>SUD Treatment Provider</th>
<th>Number Of Locations (include mobile if any)</th>
<th>Narcan Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Data Available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**

### Environmental Factors and Plan

**Syringe Services (SSP) Program Information-Table B**

<table>
<thead>
<tr>
<th>Syringe Service Program Name</th>
<th># of Unique Individuals Served</th>
<th>HIV Testing</th>
<th>Treatment for Substance Use Conditions</th>
<th>Treatment for Physical Health</th>
<th>STD Testing</th>
<th>Hep C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>ONSITE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral to testing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Footnotes:**

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Environmental Factors and Plan

24. 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:

      The Office of Substance Abuse and Mental Health Services placed the following information on a web page on the SAMHS website at:

      This information was then sent out through the various list-servs that the Office of Substance Abuse and Mental Health Services has as well as its partners that cover the Substance Abuse and Mental Health Prevention, Intervention, Treatment, and Recovery services and consumers in Maine, as well as the general public through social media links through the provider networks. This information was also shared with state level partners and stakeholders. Individuals were able to complete the online form below or call into our office to provide comments.

      Office of Substance Abuse and Mental Health Services The Maine Office of Substance Abuse and Mental Health Services (SAMHS) is in the process of developing FY 18/19 Grant Applications to Substance Abuse and Mental Health Administration (SAMHSA) for the “Community Mental Health Services Plan and Report and the “Substance Abuse Prevention and Treatment Plan and Report”. SAMHS is seeking input from the community and stakeholders to guide SAMHS in preparing and submitting two (2) separate applications to address Maine’s Mental Health and Substance Abuse systems of care and service delivery.


      The comment Form had the following information fields: Name, Organization, Phone, Email, and Comment. Comments were received, reviewed, and taken into consideration when drafting the SAPT Block Grant Behavioral Health Assessment and Plan 2018-2019.

      Please note that the F19 MiniPlan is expected to be posted online as soon as it has been reviewed by appropriate staff at the DHHS Commissioner’s Office and the SAMHS Webmaster.

   c) Other (e.g. public service announcements, print media)  
      ☐ Yes ☐ No

Footnotes: