Maine

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 2.28.22 PM)

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

Plan Year
Start Year 2017
End Year 2019

State DUNS Number
Number 809045594
Expiration Date

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

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

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 9/1/2017 2:27:28 PM
Revision Date

V. Contact Person Responsible for Application Submission
First Name Cynthia
Last Name McPherson
Telephone (207) 287-2595
Fax (207) 287-9152
Email Address cynthia.mcpherson@maine.gov
## 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
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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 nondiscrimination 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 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.): (a)


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: Scott Lever

Signature of CEO or Designee1: 

Title: Chief Operating Officer and Chief Financial Officer Date Signed: 

mm/dd/yyyy

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

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Fiscal Year 2018

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Name of Chief Executive Officer (CEO) or Designee: Scott Lever

Signature of CEO or Designee: _________________________________

Title: Chief Operating Officer and Chief Financial Officer  Date Signed: 8/31/2017

mm/dd/yyyy

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

Printed: 9/1/2017 2:28 PM - Maine - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
## State Information

### Disclosure of Lobbying Activities

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

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**Signature:**

**Date:**

8/31/17

**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:
STRUCTURE OF THE SYSTEM OF CARE

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

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

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

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

The OCFS does not provide direct service to families; rather it contracts with community providers who deliver the services to families and children. OCFS ensures that the contracted providers follow the contractual obligations and that families and youth show improvement in functioning as a result of participating in services.

**Target Populations**

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

- a. Children who have developmental disabilities or severe developmental delay, birth through 5;
- b. Children and adolescents, from birth to their 21st birthday, who have emotional/behavioral needs including children with serious emotional disturbance;
- c. Children, birth to their 21st birthday, who have intellectual disability, autism spectrum disorders or pervasive developmental delay

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

**State/Local Administrative Structure**

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

- Ensuring that any child who is eligible for Medicaid (MaineCare) between birth and their 21st birthday, and their family, identified as needing a behavioral health intervention, have access to, and receive this service in the most effective, and least restrictive setting possible:
  - That all youth transition successfully to adulthood,
  - That all possible employment options are sought for all youth,
  - That underserved populations, such as ethnic minorities, LGBTQ youth, tribal youth and those with correctional involvement are served within our System of Care
  - OCFS Requests for Proposals and subsequent contracts mandate that these underserved populations are addressed by the provider’s service.
- Ensuring that children receive evidenced-based practices whenever possible,
- Oversight and review of youth receiving residential treatment in state and out of state,
- Reviewing suicides and serious suicide attempts,
- Collaborating and consulting on child welfare cases for youth with behavioral health needs
- Work with the Office of MaineCare Services in developing and implementing policy related to children’s services,
- Overseeing the Block Grant for Community Mental Health Services funding and implementation,
- Overseeing Homeless and Transitional Living Programing for youth,
• Providing program leads and content expertise for all contracts, i.e. respite, family support, BHP training, deaf services, etc.

Other Units within the Office of Child and Family Services

OCFS: Child Protective Unit is responsible for:
• Prevention services which seek to promote the health, well-being, and safety of children and families by reducing the risk and effects of adverse childhood experiences (such as neglect, trauma, or exposure to violence). Administering best practice services that create a community of caring for intergenerational members focused on increasing protective factors such as; health, education and safety promotion, parenting education, social connections and family strengthening supports,
• Assessing the safety of children in the custody of their parents or caregivers. Developing plans to insure safety of children in their homes,
• When children cannot be cared for safely in their homes, petitioning the court for custody and licensing alternative living situations, which provide safety and stability for children in DHHS custody. Rehabilitative and reunification services are provided to families when their children are no longer safe in their care,
• Adoption services are provided for families who are interested in adopting children in DHHS custody, when the Court determined that they could not return home.
• Provide transitional services for youth in care who have reached the age of 18 and are in need of assistance to reach their educational and vocational goals.

OCFS: Early Intervention and Prevention Services:
This team seeks to promote the health, wellbeing and safety of children and families by reducing the risk and effect of adverse childhood experiences (such as neglect, trauma, or exposure to violence). This unit administers best-practice services that create a community of caring for intergenerational members focused on increasing protective factors. This work is done through Early Care and Education, Policy and Training initiatives and Prevention services.

OCFS: Operations:
This unit is responsible for managing and directing the Offices operational activities.
Services include:
• Internal quality assurance and quality improvement programs;
• Administration of the Title IV-E program;
• Administration of the Foster Care Adoption program;
• Informational services systems including the Maine Automated Child Welfare Information System (MACWIS) and Phoenix;
• Technology and reporting services;
• Financial services, including reporting, budget, and audit;
• Services related to the Interstate Compact for the Placement of Children (ICPC);
• Procurement and contracting services; and
• Primary liaison regarding federal regulations impacting OCFS financial and practice matters.

CHILDREN’S BEHAVIORAL HEALTH SERVICES TEAM

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

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

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

- **Behavioral Health Policy Coordinator**: Policy Coordinator works closely with the Office of Maine Care to write and implement Maine Care Policies that govern services for children in need of behavioral health treatment; creates and implement standards of care for Treatment Services; ensures that Evidenced-Based Practices are used as much as possible and work to increase the use of EBP in children’s behavioral health service; creates performance measures for children’s behavioral health services; works closely DHHS’s contracted Administrative Services Organization (ASO) KEPRO, which provides comprehensive healthcare management; and reviews and analyzes children’s behavioral health data. Policy Coordinator also provides program oversight for contracted services.

- **Program Coordination Team Leader**: Responsibilities include supervision of the Program Coordinators and is the OCFS Lead for Crisis Services and Transition.
  - Program Coordinators are responsible for ensuring that youth with social and emotional challenges receive the most effective treatment services in the least restrictive environment. They provide behavioral health education and resources to Child Welfare Staff and the community, and on-call coverage for out of state hospitalization. They keep abreast of promising and evidenced-based practice models, and inform policy and practice. This team is reviews children between the ages of 16 and their 21st birthday who have a developmental disability to ensure a smooth transition to adulthood. Two program coordinators are assigned to the juvenile corrections system, to ensure that youth involved in corrections have their mental and behavioral health needs met.

- **Clinical and Community Resource Team Leader**: Responsibilities include supervision of the Children’s Resource Coordinators and the Care Coordination team.
  - Resource Coordinators: Resource Coordinators develop and maintain a comprehensive array of behavioral health resources for children with Autism, Intellectual Disabilities, and mental health problems. They are the primary contact for agencies seeking to provide behavioral health services for children, and for agencies seeking information and/or technical assistance from the Department. They ensure there is clear communication between the Department and the children’s services providers, and disseminate information regarding Department policies and legal requirements. They develop resources to meet needs in underserved areas.
  - Care Coordination: A combination of Master’s Level Social Workers and Nursing Staff are responsible for ensuring that youth in treatment services are receiving effective, quality treatment, and are safe within their treatment environment. Tasks include: review and follow up on Reportable Events; three person committees for youth requiring intrusive interventions; following youth in DHHS custody who are taking psychotropic medication; providing behavioral health training to Child Welfare Staff; providing behavioral health care training to Community Providers, providing a Gate Keeping function for youth entering residential care, and providing oversight and recommendations for the comprehensive health care needs of youth entering the custody of DHHS.

- **Youth and Family Program Specialist**: Oversees and manages homeless youth service contracts; oversees and manages the Community Mental Health Block Grant and the services the MHBG funds which includes parent, family, youth peer support and the First Episode Psychosis programming; and Respite Services for youth with behavioral health diagnoses.
  - Family Information Specialist: A parent of a young adult with developmental disabilities who assists parents seeking access to services for their child/youth. Provides information to parents about community services, transition services, and maintains updated information about behavioral health providers statewide. This person also receives and processes grievances filed with the Department on behalf of families, and also processes requests for Individualized Planning Funds.

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

- **Information Systems Manager** provides oversight and management of Information services and data related to OCFS business and programs. The Information Systems Manager supervises several staff that oversees electronic data management systems, and assists OCFS with data collection and distribution. This information is used to make adjustments to programming as needed.

- **Finance Program Manager** provides oversight and management of a team that is responsible for effectively and efficiently ensuring the operation of OCFS financial systems/processes through meeting federal, state, and Department requirements and deadlines.
• **Contract Services Manager** provides management of the procurement unit, which supports program staff in accessing services for the public. The procurement unit ensures that resources are used effectively and efficiently on behalf of the taxpayer, and that procurement processes follow relevant laws and regulations.

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

For all services delivered to families and children, OCFS ensures that contracted providers have access to interpreter services so that language is not a barrier to families receiving proper treatment for their family. Additionally, contracts with provider agencies include language that ensures that the needs of diverse ethnic, racial and sexual gender minorities as well as American Indian populations are served, (ex: “ensure services are available to specific underserved individuals, such as individuals who have encountered the criminal justice system, LGBT individuals, and Indian Tribal Members.”)

**Children’s Mental Health Services:** CBHS contracts with private community-based agencies to provide the following Behavioral Health Services: case management; crisis services; Family Peer Support; Youth Peer Support; clinical home and community-based behavioral health treatment; rehabilitative community support services; outpatient counseling and therapies; respite services; medication management; homeless outreach, drop in, shelter and transitional living services; and short-term, intensive residential treatment services. Individual Planning Funds are also available to families who apply and are approved.

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

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

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

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

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

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

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

- **Residential Services** short-term intensive residential treatment services (ITRTS) for children with behavioral health treatment needs. Out-of-home residential services include specialized therapeutic homes with foster parents recruited and trained to care for children with serious emotional and behavioral challenges. Behavioral health services provide short-term, intensive temporary out of home treatment services (ITRTS).

**INTEGRATION OF CHILDREN’S SERVICES**
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.

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

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

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

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

The Department of Education conducts administrative and program operations from its central office in Augusta. The Department serves a diversified public school constituency at the local level. DOE’s Special Education unit relates primarily to Special Education Directors within the public schools. Maine currently has 242 school administrative units comprised of 492 municipalities. There are a total of 737 schools in Maine, 620 are public schools and 117 are approved private schools.

The Child Development Services system is an Intermediate Educational Unit that provides both Early Intervention (birth through two years) and Free Appropriate Public Education (for ages three through five years) under the supervision of the Maine Department of Education. CDS consists of nine regional sites and a state office. The state CDS office maintains a central data management system, system-wide policies and procedures, and provides centralized fiscal services for regional CDS sites.
**System of Integrated Services:** Chapter 790, Public Law 1997 - A Coordinated System of Children’s Mental Health Services  
One year after the 118th Legislature commissioned a study of mental health services to Maine children and their families (LD 1744), which resulted in A Plan for Children’s Mental Health Services, the legislature completed the reform process by passing LD 2295, Chapter 790, P.L. 1997, titled “An Act to Improve the Delivery of Mental Health Services to Children.”

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

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

**Section 15002: Children’s Mental Health Program:**
This program represents the structure coordinating the children’s mental health care provided by all child serving departments. The program is under the supervision of the Commissioner of DHHS. The Director of the Office of Child and Family Services has responsibility for the implementation, monitoring and oversight of the program.

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

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

**Section 15003: Responsibilities of the Departments:**
Each Department has entered into memoranda of agreement that recognize DHHS as being responsible for the implementation and operation of the Children’s Mental Health Program, and specifies the other Departments’ respective responsibilities.

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

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

Management information systems focus on care and support services delivered, needs and unmet needs for care, waiting lists, resource development, and costs of the program. Information is kept by treatment need, care provided, geographic area, and Departmental involvement. Information covers children placed out of state who transfer to care in the State of Maine.
The law (Chapter 790) placed considerable emphasis on regular reporting to newly created oversight committee and to the legislature’s Joint Standing Committee on Health and Human Services. All child-serving Departments continue to provide information to their legislative committees of jurisdiction, such as the Joint Standing Committee on Health and Human Services that oversees DHHS Office of Child and Family Services. Other committees of jurisdiction include the Joint Standing Committees on Education and Cultural Affairs and Criminal Justice and Public Safety.

**Section B-2: Planning for Children with Autism, ID and DD**
CBHS, in consultation and cooperation with the other child serving departments, was charged to develop a comprehensive system of services for children with autism, developmental disabilities, and intellectual disability. In designing the service system, the Department utilized the framework of the Children’s Mental Health Program. OCFS has fully integrated children with intellectual disability and autism spectrum disorders into the system of services developed for children with mental health needs.

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

**SYSTEMS ACCESS: PROGRAM AND UTILIZATION REVIEW**

**Inpatient Services and Hospital Capacity:** As of July 2017 the number of beds for children and adolescents at Maine inpatient psychiatric hospitals totaled 97 and were allocated as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Location</th>
<th>Service Type + amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring Harbor</td>
<td>Westbrook</td>
<td>Child=14, Adolescent=14 MR/DD/Autism Unit = 12</td>
<td>40</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>Lewiston</td>
<td>Child/ Adolescent = 18</td>
<td>18</td>
</tr>
<tr>
<td>Northern Maine Medical Center</td>
<td>Fort Kent</td>
<td>Serves age range from 4-17</td>
<td>7</td>
</tr>
<tr>
<td>Acadia (Bangor)</td>
<td>Bangor</td>
<td>Child=16, Adolescent=16</td>
<td>32</td>
</tr>
<tr>
<td>Maine Inpatient Psychiatric Beds</td>
<td></td>
<td></td>
<td>97</td>
</tr>
</tbody>
</table>

Maine has two privately operated psychiatric facilities: one is in Bangor with a child and adolescent unit of 32 beds; and one is in Portland with two child and adolescent units of 14 each, as well as a 12-bed unit for individuals with MR/DD/ASD. There are two general hospitals with child psychiatric units: a 7 bed unit in northern Maine (Fort Kent); and an 18 bed unit in central Maine (Lewiston).

**Residential Treatment Services: Intensive Temporary Residential Treatment Services (ITRTS) Policy**
ITRTS is defined as an intensive level of care that provides treatment for children and adolescents in a structured setting that includes 24- hour supervision. Treatment services/out of home placements are provided for children who do not require hospital level of care. These services cannot be delivered in a home setting, due to the unsafe behaviors of the child.

Formal prior authorization and continued stay review for residential treatment are required for all children. This integrated system ensures that all children across the state receive the most effective treatment services, in the least restrictive environment, for the right amount of time. The prior authorization process includes submission of an application and clinical documentation that is then reviewed by the state’s administrative service organization, KEPRO. Once a child is admitted into a residential treatment program, any requests for continued stay are submitted by the residential provider. KEPRO utilizes the same eligibility criteria used during the prior authorization process to determine if the child continues to require this level of care.
ITRTS residential data reflects all children who have received residential treatment. In FY17, a total of 493 children received residential treatment services. CBHS continues to monitor these numbers in an effort to ensure that children in Maine receive the most effective treatment services in the least restrictive environment possible.

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

The census of children who were placed out of state in June 2016 was 22, and the census of children placed out of state in June 2017 was 19, a net change of -3 children during the 12 month period.

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

The following agencies have specific programs for youth that are funded through SAMHS to provide substance abuse treatment to youth. **Residential** – Day One (3 sites with 27 beds); **Intensive Outpatient** - Day One; **Outpatient Program** – Day One, SequelCare of Maine, Community Concepts (school based services). While these programs have specific programs for adolescents, most substance abuse providers in the State of Maine do work clinically with adolescents as well as adults.

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

Medical services for children are provided through MaineCare. Public health services are provided through the Department of Health and Human Services (DHHS), Center for Disease Control. OCFS does not provide medical services beyond those that are characterized as behavioral health services. Maine expanded medical coverage for many children beginning in 1998 through the Cub Care program, which is now part of the State Children’s Health Insurance Plan (SCHIP). Covered MaineCare services include, but are not limited to: hospital, physician, therapies (OT, PT, and Speech), medication, lab and x-ray, durable medical equipment, vision and hearing, ambulance, transportation, behavioral health, family planning and case management. The total number of enrollees in 2016 was 123,453 between 0-20 years of age; 18,883 of this population had a KEPRO-authorized MaineCare service.

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

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

**Department of Education**
The Maine Department of Education publishes a child count, of the total number of students in Maine. The child count data is a snapshot of students ages 3-21 receiving special education and related services on December 1st. The child count is completed by school administrative units and the nine regional Child Development Services sites. It reflects all students with Individual Educational Plans regardless of placement. For FY16, there were 29,019 children with IEPs aged 6-21 years, and 3,512 children with IEPs between 3-5 years of age. The total number of IEPs for FY16 was 32,531.
The special education child count lists 14 areas of Disability/Exceptionality. Six specific areas among the total 14 categories represent a range of disabilities that suggest a level of severity or type that are likely to be included in the children’s system of behavioral health care.

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

- For FY16, in the IDEA (Part C) program for children ages 0-2, the total count of active children was 1,493. There were 3,763 referrals made for this age group, and 1,088 were determined eligible for services.
- The program for children ages 3-5 (Part B—619), accounted for 2,554 of the children in the system. There were 5,072 referrals made for this age group, and 976 were determined eligible for services. For FY16, the total served under both parts C and B was 4,047 children. The services that each child receives are determined by either an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP) which is developed by the child’s early childhood services team.

**B. Services Provided by Local School Systems**
The Maine Department of Education provides education and related services to Maine’s students with disabilities through school subsidy, contractual and federal funding through IDEA, the Individuals with Disabilities Education Act. These services include the following:

- **Certified Educational Personnel** which include: Administrator of Special Education, School Education Consultant, School Psychological Service Provider, Vocational Education Evaluator, Speech and Hearing Clinician, School Nurse, Teacher of Students with Disabilities, Teacher – Severe Impairments, Teacher-Hearing Impairments, Teacher – Visual Impairments and Adapted Physical Education.
- **Licensed Contractors** which include persons licensed by appropriate state agencies to provide supportive services to students with disabilities, including: Audiologists, Interpreter/ Translator, Licensed Clinical Professional Counselors, Occupational Therapists and Physical Therapist Assistants, Psychologists, Social Workers, Speech-Language Pathologists, Speech-Language Pathology Aides and Assistants, and Attorneys.
- **Auxiliary Staff** which include Educational Technicians I, II, and III approved by the Office of Certification and assigned full or part time to provide special education services.

**MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY**

**Target Population Defined by Chapter 790**

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

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

A. A disability, as defined by the Diagnostic and Statistical Manual of Mental Health Disorders published by the American Psychiatric Association;
B. A disorder of infancy or early childhood, as defined in the Disorders of Infancy and Early Childhood Disorders published by the National Center for Clinical Infant Programs;
C. Being assessed as at risk of mental impairment, emotional or behavioral disorder or developmental delay due to established environmental or biological risks using screening instruments developed and adopted by the departments through rulemaking after consultation, review and approval from the Children’s Mental Health Oversight Committee; or
D. A functional impairment as determined by screening instruments used to determine the appropriate type and level of services for children with functional impairments. The functional impairment must be assessed in 2 or more of the following areas:

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

The LD 790 definition includes the population known as children with severe emotional disturbance, (SED) as well as children and youth whose behavioral and emotional needs are less severe than the SED population.
Maine continues to define children with Serious Emotional Disturbance (SED) in accordance with the accepted federal definition for this segment of the target population covered under the Children’s Block Grant for Community Mental Health Services State Plan. The FY2016 State SED population figure for the 0-17 years of age was 26,519.

**Sources of Data and Information in this Application**
The FY18/19 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plans. OCFS Children’s Behavioral Health Services utilize the following sources of data and information:

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

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

- **Phoenix** The Maine Department of Health and Human Service began using the Phoenix system in 2017; it replaced the former Enterprise Information System (EIS). It is a comprehensive and integrated information system that supports planning, management, and quality improvement for all aspects of the department’s operations across all its categorical services, including adult mental health, children’s services, and adult intellectual disabilities. This integrated information system facilitates the planning, development, and maintenance of a responsive, quality, and cost-effective service system to meet the needs of its service recipients, as well as the government agencies and programs serving them. OCFS currently utilizes Phoenix for Individual Planning Funds, CANS assessment tool, Reportable Events, Grievance, CBH documentation, Mobile Crisis, Out of Home Request Form, and Transition Process between OCFS Children’s Behavioral Health Services and the Office of Aging and Disability Services. Additional projects under development are Contract Reviews and complaints in the system.

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

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

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
<th>Type of Service</th>
<th># Served</th>
<th>Type of Service</th>
<th># Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Served, by Program Type Under Community Provider Contract SFY16</td>
<td>Case Management</td>
<td>10,629</td>
<td>Outpatient Services</td>
<td>20,505</td>
</tr>
</tbody>
</table>
Crisis Services Resolution  5,106  
Medication Management  4,956  
Crisis Stabilization/Residential  646  
Parent Self Help/Support  1,850  
Residential PNMI+ Treatment Foster Care  1,037  
Youth Peer Support  496  
Homeless Services  1,275  
Rehabilitative Community Treatment  3,908  
Respite Services  678  
Home and Community-based Treatment  3,591  
Individual Planning Funds  29  
MultiSystemic Therapy (MST)*  466  
Functional Family Therapy (FFT)*  140  
Total Services Provided to Children in SFY16 (not UNDUPLICATED)  55,312

Estimation of Unduplicated Count of Children Served
Individual service categories reported above provide an unduplicated count of all children who received that service during FY17. However, when a series of individual service categories are added together, the total represents the number of services delivered to all children, and is not an unduplicated count of all children served because children are likely to receive multiple services. The unduplicated count of children 0-18 served through contracted agreement with OCFS was in 25,508 FY17.

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

Outreach to Homeless Youth
The table below illustrates the current services available for youth who are homeless in Maine. The table shows geographic areas where homeless services are now available for youth. The services were awarded through a competitive bid process. The State of Maine has recently completed a Request for Proposal for youth homeless services for each Region, and the new contracts will go into effect in January 2018.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Service Area Focus</th>
<th>Service Type</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Outreach</td>
<td>Day Drop In Center</td>
</tr>
<tr>
<td>Day One-SA &amp; MH Treatment</td>
<td>Cumberland county, Region I</td>
<td>134,500</td>
<td></td>
</tr>
<tr>
<td>Preble Street Resource Center</td>
<td>Cumberland county, Region I</td>
<td>175,000</td>
<td>175,000</td>
</tr>
<tr>
<td>Opportunity Alliance</td>
<td>York and Cumberland counties, Region I</td>
<td>197,048</td>
<td></td>
</tr>
<tr>
<td>Home Counselors Inc.</td>
<td>Lincoln county, Region II</td>
<td>46,202</td>
<td></td>
</tr>
<tr>
<td>New Beginnings</td>
<td>Androscoggin county, Region II</td>
<td>435,000</td>
<td>150,000</td>
</tr>
<tr>
<td>Shaw House</td>
<td>Bangor area, Region III</td>
<td>81,936</td>
<td>237,373</td>
</tr>
<tr>
<td>Penquis Cap</td>
<td>Bangor area, Region III</td>
<td>113,907</td>
<td></td>
</tr>
<tr>
<td>FY17 Total funding by service</td>
<td></td>
<td>1,183,593</td>
<td>562,373</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

This data covers all contracted agencies that provided children’s services in Fiscal Year 2015

### NUMBER of PROVIDERS LOCATED IN REGIONAL GROUPINGS (FY17)

<table>
<thead>
<tr>
<th>SERVICE PROVIDED</th>
<th>Number of Providers</th>
<th>Number of Providers</th>
<th>Number of Providers</th>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statewide</td>
<td>Unduplicated #</td>
<td>Region 1</td>
<td>Region 2</td>
</tr>
<tr>
<td></td>
<td>Providers by</td>
<td>Providers by</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>67</td>
<td>20</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Behavioral Health Home</td>
<td>23</td>
<td>10</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>66</td>
<td>26</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Medication Management</td>
<td>18</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Rehabilitative and Community</td>
<td>60</td>
<td>20</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Support Services (RCS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Home and Community-</td>
<td>37</td>
<td>11</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Based Treatment (HCT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Intended Use of CMHS Block Grant Fund

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

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

The Block Grant for Community Mental Health Services distribution among specific contracts are made at the central office level, identifying programs that: are not MaineCare billable, that serve children who are not covered by MaineCare and programs that provide services to children who are not eligible for MaineCare funding.  

### CBHS BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>VENDOR</th>
<th>SERVICE</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis and Counseling, GEAR Parent Network</td>
<td>Family Support Statewide Network</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>THRIVE, Youth Move Maine</td>
<td>Youth Support Statewide Network</td>
<td>$339,294.11</td>
</tr>
<tr>
<td>Maine Medical Center</td>
<td>PIER Program, First Episode Psychosis treatment and training/expansion</td>
<td>$375,387.66</td>
</tr>
<tr>
<td>Quality Improvement Council</td>
<td>State Mental Health Advisory Board - operations</td>
<td>$5,000.00</td>
</tr>
</tbody>
</table>

**TOTAL** $969,681.77
Step 1: Assess the strengths and needs of the service system to address the specific populations.

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

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

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

The State of Maine Department of Health and Human Services (DHHS), Office of Substance Abuse and Mental Health Services (SAMHS) is the designated State Public Mental Health Authority for adults. The mission of SAMHS is to promote appropriate access to efficient and effective substance abuse and mental health services in order to achieve improved outcomes for those with substance abuse disorders and mental illness. The mental health services are provided to persons age 18 and older with severe and persistent mental illness. The DHHS Office of Child and Family Services (OCFS) is the entity responsible for providing mental health services for children and adolescents.

Maine’s Department of Health and Human Services’ Office of Substance Abuse and Mental Health Services (SAMHS) provides statewide leadership in defining, measuring and improving the Quality of services and supports to adults with severe and persistent mental illness. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide an array of services and support to the people of Maine. This Office is the Single State Administrative (SSA) authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse and mental health services.
The State of Maine operates the public behavioral health system under the guidance of the Consent Decree that was established in 1988. The Consent Decree requires the State of Maine to meet established goals or measures listed out in detail as part of the document that makes up the Consent Decree. The State reports on those measures to the Court Master on a quarterly basis. As a partial result of the Consent Decree, SAMHS provides intervention, treatment and recovery services via provider contracts to independent licensed Mental Health Agencies across the state. As such, SAMHS’ role is to provide leadership in the realm of prevention through OCFS and the Centers for Disease Control. SAMHS, in collaboration with other state agencies and community partners, develops, monitors, and improves the lives of those affected by addiction and mental illness as part of ensuring managed care for its recipients.

The Department has made significant strides towards Consent Decree compliance by reducing the required Compliance Standards from ninety to twenty two. The greatest impact was the institution of monitoring community integration waitlists which have been reduced to functional zero in June 2017 from 446 in 2016. New rulemaking around timely access to services within seven days and implementation of policies and tools such as the Adults Needs and Strengths Assessment have promoted the Court Master’s approval of system upgrades.

The new SAMHS organization consists of the Office of the Director and two Associate Directors for Operational Management and Treatment and Recovery Systems. A new contract management unit has been implemented to oversee the development and assist in contract management and enforcement to ensure excellence in provider’s services and performance measurement.

The SAMHS organization consists of (3) Treatment and Program Recovery Managers with a team of (6) Mental Health Program staff and (5) substance abuse program staff. SAMHS also staffs a Residential and Housing Services line of (6) team members. The Driver Education and Evaluation Program includes (8) members. The Prescription Monitoring Program has (3) staff devoted to it. Support Services includes administration, financial, quality, data, legal and special projects for an additional (21) staff.

The State of Maine of Maine is also regulated by specific statutes such as Maine Revised Statutes title 22-A: HEALTH AND HUMAN SERVICES HEADING: PL 2003, c. 689, Pt. A, §1 (new) as well as Maine’s Medicaid Program (MaineCare) which covers many services for adults and children. The MaineCare Benefits Manual can be accessed here: https://www1.maine.gov/sos/cec/rules/10/ch101.htm


Major Initiatives for FY16 in Policy Development and Implementation across offices

Rule Making efforts in Section 17 and 65 of the MaineCare Benefits Manual have served to implement and enforce evidence-based best practices such as those listed below:
• Section 17: In addition to the 7-Day rule mentioned earlier, substantial edits include the implementation of a functional diagnostic tool, the Adult Needs and Strengths Assessment (ANSA), used to provide enhanced assessment of consumer needs and to better define acuity by matching the right level of care for each diagnosis.

• Section 92: The Behavioral Health Home (BHH) initiative has helped support the long awaited integration of primary health care and mental health care. In the last 6 months, 2,592 persons have taken advantage of BHH services providing them more access to traditional Primary Care which results in better outcomes.

• Section 65: The mandate to provide concurrent behavioral health therapies with the administration of Methadone or Suboxone, otherwise known as medication assisted treatment, is now a standard of service provision.

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

Summary of Treatment and Recovery Services

Crisis

SAMHS contracts with statewide provider agencies to administer the Maine 24 hour Crisis 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.

**Intensive Case Management (ICM) Team**

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

**Prescription Monitoring Program:**

Maine’s Prescription Monitoring Program (PMP) is a secure, online database that is used across the State of Maine to improve public health. All prescribers and dispensers are able to review their patient’s controlled substance drug history prior to prescribing or dispensing any Schedule II – IV drugs. The PMP helps to prevent adverse drug-related events, through monitoring, education, and academic detailing. This Program’s focus is to regulate overprescribing Schedule II-IV drugs due to lack of education or regulation. Maine is an active member of the PMP Interconnect (PMPi) through the National Association of Boards of Pharmacy (NABP). PMPi allows participating states to be linked and be more effective in combating drug diversion and drug abuse on a national scale. Maine is currently connected with New Hampshire, Massachusetts, Rhode Island, New Jersey and Minnesota and have discussions scheduled with Connecticut and Vermont in the next month. Maine has recently had legislative mandates that now require prescribers to review a patient’s PMP report prior to prescribing an opioid or benzodiazepine medication every 90 days so long as the prescription is active. This new mandate also includes limiting chronic opioid prescriptions to a 30 day supply, acute opioid prescriptions to a 7 day supply, electronic prescribing of all opioid medications, and decreasing the allowable daily morphine milligram equivalent from 300 to 100.

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

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

**Behavioral Health Homes**

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

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

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

A community residence (PNMI) provides integral mental health treatment and rehabilitative services, and is licensed by the Department, funded as a mental health residential treatment or supportive housing service by DHHS, Substance Abuse and Mental Health Services, and operated in compliance with treatment standards established through these rules and the pertinent Principles of Reimbursement.

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

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

Integrated treatment services shall also include independent living skills and social skills services, necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives of such services shall be documented in each member’s individual service plan.
SAMHS administers policies and procedures to ensure that the Maine's two psychiatric state hospitals can discharge patients in a timely manner and prevent back up due to lack of placements and to insure priorities placements in PNMI Residential facilities. Priority are listed as 1) discharge from a State Psychiatric hospital, 2) discharge from a community psychiatric hospital 3) Discharge from a jail and 4) Homelessness.

SAMHS also monitors PNMI Residential contracts through site reviews and on sight visits, acts as a liaison between state psychiatric hospitals and providers, a program consultation to insure treatment plans and ANSA scores are consistent with each other.

New for 2017 was the implementation of the Adult Needs Strengths Assessment ANSA Tool for all PNMI facilities to complete on each consumer, every 90 days to review status, documentation, and show improvements in a consumer’s functioning; as noted in their quarterly Individual Service Plan (ISP). The ANSA tool was also put into MaineCare rule under Section 17 Community Support Services.

SAMHS developed an additional 64 individual PNMI beds statewide for hard to place and complex cases leaving the psychiatric hospitals in FY 17.

SAMHS assists consumer psychiatric discharge by developing relations with providers prior to discharge.

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

SAMHS oversees discharges from PNMI placements and grants permission for PNMI placements as outlined in the Consent Decree Protocol to insure access to Mental Health/Behavioral Health Services and other needs identified in consumer ISP. SAMHS also manages Medicaid spend down for consumers in PNMI residences.

Recovery

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, the clubhouse model, 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.

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

**The Peer Run Warm Line:**

The Peer Run Warm line is a service to operate the toll-free Warm Line. The Provider shall operate the Warm Line shall twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. The Warm Line shall target support towards people sixteen (16) years of age and older, living in Maine, and experiencing issues related to mental illness or co-occurring substance use disorders, emotional distress, and trauma, who are not in Behavioral Health Crisis. 1,624 unduplicated individuals utilized the warm line from 7/1/16-June 30, 2017.

**Peer Run Recovery Centers**

Proposals are for the provision and management of Peer Run Recovery Centers throughout the State of Maine. Services will be provided only to Adults with SMI and/or co-occurring SUDs and such services must be consistent with the COSP model. The COSP model has been evidenced to effectively promote empowerment, and hope of recovery, among participating adults diagnosed with severe mental illness. The Department will use the Fidelity Assessment/Common Ingredients Tool (FACIT) as a core measure of the performance of the Awarded Bidder(s), which will determine future funding of this service. The Awarded Bidder(s) will provide Peer Support through Structured Group Support and through educational activities focused on goal planning, self-management and problem solving skills, and Vocational Preparedness. The Awarded Bidder(s) will develop relationships with local community mental health, substance abuse, and community service agencies and shall assist with Successful Linkages.

Eleven (11) conditional awards have been made to provide Peer Run Recovery Centers throughout the state located in both rural and urban settings.

**Mental Health Psychosocial Clubhouse Services**

Maine has four Clubhouses and these services must maintain accreditation with Clubhouse International. Clubhouse services are provided both as a MaineCare service and as a grant funded service for uninsured individuals. In FY17, 75 unique uninsured individuals were served with grant funding and an additional 74 individuals were served “pro bono” through Clubhouse services. 29.2% of individuals served were employed either in competitive employment or in a transitional employment site. All Clubhouses have healthy lifestyle programming and between 33% and 82% of the average daily attendance participated in each site.
Certified Intentional Peer Support Specialists Training Program (CIPS) and Peer Support 101

In collaboration with Sherry Mead, the former Office of Consumer Affairs and consumers from throughout Maine developed a trauma informed curriculum "Intentional Peer Support: An Alternative Approach." This curriculum is used for the Certified Intentional Peer Support Specialist Training Program as well as other trainings offered through the Office of Consumer Affairs.

SAMHS has two training programs that offer Certified Intentional Peer Support Specialists Training Program (CIPS) and Peer Support 101.

CIPSS nine-day training is a requirement for Peer Support Specialists working on the Maine Warm line, in Emergency Departments, Behavioral Health Homes in State Psychiatric Hospitals and on some ACT teams. Topics covered include; Creating Learning Environments, First Contact, Language, Listening Differently, Challenging Situations and Working in the System.

Peer Support 101 is an opportunity to take a peek at Intentional Peer Support, learn about the tasks of peer support and hear about peer support in Maine. Peer Support 101 is a 3-hour class offered to anyone interested in learning more about peer support. It is also a requirement for participation in the Peer Support Specialists Certification.

Recovery Based Training

Through the Request for Proposal process, The Mental Health Block Grant funds were awarded to Sweeter in January 2017. Sweeter is located in Brunswick and will provide Recovery Based Training program designed to utilized the Peers in the delivery of Recovery Based training curriculum. This also includes ensuring that all Recovery Based trainings are assessable and available Statewide, including rural and underserved areas of Maine. Trained Peers will then become facilitators, who then 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 for this training provides skills to support individuals in Recover from the 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.

Consumer Groups in Maine

The Consumer Council System of Maine (CCSM) is an independent agency, 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.

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. QIC main focus is the SAMHSA Block Grant allocations which include behavioral, developmental and substance abuse issues for children, youth, family, young adults and adults.

**Housing**

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

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

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

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

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

- Vouchers can be used in either the community or group settings—at the consumer’s discretion. Independent housing vouchers are a logical extension of the concept, Money Follows the Person, in which the consumer directs their own care, and in this case, their housing as well.

Since the inception of the Consent Decree, Maine’s DHHS has supported voucher programs (BRAP and Shelter plus Care) that are built on the premise of not demanding participation in any particular service program as a pre-condition of housing. Vouchers provide the consumer with choice, independence, and control over where they live and what services they choose to engage in. In 2016 BRAP and Shelter plus Care participants alone received over $48.5 million of MaineCare reimbursable services helping to keep them successfully housed in the community.

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

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

100% of Shelter Plus Care vouchers are dedicated to homeless persons with mental illness and over 50% of all BRAP vouchers are being utilized by the homeless with mental illness. Combined, there are over 1,800 vouchers serving 3,640 homeless individuals and families in 2016. Recognizing the effectiveness of BRAP, the current administration has supported increased funding since 2012 of $2.3 million resulting in a complete elimination of the BRAP waitlist today.

Maine is the First in Hot-Spotting:

In April of 2014, taking a page from Dr. Jeffery Brenner’s ‘Camden Project’ which recognized that a small group of chronically homeless persons were utilizing a tremendously disproportionate amount of resources, DHHS was the first HUD applicant in Maine to focus 100% of Shelter Plus Care vouchers to the longest, hardest to serve, homeless first. Prior to 2014, DHHS recognized many vouchers were going to homeless persons with mental illness on a waitlist or who were comparatively easy to engage. With the adoption of hot-spotting techniques the voucher award process became based on length of time someone is homeless (longest homeless have 1st priority) vs. easiest to serve first.

Since 2013 there is a 19% reduction in overall homelessness, a 62% reduction in total shelter bed-nights and Statewide Chronic Homelessness in a shelter is currently at functional zero. Today, SAMHS is working in partnership with Maine Housing, and provider agencies, on the implementation of a Coordinated Entry system into homeless services, which takes into account both length of stay and vulnerability.

SAMHS Employment Initiatives to promote recovery include:

Work and Benefits Navigator Training

- Over 84,000 working-age adults in Maine receive Social Security disability benefits, which is 9.88% per capita, ranking Maine 6th in the nation. All of these individuals receive Medicare and/or MaineCare on which they rely to cover for their health costs.

- MaineCare members with Social Security disability income receive MaineCare funded services from DHHS Provider Agencies. Provider agency staff does not have expertise regarding the impact of earning wages on MaineCare and other benefit eligibility; some may discourage increased income fearing MaineCare or other benefit loss. This is often an unfounded fear, as there are special rules in MaineCare and Social Security for people with disabilities who work.
In supporting an “Employment First” goal for all Maine people with disabilities, providers must develop a working knowledge of employment resources and rules related to work and benefits. This will equip them to more effectively engage individuals in conversations about employment, opening up opportunities for individual growth and adding to Maine’s workforce.

In coordination with and funding from DHHS, Department of Labor (DOL)- Bureau of Rehab Services (BRS) contracted with Maine Medical Center Department of Vocational Services’ Benefits Counseling Services program (Maine’s WIPA provider), to create and deliver a training for disability service providers. This training, called Work and Benefits Navigation Training (WBNT), equips providers with basic knowledge of the real rules about work and benefits, increases awareness of employment resources for Mainers with disabilities, and guides trainees in why and how to start and continue employment conversations with all clients they serve.

Employment First Maine Coalition: SAMHS has been an active participant and collaborator with DOL, Department of Education (DOE) and the stakeholders of the Employment First Maine (EFM) Coalition and the implementation of the EFM legislation. The final report of the Coalition may be found at http://employmentfirstmaine.org/

Community Employment Specialists Services: Employment specialists assist individuals living with serious mental illness with securing employment and with additional employment issues as needed, such as negotiating job accommodations and arranging for SAMHS funded Long Term Supported Employment Services. SAMHS contracts with Maine Medical Center Division of Vocational Services to embed Employment Specialists in seven mental health agencies across the state to serve Section 17 Community Integration and Section 92 Behavior Health Homes clients. This service is a supplemental, not necessarily a replacement service for Vocational Rehabilitation services through DOL. DOL holds a companion contract with the provider and coordinates with SAMHS for the provision of this service.

Local and regional entities that provide services funded by the Mental Health Block Grant include: See Table below
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**ADMIN**

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SAMHS has made a commitment to set aside up to 25% of its allocation towards supporting Peer related services in the SFY 2018-2019 MHBG application. SAMHS envisions a continuum of Peer related services and supports funded by a variety of measures which could include: State General Funds, SAMHSA Block Grant Funds, as well as Medicaid funding. Currently, agencies receiving Block Grant funding through SAMHS are focusing on serving the uninsured and those services not covered by other insurance. Maine is unique in that 50% of its state Block Grant funds are dedicated to prevention activities which are administered through the state Office of Children’s and Family Services—a description of these services is included later on in this section of the document.

Adherence to the CLAS standards

Our providers of local services adhere to the enhanced National Standards for Cultural and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This includes:

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

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

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

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

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

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

A Brief Collective History of Maine Tribes

Collectively, the four Native tribes of Maine, the Passamaquoddy, Penobscot, Maliseet and Micmac tribes are known as Wabanaki, “People of the Dawn”. Each of these four federally recognized tribes, consisting of five tribal communities, maintains their own governments, cultural centers and schools, and manages their respective land and resources. Passamaquoddy, Penobscot, and Maliseets have their own Health Centers, and Micmacs having a service unit through Indian Health Services. Although most of the Native population of Maine belongs to one of these four tribes, and reside on tribal lands, there are still many who live in towns and cities across the state.

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

Micmac Service Unit, Presque Isle - Aroostook County.
Houlton Band of Maliseet Health Department, Littleton - Aroostook County
Indian Township Health Center, Indian Township-Washington County
Penobscot Nation Health Department, Indian Island- Penobscot County
Pleasant Point Health Center, Sipayik –Washington County

Tribal Health Liaisons:
The Tribal Liaisons work in partnership with the Tribes, DHHS districts, state public health entities, Tribal Health Directors, and the Division of Local Public Health. Additionally, the Tribal Liaisons, serve as tribal representatives for Aroostook Public Health District Coordinating Council (DCC), Penquis Public Health District Coordinating Indian Township Health Center, Indian Township Council (DCC) and Down east Public Health District.

Established in 1996, Wabanaki Health and Wellness is a not-for-profit organization for tribally-enrolled Native Americans, serving the Penobscot, Washington and Aroostook Counties of Maine. Located in Bangor, the agency provides case management, administers free HIV testing and hosts wellbriety meetings, among other services. Its board is intertribal, comprised of Native people. Its board members bring a variety of professional expertise and client perspectives to their work. Formerly known as Wabanaki Mental Health Association, Wabanaki Health and Wellness is affiliated with Cornerstone Behavioral Health for clinical case management programs.

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

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

Summary Statement on Unmet Needs and Critical Gaps
It has been the practice of OCFS/Children’s Behavioral Health Services to identify system needs each year and to include the most pressing and significant of those needs in the priorities section of the Block Grant for Community Mental Health Services application/plan. Progress and outcomes for these areas and topics are accounted for in the subsequent plan. Identification of needed services comes from the district level, and from Resource Coordination activities, as well as from ongoing discussions among Maine’s child-serving state agencies.

Sources of Data and Information
The FY18/19 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes. OCFS Behavioral Health Services for Children utilize the following sources of data and information:

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

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

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

- **Advantage ME** is the current State financial information system. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY17 data used to calculate and document the State’s total current expenditures for all mental health services provided by the Department of Health and Human Services for children, through the Office of Child and Family Services, and for adults, through the Office of Substance Abuse and Mental Health Services. These expenditure are the source for reporting the State’s general fund contributions to the maintenance of effort data that is required by CMHS and reported Block Grant for Community Mental Health Services application and plan.

Service Gaps and Unmet Needs
Currently KePRO, our state’s Administrative Services Organization (ASO) provides Behavioral Health Authorization for services and Utilization Review, and generates data to track children who have requested, are waiting for, and utilizing all MaineCare billable behavioral health services. OCFS receives data on a weekly basis about authorization and utilization review. Service utilization, wait list data, outcomes, service gaps and trends are examined by OCFS staff; OCFS and KePRO meet regularly to review, discuss and make changes as needed.

At this time, OCFS has identified a critical gap, and is focused on ensuring that contracted providers deliver in home supports, such as Home and Community Treatment (HCT) and Rehabilitative Community Support (RCS), in a timely manner to children who have been approved to receive the services. These critical services provide behavioral support and skill building to youth and families, often times reducing the likelihood that a more restrictive level of care is needed. At times, children and families in rural areas are unable to receive supports in a timely manner, due in part to staffing
shortages statewide. There are ample providers to ensure that every child who qualifies receives the service, but provider agencies are unable to retain the necessary staffing to work with families. As of 6/2017, the waitlists were as follows: 127 children waiting for Specialized RCS services between 3 and 790 days; 281 children waiting for Non-Specialized RCS services between 2 and 684 days; and 198 children waiting for HCT services between 4 and 389 days. CBHS has focused on extensive service development to address wait time issues; wait times for these services will continue to be monitored in FY18/19. This item has been added as a priority area in this year’s MHBG application and will be monitored.

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

Finally, youth are presenting with very high behavioral health needs; they need to be served safely and appropriately in their communities using Evidence Based Practices. This has prompted OCFS to look at the System of Care to determine if Maine can adequately care for each individual youth in need of treatment within the current array of services available. Leadership is meeting on a weekly basis to discuss whether Maine has adequate services to meet the needs of all youth in Maine.

The Office of Child and Family Services has a Strategic plan in place to focus on specific areas for development; the identified outcomes are tracked, and data is provided on a monthly basis. Building upon the work our previous plan, below is an overview of the objectives related to Children’s Behavioral Health services from the current Office of Child and Family Services STRATEGIC PLAN; for July 2016 – June 2018

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

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

**Desired Outcomes:**
- Increase by 10% the number of children who receive evidence based services.
- 90% of children eligible to receive Section 28 and HCT will receive services within 120 days of referral.

**Timeline:** Begin 7/2016, Complete 6/2018

**Critical Action Steps:**
- Identify capacity barriers to EBP and create steps to increase capacity
- Examine referral processes to EBPs and implement needed changes
- Increase access to BCBA Providers
- Establish baseline of children eligible to receive Section 28 and HCT and are not yet receiving the service
- Increase data integrity of referral management
- Meet with individual Providers in underserved areas using data to promote increased service delivery
- Create blended BHP online/in-person training to increase BHP capacity

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

**OBJECTIVE #2: Increase provider ability to safely serve high need youth effectively.**

**Desired Outcomes:**
- Reduce number of inappropriate extended days in Emergency Departments by 10%.
- 95% of youth eligible and receiving residential treatment will be served within the State of Maine.

**Timeline:** Begin 7/2016, Complete 6/2018

**Critical Action Steps:**
- Establish baseline number of inappropriate, extended days in acute settings (EDs)
- Create action steps to address system’s barriers impacting extended stays
- Implement standardized Rapid Response Protocols statewide
- Creation of Referral Management System for Residential Treatment
• Research residential options and partner with OMS to develop creative solutions
• Implementation of Behavior Regulations and Three-Person-Committee’s
• Provide training and technical assistance to Residential Providers

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

**OBJECTIVE #1: Improve all children’s ability to transition successfully to adulthood through identification, planning, and employment services.**

**Desired Outcomes:**
• 80% of youth identified of transition age will have a transition to adulthood questionnaire completed and entered in Phoenix.
• 100% of parents with a 16 year old child (who is also a MaineCare member) diagnosed with IDD will have contact by OCFS to offer assistance with transition.
• Caseworkers will ensure the Youth Transition Planning tool is completed with youth age 14-18 95% of the time.

**Timeline:** Begin 7/2016, Complete 6/2018

**Critical Action Steps:**
• Create a universal transition to adulthood questionnaire and provide training to effectively use
• Implement a CBHS Planning Process
• OCFS will monitor youth with IDD and have contact with families on a monthly basis
• Child Welfare staff will ensure that transition plans are developed for all youth age 14-18 years.

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

**OBJECTIVE #2: Implement the use of a standardized assessment in behavioral health services.**

**Desired Outcomes:**
• 100% use of CANS by TCM and HCT providers.

**Timeline:** Begin 7/2016, Complete 6/2018

**Critical Action Steps:**
• Implement new CANS tool.
• Coordinate with Operations Staff to build a new CANS assessment into electronic database.
• Coordinate with OCQI to develop outcomes measures and processes.
• Create rules and processes in regards to utilization of the CANS in multiple services.
• Create ongoing provider support processes to enhance the CANS utilization.
• Development of client outcome reporting by provider.
Step 1: Assess the strengths and needs of the service system to address the specific populations.

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

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

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

The areas of Maine located outside the three CBSA’s are clearly rural. The population living outside Maine’s primary CBSA’s totals 584,593 or 52.73% of the population. A closer examination of the towns that comprise CBSA’s shows a substantial number of towns and villages that are essentially rural in nature.

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

The State of Maine Department of Health and Human Services (DHHS), Office of Substance Abuse and Mental Health Services (SAMHS) is the designated State Public Mental Health Authority for adults. The mission of SAMHS is to promote appropriate access to efficient and effective substance abuse and mental health services in order to achieve improved outcomes for those with substance abuse disorders and mental illness. The mental health services are provided to persons age 18 and older with severe and persistent mental illness. The DHHS Office of Child and Family Services (OCFS) is the entity responsible for providing mental health services for children and adolescents.

Maine’s Department of Health and Human Services’ Office of Substance Abuse and Mental Health Services (SAMHS) provides statewide leadership in defining, measuring and improving the Quality of services and supports to adults with severe and persistent mental illness. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide an array of services and support to the people of Maine. This Office is the Single State Administrative (SSA) authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse and mental health services.
The State of Maine operates the public behavioral health system under the guidance of the Consent Decree that was established in 1988. The Consent Decree requires the State of Maine to meet established goals or measures listed out in detail as part of the document that makes up the Consent Decree. The State reports on those measures to the Court Master on a quarterly basis. As a partial result of the Consent Decree, SAMHS provides intervention, treatment and recovery services via provider contracts to independent licensed Mental Health Agencies across the state. As such, SAMHS’ role is to provide leadership in the realm of prevention through OCFS and the Centers for Disease Control. SAMHS, in collaboration with other state agencies and community partners, develops, monitors, and improves the lives of those affected by addiction and mental illness as part of ensuring managed care for its recipients.

The Department has made significant strides towards Consent Decree compliance by reducing the required Compliance Standards from ninety to twenty two. The greatest impact was the institution of monitoring community integration waitlists which have been reduced to functional zero in June 2017 from 446 in 2016. New rulemaking around timely access to services within seven days and implementation of policies and tools such as the Adults Needs and Strengths Assessment have promoted the Court Master’s approval of system upgrades.

The new SAMHS organization consists of the Office of the Director and two Associate Directors for Operational Management and Treatment and Recovery Systems. A new contract management unit has been implemented to oversee the development and assist in contract management and enforcement to ensure excellence in provider’s services and performance measurement.

The SAMHS organization consists of (3) Treatment and Program Recovery Managers with a team of (6) Mental Health Program staff and (5) substance abuse program staff. SAMHS also staffs a Residential and Housing Services line of (6) team members. The Driver Education and Evaluation Program includes (8) members. The Prescription Monitoring Program has (3) staff devoted to it. Support Services includes administration, financial, quality, data, legal and special projects for an additional (21) staff.

The State of Maine of Maine is also regulated by specific statutes such as Maine Revised Statutes title 22-A: HEALTH AND HUMAN SERVICES HEADING: PL 2003, c. 689, Pt. A, §1 (new) as well as Maine’s Medicaid Program (MaineCare) which covers many services for adults and children. The MaineCare Benefits Manual can be accessed here: https://www1.maine.gov/sos/cec/rules/10/ch101.htm


Major Initiatives for FY16 in Policy Development and Implementation across offices

Rule Making efforts in Section 17 and 65 of the MaineCare Benefits Manual have served to implement and enforce evidence-based best practices such as those listed below:
- Section 17: In addition to the 7-Day rule mentioned earlier, substantial edits include the implementation of a functional diagnostic tool, the Adult Needs and Strengths Assessment (ANSA), used to provide enhanced assessment of consumer needs and to better define acuity by matching the right level of care for each diagnosis.

- Section 92: The Behavioral Health Home (BHH) initiative has helped support the long awaited integration of primary health care and mental health care. In the last 6 months, 2,592 persons have taken advantage of BHH services providing them more access to traditional Primary Care which results in better outcomes.

- Section 65: The mandate to provide concurrent behavioral health therapies with the administration of Methadone or Suboxone, otherwise known as medication assisted treatment, is now a standard of service provision.

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

**Summary of Treatment and Recovery Services**

**Crisis**

SAMHS' contracts with statewide provider agencies to administer the Maine 24 hour Crisis 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.

Intensive Case Management (ICM) Team

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

Prescription Monitoring Program:

Maine’s Prescription Monitoring Program (PMP) is a secure, online database that is used across the State of Maine to improve public health. All prescribers and dispensers are able to review their patient’s controlled substance drug history prior to prescribing or dispensing any Schedule II – IV drugs. The PMP helps to prevent adverse drug-related events, through monitoring, education, and academic detailing. This Program’s focus is to regulate overprescribing Schedule II-IV drugs due to lack of education or regulation. Maine is an active member of the PMP Interconnect (PMPi) through the National Association of Boards of Pharmacy (NABP). PMPi allows participating states to be linked and be more effective in combating drug diversion and drug abuse on a national scale. Maine is currently connected with New Hampshire, Massachusetts, Rhode Island, New Jersey and Minnesota and have discussions scheduled with Connecticut and Vermont in the next month. Maine has recently had legislative mandates that now require prescribers to review a patient’s PMP report prior to prescribing an opioid or benzodiazepine medication every 90 days so long as the prescription is active. This new mandate also includes limiting chronic opioid prescriptions to a 30 day supply, acute opioid prescriptions to a 7 day supply, electronic prescribing of all opioid medications, and decreasing the allowable daily morphine milligram equivalent from 300 to 100.

Driver Education and Evaluation Program (DEEP)

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

Behavioral Health Homes

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

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

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

A community residence (PNMI) provides integral mental health treatment and rehabilitative services, and is licensed by the Department, funded as a mental health residential treatment or supportive housing service by DHHS, Substance Abuse and Mental Health Services, and operated in compliance with treatment standards established through these rules and the pertinent Principles of Reimbursement.

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

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

Integrated treatment services shall also include independent living skills and social skills services, necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives of such services shall be documented in each member’s individual service plan.
SAMHS administers policies and procedures to ensure that Maine's two psychiatric state hospitals can discharge patients in a timely manner and prevent backup due to lack of placements and to insure priorities placements in PNMI Residential facilities. Priority are listed as 1) discharge from a State Psychiatric hospital, 2) discharge from a community psychiatric hospital 3) Discharge from a jail and 4) Homelessness.

SAMHS also monitors PNMI Residential contracts through site reviews and on site visits, acts as a liaison between state psychiatric hospitals and providers, a program consultation to insure treatment plans and ANSA scores are consistent with each other.

New for 2017 was the implementation of the Adult Needs Strengths Assessment ANSA Tool for all PNMI facilities to complete on each consumer, every 90 days to review status, documentation, and show improvements in a consumer’s functioning; as noted in their quarterly Individual Service Plan (ISP). The ANSA tool was also put into MaineCare rule under Section 17 Community Support Services.

SAMHS developed an additional 64 individual PNMI beds statewide for hard to place and complex cases leaving the psychiatric hospitals in FY 17.

SAMHS assists consumer psychiatric discharge by developing relations with providers prior to discharge.

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

SAMHS oversees discharges from PNMI placements and grants permission for PNMI placements as outlined in the Consent Decree Protocol to insure access to Mental Health/Behavioral Health Services and other needs identified in consumer ISP. SAMHS also manages Medicaid spend down for consumers in PNMI residences.

Recovery

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, the clubhouse model, 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.

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

The Peer Run Warm Line:

The Peer Run Warm line is a service to operate the toll-free Warm Line. The Provider shall operate the Warm Line shall twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) day per year. The Warm Line shall target support towards people sixteen (16) years of age and older, living in Maine, and experiencing issues related to mental illness or co-occurring substance use disorders, emotional distress, and trauma, who are not in Behavioral Health Crisis. 1,624 unduplicated individuals utilized the warm line from 7/1/16-June 30, 2017.

Peer Run Recovery Centers

Proposals are for the provision and management of Peer Run Recovery Centers throughout the State of Maine. Services will be provided only to Adults with SMI and/or co-occurring SUDs and such services must be consistent with the COSP model. The COSP model has been evidenced to effectively promote empowerment, and hope of recovery, among participating adults diagnosed with severe mental illness. The Department will use the Fidelity Assessment/Common Ingredients Tool (FACIT) as a core measure of the performance of the Awarded Bidder(s), which will determine future funding of this service. The Awarded Bidder(s) will provide Peer Support through Structured Group Support and through educational activities focused on goal planning, self-management and problem solving skills, and Vocational Preparedness. The Awarded Bidder(s) will develop relationships with local community mental health, substance abuse, and community service agencies and shall assist with Successful Linkages.

Eleven (11) conditional awards have been made to provide Peer Run Recovery Centers throughout the state located in both rural and urban settings.

Mental Health Psychosocial Clubhouse Services

Maine has four Clubhouses and these services must maintain accreditation with Clubhouse International. Clubhouse services are provided both as a MaineCare service and as a grant funded service for uninsured individuals. In FY17, 75 unique uninsured individuals were served with grant funding and an additional 74 individuals were served “pro bono” through Clubhouse services. 29.2% of individuals served were employed either in competitive employment or in a transitional employment site. All Clubhouses have healthy lifestyle programming and between 33% and 82% of the average daily attendance participated in each site.

Certified Intentional Peer Support Specialists Training Program (CIPS) and Peer Support 101
In collaboration with Sherry Mead, the former Office of Consumer Affairs and consumers from throughout Maine developed a trauma informed curriculum "Intentional Peer Support: An Alternative Approach." This curriculum is used for the Certified Intentional Peer Support Specialist Training Program as well as other trainings offered through the Office of Consumer Affairs.

SAMHS has two training programs that offer Certified Intentional Peer Support Specialists Training Program (CIPS) and Peer Support 101.

CIPSS nine-day training is a requirement for Peer Support Specialists working on the Maine Warm line, in Emergency Departments, Behavioral Health Homes in State Psychiatric Hospitals and on some ACT teams. Topics covered include; Creating Learning Environments, First Contact, Language, Listening Differently, Challenging Situations and Working in the System.

Peer Support 101 is an opportunity to take a peek at Intentional Peer Support, learn about the tasks of peer support and hear about peer support in Maine. Peer Support 101 is a 3-hour class offered to anyone interested in learning more about peer support. It is also a requirement for participation in the Peer Support Specialists Certification.

**Recovery Based Training**

Through the Request for Proposal process, The Mental Health Block Grant funds were awarded to Sweeter in January 2017. Sweeter is located in Brunswick and will provide Recovery Based Training program designed to utilized the Peers in the delivery of Recovery Based training curriculum. This also includes ensuring that all Recovery Based trainings are assessable and available Statewide, including rural and underserved areas of Maine. Trained Peers will then become facilitators, who then 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 for this training provides skills to support individuals in Recover from the 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.

**Consumer Groups in Maine**

The Consumer Council System of Maine (CCSM) is an independent agency, 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.
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. QIC main focus is the SAMHSA Block Grant allocations which include behavioral, developmental and substance abuse issues for children, youth, family, young adults and adults.

Housing

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

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

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

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

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

- Vouchers can be used in either the community or group settings—at the consumer’s discretion. Independent housing vouchers are a logical extension of the concept, Money Follows the Person, in which the consumer directs their own care, and in this case, their housing as well.

Since the inception of the Consent Decree, Maine’s DHHS has supported voucher programs (BRAP and Shelter plus Care) that are built on the premise of not demanding participation in any particular service program as a pre-condition of housing. Vouchers provide the consumer with choice, independence, and control over where they live and what services they choose to engage in. In 2016 BRAP and Shelter plus Care participants alone received over $48.5 million of MaineCare reimbursable services helping to keep them successfully housed in the community.

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

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

100% of Shelter Plus Care vouchers are dedicated to homeless persons with mental illness and over 50% of all BRAP vouchers are being utilized by the homeless with mental illness. Combined, there are over 1,800 vouchers serving 3,640 homeless individuals and families in 2016. Recognizing the effectiveness of BRAP, the current administration has supported increased funding since 2012 of $2.3 million resulting in a complete elimination of the BRAP waitlist today.

Maine is the First in Hot-Spotting:

In April of 2014, taking a page from Dr. Jeffery Brenner’s ‘Camden Project’ which recognized that a small group of chronically homeless persons were utilizing a tremendously disproportionate amount of resources, DHHS was the first HUD applicant in Maine to focus 100% of Shelter Plus Care vouchers to the longest, hardest to serve, homeless first. Prior to 2014, DHHS recognized many vouchers were going to homeless persons with mental illness on a waitlist or who were comparatively easy to engage. With the adoption of hot-spotting techniques the voucher award process became based on length of time someone is homeless (longest homeless have 1st priority) vs. easiest to serve first.

Since 2013 there is a 19% reduction in overall homelessness, a 62% reduction in total shelter bed-nights and Statewide Chronic Homelessness in a shelter is currently at functional zero. Today, SAMHS is working in partnership with Maine Housing, and provider agencies, on the implementation of a Coordinated Entry system into homeless services, which takes into account both length of stay and vulnerability.

SAMHS Employment Initiatives to promote recovery include:

Work and Benefits Navigator Training

- Over 84,000 working-age adults in Maine receive Social Security disability benefits, which is 9.88% per capita, ranking Maine 6th in the nation. All of these individuals receive Medicare and/or MaineCare on which they rely to cover for their health costs.

- MaineCare members with Social Security disability income receive MaineCare funded services from DHHS Provider Agencies. Provider agency staff does not have expertise regarding the impact of earning wages on MaineCare and other benefit eligibility; some may discourage increased income fearing MaineCare or other benefit loss. This is often an unfounded fear, as there are special rules in MaineCare and Social Security for people with disabilities who work.

- In supporting an “Employment First” goal for all Maine people with disabilities, providers must develop a working knowledge of employment resources and rules related to work and benefits. This will
equip them to more effectively engage individuals in conversations about employment, opening up opportunities for individual growth and adding to Maine’s workforce.

• In coordination with and funding from DHHS, Department of Labor (DOL)- Bureau of Rehab Services (BRS) contracted with Maine Medical Center Department of Vocational Services’ Benefits Counseling Services program (Maine’s WIPA provider), to create and deliver a training for disability service providers. This training, called Work and Benefits Navigation Training (WBNT), equips providers with basic knowledge of the real rules about work and benefits, increases awareness of employment resources for Mainers with disabilities, and guides trainees in why and how to start and continue employment conversations with all clients they serve.

Employment First Maine Coalition: SAMHS has been an active participant and collaborator with DOL, Department of Education (DOE) and the stakeholders of the Employment First Maine (EFM) Coalition and the implementation of the EFM legislation. The final report of the Coalition may be found at http://employmentfirstmaine.org/

Community Employment Specialists Services: Employment specialists assist individuals living with serious mental illness with securing employment and with additional employment issues as needed, such as negotiating job accommodations and arranging for SAMHS funded Long Term Supported Employment Services. SAMHS contracts with Maine Medical Center Division of Vocational Services to embed Employment Specialists in seven mental health agencies across the state to serve Section 17 Community Integration and Section 92 Behavior Health Homes clients. This service is a supplemental, not necessarily a replacement service for Vocational Rehabilitation services through DOL. DOL holds a companion contract with the provider and coordinates with SAMHS for the provision of this service.

Local and regional entities that provide services funded by the Mental Health Block Grant include: See Table below
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<th>Program/Service</th>
<th>Amount</th>
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<tr>
<td>SAMHS</td>
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<td>6,119</td>
</tr>
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<td>2,000</td>
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<tr>
<td>SAMHS</td>
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<td>23,295</td>
</tr>
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<td>SAMHS</td>
<td>Day Supports/Clubhouse</td>
<td>65,000</td>
</tr>
<tr>
<td>SAMHS</td>
<td>Medication Management</td>
<td>21,150</td>
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<td>Peer Recovery</td>
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<td>34,768</td>
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<td>SAMHS</td>
<td>Peer Recovery</td>
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<tr>
<td>SAMHS</td>
<td>Medication Management</td>
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**Subtotal, Contractual Services** $1,889,945

**OTHER SERVICES**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Non-Contract Expenditures</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

*Includes travel, training, supplies, indirect costs and other miscellaneous expenditures for operations*

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services Manager I (Personal Services)</td>
<td>$95,591</td>
</tr>
</tbody>
</table>

**Subtotal, Other Services** $110,591

**Grand Total** $2,000,536
SAMHS has made a commitment to set aside up to 25% of its allocation towards supporting Peer related services in the SFY 2018-2019 MHBG application. SAMHS envisions a continuum of Peer related services and supports funded by a variety of measures which could include: State General Funds, SAMHSA Block Grant Funds, as well as Medicaid funding. Currently, agencies receiving Block Grant funding through SAMHS are focusing on serving the uninsured and those services not covered by other insurance. Maine is unique in that 50% of its state Block Grant funds are dedicated to prevention activities which are administered through the state Office of Children’s and Family Services—a description of these services is included later on in this section of the document.

Adherence to the CLAS standards

Our providers of local services adhere to the enhanced National Standards for Cultural and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This includes:

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

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

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

Tribal Outreach

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

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

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

A Brief Collective History of Maine Tribes

Collectively, the four Native tribes of Maine, the Passamaquoddy, Penobscot, Maliseet and Micmac tribes are known as Wabanaki, “People of the Dawn”. Each of these four federally recognized tribes, consisting of five tribal communities, maintains their own governments, cultural centers and schools, and manages their respective land and resources. Passamaquoddy, Penobscot, and Maliseets have their own Health Centers, and Micmacs having a service unit through Indian Health Services. Although most of the Native population of Maine belongs to one of these four tribes, and reside on tribal lands, there are still many who live in towns and cities across the state.

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

Micmac Service Unit, Presque Isle - Aroostook County.
Houlton Band of Maliseet Health Department, Littleton - Aroostook County
Indian Township Health Center, Indian Township-Washington County
Penobscot Nation Health Department, Indian Island- Penobscot County
Pleasant Point Health Center, Sipayik –Washington County

Tribal Health Liaisons:

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

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

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

#### Priority #1

**Priority Type:** MHS  
**Population(s):** SMI

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

**Objective:**
By FY 19, to reduce the number of re admissions to inpatient psychiatric hospitals within 180 days of discharge to 30% in FY 19.

**Strategies to attain the objective:**
This will be accomplished by the dissemination of available housing options to providers and PNM1 contract performance measures.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Reduce adults who are discharged from in-patient psychiatric facilities who are readmitted within 180 days</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>Inpatient re admissions is 31.3% (235) @ FY17Q4</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Second-year target/outcome measurement:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Data Source:**
1. KePRO Acquisitions - Utilization Management Services

**Description of Data:**
Number of adults discharged from in-patient who are readmitted to any inpatient psychiatric facility within 180 days as reported Quarterly

**Data issues/ caveats that affect outcome measures:**
1. Ability to affect change at the hospital level of care dependent on working inter agency relationships

#### Priority #2

**Priority Area:** Improved Outcomes for Mental Health  
**Priority Type:** MHS  
**Population(s):** SMI

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

**Objective:**
By FY 19, to reduce use of Emergency Department for initial point of contact in the Crisis System from 66.7% (FY17Q4) to 50% or less

**Strategies to attain the objective:**
Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Reduce use of Emergency Department for initial point of contact in the Crisis System
Baseline Measurement: Crisis baseline is 66.7% (2,339 Adults) @ FY17Q4
First-year target/outcome measurement: 64%
Second-year target/outcome measurement: 50%
Data Source: SAMHS Crisis Database

Description of Data:
The number of individuals receiving crisis services in the Emergency Department is provided by contracted provider agencies who submit reports monthly to SAMHS Data team who create an integrated report quarterly “Integrated Quarterly Crisis Report”

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

Priority #: 3
Priority Area: Improved Outcomes for Mental Health
Priority Type: MHS
Population(s): SMI
Goal of the priority area:
Increase the number of recipients of mental health services with an individual service plan to become competitively employed

Objective:
By FY 19, To Increase the number of recipients of mental health services with an individual service plan to become competitively employed Increase from 18% (2016) to 20%

Strategies to attain the objective:
Through training and education of employment assessment tools and contract enforcement of performance measures requiring employment assessments

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase the number of recipients of mental health services with an individual service plan to become competitively employed
Baseline Measurement: Employment baseline is 18% (3,769) @ 2016
First-year target/outcome measurement: 19%
Second-year target/outcome measurement: 20%
Data Source: EIS System

Description of Data:
Individual service plan data is captured through the EIS system and a SAMHS Data Team member pulls ISP and MaineCare ID and matched with data received by the Office of Family Independence by MaineCare ID and employment financial data. Now being created quarterly.
Data issues/caveats that affect outcome measures:
Only reflects those individuals with a MaineCare ID and ISP

Priority #: 4
Priority Area: Improved Outcomes for Mental Health
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score

Objective:
By FY 19, to decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score from 20% to 5%

Strategies to attain the objective:
By coordinating efforts of the Utilization Review Nurse and the Complex Care Unit, the Office of Aging and Disability Services, and Community Provider agencies

Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator | Decrease the number of individuals in Private, Non-Medical Institutions who are inappropriately placed based on their LOCUS score |
| Baseline Measurement | PNMI baseline is 20% (135) @ 7/31/17 |
| First-year target/outcome measurement | 13% |
| Second-year target/outcome measurement | 7% |

Data Source:
Kepro Acquisitions – Utilization Management Services

Description of Data:
The number of individuals in PNMI Services by Locus Score is captured in KEPRO as submitted by providers and report is produced as needed.

Data issues/caveats that affect outcome measures:
LOCUS system will be eliminated upon the successful implementation of the ANSA assessment. A new computation system is being developed using ANSA to determine appropriate placement

Priority #: 5
Priority Area: Improved Outcomes for Mental Health
Priority Type: MHS
Population(s): SMI

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

Objective:
by FY 19, to increase timely access to mental health treatment services from 86% to 95%
Strategies to attain the objective:

Through contract performance measures and contract enforcement

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### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Increase timely access to mental health treatment services through contract performance measures and contract enforcement</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>7 day access baseline is 85.8% (59) @ FY17Q4</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>90%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>95%</td>
</tr>
</tbody>
</table>

Data Source:

Kepro Acquisitions – Utilization Management Services

Description of Data:

The number of non-hospitalized applicants who are assigned CI or ACT services is captured through Prior Authorization for Services at the application and approval for service through Kepro and is reported in the Adult System Goals Measures Quarterly Report.

Data issues/caveats that affect outcome measures:

Currently, wait lists for grant-funded reflect functional zero. Focus is to affect change through the OMS (MaineCare funded recipients)

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Priority #: 6

Priority Area: CHILD -- SAFETY

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Improve safety of youth, families and communities.

Objective:

Increase Provider ability to safely serve high needs youth effectively.

Strategies to attain the objective:

Create actions steps to address system's barriers impacting extended stays in Emergency Departments; implement standardized Rapid Response protocols statewide; Creation of Referral Management System for Residential Treatment; research residential options and partner with OMS to develop creative solutions; provide training and technical assistance to Residential Providers.

---

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>95% of youth eligible and receiving residential treatment are being served in the State of Maine.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>93% of youth eligible and receiving residential treatment are served in the State of Maine (274/293 youth),</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase the number of youth receiving residential treatment in Maine by 3% (280 youth)</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase the number of youth receiving residential treatment in Maine by 3% (285 youth)</td>
</tr>
</tbody>
</table>

Data Source:

KePRO, Prior Authorization and Utilization Review
Description of Data:
Count of youth approved and placed in PNMI both within Maine and out of State.

Data issues/caveats that affect outcome measures:
None identified.

Indicator #: 2
Indicator: Reduce the number of inappropriate extended days in Emergency Departments by 10%
Baseline Measurement: Establishing Baseline in FY2018
First-year target/outcome measurement: Establishing Baseline
Second-year target/outcome measurement: Reduce the number of inappropriate extended days in Emergency Departments by 10%

Data Source:
KePRO, Prior Authorization and Utilization Review; Crisis Dashboard data from SAMHS

Description of Data:
KePRO is Maine's ASO, providing PA/UR; Crisis Dashboard data from SAMHS includes all crisis and emergency room usage information. This information is provided on a monthly basis.

Data issues/caveats that affect outcome measures:
It has been difficult to obtain the accurate number of youth throughout the State of Maine who spend extended time in Emergency Departments. OCFS needs full cooperation of Emergency Departments to obtain the necessary data to provide baseline and continued measure of this area.

Priority #: 7
Priority Area: CHILD -- EVIDENCE BASED PRACTICES
Priority Type: MHS
Population(s): SED

Goal of the priority area:
Improve stability, health and well-being, and quality permanent connections of individuals and families.

Objective:
Increase access to Evidence Based children's behavioral health services.

Strategies to attain the objective:
Support current Evidence Based Practices including: Applied Behavior Analysis (ABA), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), and Multi-Systemic Therapy, Problem Sexualized Behavior (MST-PSB). Continue to focus on the expansion of the types of EBPs within the service delivery.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Children receiving Evidence Based treatment modalities will increase by 10%
Baseline Measurement: In FY16, the following youth received Evidence Based treatment: FFT - 140; MST - 466; ABA - 687.
First-year target/outcome measurement: Increase each Evidence Based treatment by 5%: FFT - 147; MST - 489; ABA - 721
Second-year target/outcome measurement: Increase each Evidence Based treatment by 5%: FFT - 154; MST - 513; ABA - 757

Data Source:
KePRO, Prior Authorization and Utilization Review Data
Description of Data:
KePRO PA/UR for all services.

Data issues/caveats that affect outcome measures:
Providers must continue to expand their provision of EBPs, and case managers must understand the importance of proper referrals for services.

Priority #: 8
Priority Area: CHILD -- TRANSITION TO ADULTHOOD
Priority Type: MHS
Population(s): SED

Goal of the priority area:
Provide youth and families with information necessary for transition to adulthood

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

Strategies to attain the objective:
OCFS will monitor youth with IDD and have contact with their families on a monthly basis.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: 100% of families with a 16 year old child (who is also a MaineCare member) diagnosed with IDD will have contact by OCFS to offer assistance with transition

Baseline Measurement: 87% of families are contacted by OCFS to offer assistance with transition.

First-year target/outcome measurement: OCFS will monitor youth with IDD and have contact with 95% families or case managers on a monthly basis.

Second-year target/outcome measurement: OCFS will monitor youth with IDD and have contact with 100% families or case managers on a monthly basis.

Data Source:
EIS/PHOENIX

Description of Data:
The OCFS database, EIS/PHOENIX, tracks all transition efforts and generates the Transition Dashboard Report on the 5th day of the month.

Data issues/caveats that affect outcome measures:
Contacts with families must be entered in the database by the end of the month to ensure that the reporting is accurate.

Priority #: 9
Priority Area: CHILD -- STATEWIDE YOUTH PEER SUPPORT
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:
To provide a statewide Youth Peer Support Network that is "Youth Driven."
Objective:

Youth participating in Youth Peer Support services will experience an improvement in overall functioning and well-being.

Strategies to attain the objective:

Ensure that youth receive individualized support and training as needed; ensure that youth have the support of others with Lived Experience via group/drop-in services; ensure that youth are involved in the youth advisory council, are part of the Quality Improvement Council, and that their voices are heard at the State level.

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Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Improved functionality and well-being through Recovery and Resiliency of individuals living with SED, SM I or Co-Occurring SUD.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>143 of 167 participating youth (86%) reported improvement in functionality and well-being.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Youth Peer Support Network program participants who demonstrate in functioning/well-being 5% increase (150).</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Youth Peer Support Network program participants who demonstrate in functioning/well-being 5% increase (158).</td>
</tr>
</tbody>
</table>

Data Source:
The Youth Move Maine Individual Support Survey, measured at program entry, six months and at discharge from the program.

Description of Data:
The use of the Youth Move Maine Individual Support Survey began 1/1/17; baseline was established from 1/1/17 to 6/30/17. This is reported to OCFS on a quarterly basis.

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

---

Priority #: 10

Priority Area: CHILD -- STATEWIDE FAM ILY PEER SUPPORT

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:
To provide a statewide Family Peer Support Network that is “family driven”.

Objective:
Families participating in Family Peer Support services will experience an improvement in functioning and well-being.

Strategies to attain the objective:
Ensure that participating families receive support, training, referrals and education as needed/requested; ensure that they are involved in advisory councils, are part of the Quality Improvement Council and that their voices are heard at the State level as well as within the State of Maine family organizational alliance, MAFO.

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Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Improved functionality and well-being through Recovery and Resiliency of families of youth with SED/SM I, or co-occurring SUD.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>73% participating families show an increase in functioning and well-being as a result of six months of 1:1 Family Peer Support.</td>
</tr>
</tbody>
</table>
**First-year target/outcome measurement:** 78% 1:1 Family Peer Support participants will demonstrate improvement in functioning/well-being.

**Second-year target/outcome measurement:** 83% 1:1 Family Peer Support participants will demonstrate improvement in functioning/well-being.

**Data Source:**

The following tools will be used to measure functioning and well-being:

- ACEs Questionnaire—Adverse Childhood Experiences
- TPA—Targeted Parent Assessment
- FJA—Family Journey Assessment

**Description of Data:**

- ACEs Questionnaire—Adverse Childhood Experiences, to be completed when the family becomes involved in Family Peer 1:1 Support
- TPA—Targeted Parent Assessment to be completed quarterly with each family involved in 1:1 Family Peer Support
- FJA—Family Journey Assessment, the provider has a contract with Georgetown University to utilize this tool and report de-identified data to Georgetown on a quarterly basis, this is completed quarterly.

Assessments are completed at program entry, six months, and at discharge from the program.

All data is reported to OCFS on a quarterly basis.

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

OCFS relies upon the objective reporting of the contracted provider to measure progress toward this objective.

**Footnotes:**
## Planning Tables

**Table 2 State Agency Planned Expenditures**

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
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<td></td>
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<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
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<td></td>
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<td>b. All Other</td>
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<td>2. Primary Prevention</td>
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<td>3. Tuberculosis Services</td>
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<td>4. Early Intervention Services for HIV</td>
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<td>5. State Hospital</td>
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<td>7. Ambulatory/Community Non-24 Hour Care</td>
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<td>8. Mental Health Primary*</td>
<td></td>
<td></td>
<td>$0</td>
<td>$9,349,524</td>
<td>$0</td>
<td>$100,000</td>
<td>$0</td>
</tr>
<tr>
<td>9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$966,294</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>$428,480</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)</td>
<td>$0</td>
<td>$4,284,082</td>
<td>$493,524,114</td>
<td>$27,139,248</td>
<td>$95,902,308</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED
** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

### Footnotes:
- Other 24 hour care=0
- Ambulatory/community non-24 hour care= $2,890,028 for two years supporting all MHBG direct services
- Evidence Based Practices (10% set-aside FEP)= $966,294 for two years of contract with MMC/PIER
- Administration 5%= $428,480 for two years
total for two years = $4,284,802
**Planning Tables**

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

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

<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></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td>$350,658</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Total</td>
<td>$664,246</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**Footnotes:**
Partnerships, community outreach, and needs assessment: Salary of Grant Manager (95,591 yearly, 191,182); Non-contract Expenditures (15,000 travel, training, supplies yearly, 30,000); and Indirect Costs (64,738 yearly, 129,476 from 8.8.16).
Training and Education: Peer Recovery Training with Sweetser.
Environmental Factors and Plan

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

Narrative Question

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 "health system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

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

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and 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 stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who...
experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with 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 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.


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 disorders settings.

Maine has dedicated significant funding toward integrated systems through Behavioral Health Homes and Opioid Health Homes. Ground breaking efforts have been made in bi-directional sharing of information between Behavioral Health Homes and Primary Care, resulting in a comprehensive approach to each individual.

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 funding, management, payment strategies that foster co-occurring capability.

Maine has dedicated significant funding toward integrated systems through Behavioral Health Homes and Opioid Health Homes. Ad-Care, SAMHS-contracted workforce development training provider, is responsible for providing co-occurring training statewide, as well as academic detailing for physicians.

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

Yes

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

Yes

5. Are there plans for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

Yes

6. Who is responsible for monitoring access to M/SUD services by the QHP?
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  
   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?  
   See footnote

10. Does the state have any activities related to this section that you would like to highlight?  
    Maine's roll out of Behavioral Health Homes and Opioid Health Homes and linking physical health to these services.  
    All of our technical assistance, public reporting, metrics and use of Evidence Based Practices  
    Information technology/infrastructure support would help Maine better integrate funding for uninsured populations. Also, 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:
7. Maine is in the process of underwriting BHH for uninsured and are exploring mechanisms to cover uninsured individuals in BHHs. OHHs will cover uninsured individuals.
   Maine has begun reporting publically the rates of employment in BHHs.
   Maine plans to implement pay for performance within the BHH, providers will need to meet a certain level of service, or funds will be taken back.
   In order to produce clinical measures in OHHs, providers must be connected to Health InfoNET; this will allow providers a comprehensive view of each individual's care history, and will be crucial in treatment decision making.
   In 2002, Maine was one of the first states in the nation to formally introduce and pass legislation regarding Mental Health insurance parity. In effect, the Maine Mental Health Parity law mandates offering coverage for all individuals and group plans for serious mental illness and for them to be paid at a rate equal to physical health. There are a few exceptions to this law, such employers with fewer than 20 employees.
   In 2013, the Obama administration issued clarity on how the parity law should be implemented. While Maine has had a parity law in place for quite a while, there is still much effort being put forth to address the shortage of psychiatrists in the state that are needed to provide services for mental health and substance abuse treatment. In the past, payment rates to psychiatrists have been so low, that they have effectively minimized coverage. There is still a shortage of psychiatrists in Maine for both children and adults.
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, 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).

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."

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. 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. 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 under age 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.

48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb/fedreg_race-ethnicity
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
   b) Ethnicity
   c) Gender
   d) Sexual orientation
   e) Gender identity
   f) Age

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?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

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?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?

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

The Office of Health equity is working to address health disparities by improving health systems and building capacity within Maine’s public health infrastructure. In 2012, the Maine Center for Disease Control went through an agency-wide Cultural Competence Assessment and OHE is working to put into action the recommendations that were created based on the assessment findings. To view the Cultural Competence Assessment Recommendations, follow this link: http://www.maine.gov/dhhs/mecdc/health-equity/Cultural.shtml

The Maine Office of Health Equity is dedicated to supporting the Maine CDC and our partners throughout the state to address the CLAS Standards (Culturally and Linguistically Appropriate Services). The Office of Minority Health developed the CLAS Standards to provide public health and healthcare professionals with a framework to improve health equity. CLAS was created to contribute to the elimination of racial and ethnic health disparities and to make services more responsive to individual need. The CLAS Standards also provide strategies for organizations and systems to be culturally competent.

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

Governance, Leadership and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Please indicate areas of technical assistance needed related to this section

Footnotes:
According to our Rural Health Centers, patients identify as follows:
87.63% Non-Hispanic White
12.64% Racial and/or Ethnic Minority
5.05% Hispanic/Latino
7.62% Black/African American
.46% Asian
2.1% American Indian/Alaska Native
.06% Native Hawaiian/Other Pacific Islander
.81% More than one race
8% Best served in another language

Footnote to Question 4: The State's Workforce development plan includes training’s for cultural competency and Gender responsiveness (orientation, i.e. transgender or gender specific) for outreach, engagement prevention treatment and recovery services.
MAINE PATH PROGRAM DISPARITY STATEMENT

1. Proposed Number of individuals to be served by subpopulations in the grant service area, and identification of disparate population.

The numbers in the chart below reflect the proposed number of individuals to be served during the grant period, set at 70% of the total number of homeless persons within grant service area with the expectation that 80% of those outreached will be enrolled, and all identified subpopulations in the grant service area. The disparate population is identified in the narrative below.

<table>
<thead>
<tr>
<th>Direct Services: Total number to be served</th>
<th>Outreach</th>
<th>Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>75</td>
<td>60</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>512</td>
<td>410</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Two or more Races</td>
<td>30</td>
<td>25</td>
</tr>
</tbody>
</table>

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

The homeless population in Maine is located in both urban and rural areas. The 2016 HUD Continuum of Care grants require recipients to conduct a biannual, statistically reliable, and unduplicated count of people who are homeless over the course of one day in the last ten days of January. This is done using the Point in Time Survey (PIT). Maine’s 2016 PIT shows that a disproportionate number of minorities are homeless in the state (15%) when compared to the overall percent of minorities in the state (3.85% or less) according to GIS policy map.
Outreach to minority populations will continue at the same rate of expectation as all populations of homeless persons throughout the State of Maine to make sure that the disparity in homelessness that minority populations experience is not overlooked.

2. Quality Improvement Plan and Corrective Action Plans

PATH uses data to drive programmatic quality improvement initiatives to ensure that services being delivered align with the goals of Maine’s PATH program. State PATH program management uses HMIS PATH reports to monitor and manage program outcomes by race, ethnicity, and gender status. Programmatic adjustments are made when or if issues are identified, and if necessary corrective actions are put in place to ensure that changes occur. Semi-annual site audits are conducted with the State PATH program staff along with contracted primary provider. The contracted provider is responsible for the administration of Maine PATH program, providing both client services and administrative oversight of PATH subcontractors covering the entire service area. These visits are used to make programmatic corrections as needed, but to also applaud programmatic successes made by sub-contractors. State PATH program works collaboratively with our PHA Maine State Housing Authority which manages the HUD HMIS to identify issues and implement training based on the State PATH Program’s ongoing assessment of quarterly data reports.

3. Adherence to the CLAS standards

Our providers of local services adhere to the enhanced National Standards for Cultural and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This includes:

a. PATH workers are trained in diverse cultural health beliefs and practices. PATH providers continue to look at cultural training to meet the ongoing needs of the populations they serve in urban and rural areas. PATH providers will access Maine Department of Health and Human Services, which promotes health and wellness in Maine’s racial and ethnic minority communities for further information and trainings.

b. Priority Areas

Preferred languages – interpreter and translated materials are available 24/7 for non-English speaking clients as well as those who speak English, but prefer materials to be translated in their primary language. The Maine Department of Health and Human Services is committed to providing services that are accessible to people who have Limited English Proficiency (LEP). To LEP individuals seeking services from DHHS, qualified interpreters are available (at no cost to the client) to help communicate with the Department. Important documents are being identified and gradually translated into the predominant languages spoken in Maine. PATH providers will be encouraged to utilized DHHS/Office Multicultural Resources to access this service for minority populations they serve.

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. 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 General52, The New Freedom Commission on Mental Health53, the IOM54, and the NQF55. 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.”56 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)57 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)58 was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA’s priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and
training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Behavioral Health Homes and Opioid Health Homes are able to link behavioral health and primary care. This allows for information sharing and results in a more comprehensive plan of care for each unique individual.

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

Information technology/infrastructure support would help Maine better integrate funding for uninsured populations. Also, 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:
1. All TA/Public Reporting for performance Metric is based on Evidence Based Practices. All recent rule changes to Section 17 of MaineCare have been based on Evidence Based Practices. Behavioral Health Home and Opioid Health Home models are also based on Evidence Based Practices.
2.c. Incentives for providers include pay for performance.
2.d. Rule Making and rate setting involve the provider community as well as stakeholders.
2.h. To assess purchasing decisions, The State examines costs as well as performance measures for each service to evaluate contract performance.
Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?

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2. Has the state implemented any evidence-based practices (EBPs) for those with ESM I?

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

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

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

   Maine Medical Center's PIER program is the first FEP treatment provider in Maine. They are contracted to not only provide the treatment for those experiencing FEP, but also to train and supervise two community mental health providers in the PIER model. Each youth referred to the PIER program receives individualized treatment from the program; all components of coordinated care are available to each individual/family, and it is up to each individual how they will receive the services offered by the program.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESM I?

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5. Does the state collect data specifically related to ESM I?

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6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESM I?

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7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESM I.

   The State of Maine will utilize Maine Medical Center's PIER (Portland Identification Early Referral) program, which is based on the...
RAISE model of treatment for First Episode Psychosis.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

In the last contract (FY17), two community mental health providers were trained to provide the components of Coordinated Specialty Care. It is our hope to expand the catchment area to more rural parts of Maine with our next contract which begins on 10/1/17.

Activities will include: One large training for at least 200 people in Maine to educate and increase attendee’s ability to recognize signs of FEP; Monthly Outreach and Education opportunities to communities; one-hour trainings to student providers; provide Coordinated Specialty Care treatment to qualifying youth/young adults at MMC/PIER; train and provide one year of supervision to two community mental health providers on components of Coordinated Specialty Care.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Individual level and aggregate data are collected by MMC/PIER and reported to the DHHS on a quarterly basis. The following are examples of outcomes that are tracked: school participation, legal involvement, program involvement, improved system, substance use, psychiatric hospitalization, use of emergency rooms, suicidality, global functioning, employment, social connectedness, emotional wellbeing, and physical health.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia, Schizoaffective Disorder, Bipolar Disorder with Psychosis.

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

MMC/PIER partnered with a Youth Advocacy organization to add Youth Peer Support, which incorporated youth voice at the multidisciplinary treatment table for those with FEP. This addition of Youth Peer Support to the work being done in the PIER program has been an invaluable addition for the youth receiving treatment at MMC/PIER.

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

Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

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

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

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

   Through MaineCare Rule making, the state has implemented the use of the ANSA (Adult Needs and Strengths Assessment Tool) that is completed annually to engage consumer and their caregivers in creation of their person centered plans. Adult Needs and Strengths Assessment (ANSA) is a multipurpose tool that assesses the needs and strengths of adults seeking behavioral health services. The ANSA may be used to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

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

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

   Rights of Recipients of Mental Health Services; Part B - II. Individualized Support Planning Process

   A. The individualized support planning (ISP) process will result in the development of a life plan based upon the wants and needs of the recipient.

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

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

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

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

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

      Action plans will be developed in instances in which recipients and providers agree to work toward the achievement of a goal. The action plan will be consistent with the recipient’s life plan, priority needs and targets. The action plan will contain the following:

      a. Measurable outcomes;
      b. Criteria for success;
      c. Time frames; and
      d. Assignment of responsibilities.

      D. All unmet needs identified in the ISP process will be reported to the Division of Mental Health. E. ISP’s will be reviewed with the recipient no less frequently than every 90 days and revised as needed.

   Children’s TCM and BHH are time-limited services that provide organized structured processes for assisting youth and their families to address the functional impact of Behavioral Health challenges. The Children's Behavioral Health Services (CBHS) planning process is a shared partnership between the child/youth and family and the case manager. Children, youth, and families...
are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources. TCM and BHH ensure available resources are efficiently accessed and being used in a timely and cost effective manner. The CBHS Planning Process is the required planning process for children receiving Children’s Targeted Case Management (TCM) or Children’s Behavioral Health Home (BHH) services funded through the Office of MaineCare Services (OMS). The process is youth guided and family-driven, and while the child/youth is the primary focus, parents and guardians play key roles in identifying needs and preferences for their children as well as services and resources that will be coordinated through TCM and BHH services. CBHS Planning Process Components:

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

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

The ANSA tool was adopted into Maine Care rule to identify the strengths and needs of adults with SMI; the tool is used to engage consumers and their providers in planning and enhancing their person centered planning process. The ANSA must be completed by a certified ANSA provider within the scope of their certification, during the initial thirty (30) day assessment process for covered services described in section 17.04-1, Community Integration Services. The ANSA must be reviewed by the treatment team every ninety (90) days and updated when major changes occur, or annually at minimum. The ANSA must be entered into the Department’s Enterprise Information System, or equivalent data system managed by the Department, for tracking and reporting purposes. Information gathered via the ANSA shall be considered in the development of the Individual Support Plan (ISP), described in 17.01-11.

In Conjunction with Dr. John Lyons, Developer of the CANS Assessment Tool, CBHS created a single CANS assessment tool to be completed for all children involved in CBHS beginning with Targeted Case Management and Behavioral Health Homes and to later expand to other children’s services. The CANS assessment is used in the CBHS Planning Process every 90 days, or as needed. It is used to develop goals and also measure progress toward goals and objectives on the individualized plan.

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

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?

   Please indicate areas of technical assistance needed to this section.

Footnotes:

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

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

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

• To the greatest extent practicable, SAMHS allocates tenant-based housing vouchers which empower consumers and enhance individual choice, independence, and allow the consumer to control their housing and the amount and type of services they choose receive.
• Independent housing vouchers deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care.

• Vouchers can be used in either the community or group settings—at the consumer’s discretion. Independent housing vouchers are a logical extension of the concept, Money Follows the Person, in which the consumer directs their own care, and in this case, their housing as well.

Since the inception of the Consent Decree, Maine’s DHHS has supported voucher programs (BRAP and Shelter Plus Care) that are built on the premise of not demanding participation in any particular service program as a pre-condition of housing. Vouchers provide the consumer with choice, independence, and control over where they live and what services they choose to engage in. In 2016 BRAP and Shelter Plus Care participants alone received over $48.5 million of MaineCare reimbursable services helping to keep them successfully housed in the community.

100% of Shelter Plus Care vouchers are dedicated to homeless persons with mental illness and over 50% of all BRAP vouchers are being utilized by the homeless with mental illness. Combined, there are over 1,800 vouchers serving 3,640 homeless individuals and families in 2016. Recognizing the effectiveness of BRAP, the current administration has supported increased funding since 2012 of $2.3 million resulting in a complete elimination of the BRAP waitlist today.

Maine inserted ‘homelessness’ into the eligibility sections of State Medicaid Plan, Section 13, 17, 65. New for 2017 was the implementation of the Adult Needs Strengths Assessment Tool (ANSA) for all PNMI to complete on each consumer every 90 days to review status, document changes, and document/show improvements/client function as noted in their¼.Homelessness was built into the ANSA tool as a risk factor. The ANSA tool was also put into MaineCare rule under Section 17 Community Support Services.

OCFS is partnering with MaineHousing on two pilot projects with MaineHousing for youth. The first project is the Family Unification Program pilot, which involves youth who have been involved in the Child Welfare System. A partner agency provides intensive case management services to the youth placed in an independent living apartment with a voucher from FUP. The youth is supported as he/she obtains additional educational or vocational skills and works toward independence.

The Pathways to Opportunity pilot also involves youth (and families) up to age 25 who have been homeless. The pilot provides them with a housing and educational navigator to help them to either gain a vocational certificate or graduation from further education. Youth in this pilot must be eligible for TANF, yet by electing to participate in this program, they agree not to apply for TANF benefits. So far, youth are increasing their employment and wages as result of the program, and are rapidly rehoused at the completion of the program. MaineHousing plans to apply for more vouchers in the near future, and will dedicate them to either continuing with these initiatives if they prove to be successful, or will in another way assist the homeless youth population to safe, affordable housing.
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 SM1 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 SM1 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](http://example.com/yes.png) ![No](http://example.com/no.png)

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  
   ![Yes](http://example.com/yes.png) ![No](http://example.com/no.png)

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

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

   Additionally, State Planners conduct periodic announced site visits to ensure compliance and understanding of the fiscal and program expectations that include members from the State Behavioral Health Planning /Advisory Council.

   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 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.

Please respond to the following items:

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

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

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

   Please indicate areas of technical assistance needed to this section

Footnotes:
After the collaboration at the Maine MHBG site visit in November 2016 with WABNAKI Tribal members, it was recommended that the Maine DHHS contact Tribal Leadership in order for SAMHS and OCFS to further the collaboration moving forward. On June 5, 2017, letters were sent to 5 Tribal Chiefs and Councils of each tribal community in Maine, as well as the Health Directors. The letter requested involvement with State Planners on the MHBG activities and QIC initiatives.

Once State Planners have completed and submitted Maine's draft MHBG application, they will solicit input and recommendations once again from Tribal leadership, Councils and Health Directors.
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

**Narrative Question**

**Criterion 1: Comprehensive Community-Based Mental Health Service Systems**

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

**Please respond to the following items**

**Criterion 1**

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

Services and resources available for outpatient care are: Adult--Mental health services are primarily accessed through MaineCare Section 17 Community Support Services (Maine's Medicaid program) and through state general funds.

Direct Treatment Services are provided by contracted agencies, which include: peer to peer services, Community Integration/case management, residential supports and services, daily living supports, Community Rehabilitation Services, Crisis and mobile crisis and crisis outreach services/intervention, outpatient counseling, Jail diversion, Intensive Case Management Program, and Supportive Employment/Long Term Supportive Employment. Evidence based practices such as accredited Club Houses under the International Club House Model, Assertive Community Treatment, Medication Management, Trauma Informed Care, and Behavioral Health Home Models are provided via MaineCare.

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

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

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

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<tr>
<th></th>
<th>Physical Health</th>
<th>Mental Health</th>
<th>Rehabilitation services</th>
<th>Employment services</th>
<th>Housing services</th>
<th>Educational Services</th>
<th>Substance misuse prevention and SUD treatment services</th>
<th>Medical and dental services</th>
<th>Support services</th>
<th>Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)</th>
<th>Services for persons with co-occurring M/SUDs</th>
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Please describe as needed (for example, best practices, service needs, concerns, etc)

SAMHS has implemented the use of the ANSA Tool through MaineCare rule making this past year. The Adult Needs and
3. **Describe your state's case management services**

For children, Maine offers Targeted Case Management services in Section 13 of MaineCare for children 0-20 years of age. Eligibility criteria include a diagnosis rendered by a licensed clinician, Physician or Physician Assistant; the Member must have one of the following: Behavioral Health Disorders, Developmental Disabilities, Chronic Medical Conditions, or Homeless. The Child and Adolescent Needs and Strength assessment is utilized for eligibility and redetermination of need.

Behavioral Health Homes are another model of support that many Adults and Children utilize, rather than case management services. Behavioral Health Homes are a partnership between a licensed community mental health provider (the "Behavioral Health Home Organization" or BHHO) and one or more Health Home practices (an HHP) to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers.

For Adult Case Management Services, This is described in the MaineCare Manual Chapter II Section 17 Community Supports, Last updated on 2/26/17.

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

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

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

17.04 COVERED SERVICES

A. Identifies the medical, social, residential, educational, vocational, emotional, and other related needs of the member;
B. Performs a psychosocial assessment, including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs;
C. Facilitate formal and informal opportunities for career exploration during service delivery time for working-age and transition age youth participants;
D. Provides assertive, persistent engagement to build rapport and trust with individuals who may be reluctant to accept those services necessary to meet their individual goals;
E. Develops an ISP that is based on the results of the assessment in Section 17.04-1(B), which includes:
   1. Statements of the member's desired goals and related treatment and rehabilitation goal(s);
   2. A description of the service(s) and natural support(s) needed by the member to address the goal(s);
   3. A statement for each goal of the frequency and duration of the needed service(s) and support(s);
   4. The identification of providers of the needed service(s) and natural support(s);
   5. The identification and documentation of the member's unmet needs; and
   6. A review of the plan at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary.
F. Coordinates referrals, and advocates access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan;
G. Participates in ensuring the delivery of crisis intervention and resolution services, providing follow-up support to ensure that a crisis is resolved and assistance in the development and implementation of crisis management plans;
H. Assists in the exploration of less restrictive alternatives to hospitalization;
I. Makes face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate - services for the member per their ISP;
J. Contacts the member's guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings;
K. Evaluates service provision to determine whether the member's ISP needs to be revised, whether a new plan is needed, or whether services should be terminated;
L. Provides information and consultation with the member receiving Community Support Services, to the member, his or her family,
or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence; and

M. Assists the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers when needed and in enhancing skills and employing strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job.

N. Documents evidence of the member’s access to primary and specialty care appointments, to minimally include an annual primary care provider visit. This can be in the form of a clinical note or after visit summary.

4. Describe activities intended to reduce hospitalizations and hospital stays.

   ANSA tool, 7 day contact (Maine Care rule)

For Children’s Behavioral Health Services:

1. Targeted resource development to increase community based supports for youth in their home and community. This includes attempts at increasing capacity for current providers to serve youth through HCT, RCS, MST, and FFT. In addition, resource development is utilized to expand the number of providers providing Sec. 28 and HCT.

2. Developing a new process with our ASO/KEPRO to increase length of approval for Temporary High Intensity Service (Staffing) for youth at risk of hospitalization in a residential program. As of September 2017, programs will move from a maximum 7 day approval to provide these crisis supports for stabilization to up to 90 day approvals. This will allow residential providers more flexibility to provide increased staff supports in the lower level of care, to hopefully reduce the need for acute hospitalization for stabilization. In addition, providers will be able to access these supports upon admission, which should result in a reduction in hospital lengths of stay.

3. Youth exiting hospitals and needing HCT or section 28 are automatically placed in priority status on our Referral Management process for these supportive home/community based services. This also applies to kids leaving Residential Treatment, an attempt to provide in-home in-community support as quickly as possible to reduce the risk of re-hospitalization.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
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<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>40,181</td>
<td>25.2% (40181/159635)</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>26,181</td>
<td>22% (26181/119105)</td>
</tr>
</tbody>
</table>

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

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

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

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

It should be noted that for Children with SED, Targeted Case Management was not included, therefore it is likely that the prevalence is higher than reported. TCM was excluded because children with developmental disabilities are authorized in the same manner as those with SED—there is no way to differentiate between the two. Also, TCM is often utilized by families who need help accessing the System of Care and children do not require a SED to receive TCM services.
**Narrative Question**

**Criterion 3: Children's Services**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

**Criterion 3**

Does your state integrate the following services into a comprehensive system of care?

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<tr>
<td>a)</td>
<td>Social Services</td>
<td>Yes</td>
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<tr>
<td>b)</td>
<td>Educational services, including services provided under IDEA</td>
<td>Yes</td>
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<td>c)</td>
<td>Juvenile justice services</td>
<td>Yes</td>
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<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
<td>Yes</td>
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<td>e)</td>
<td>Health and mental health services</td>
<td>Yes</td>
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<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
<td>Yes</td>
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Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

To address the unmet need of older adults with SMI, The Office of Aging and Disability Services (OADS) administers the contract and oversight of the Geri - Psych Services and Specialized Nursing Level Care involving three facilities: Mountain Top in Fairfield with ~ 18 Nursing Care Beds, 16 Residential Care beds; (16 bed are utilized by Adult 55 and over) Hawthorne House- Freeport- 17 Beds (16 being utilized by Adults 55 and older) and Gorham House- Gorham- 18 Beds. (15 are being utilized by Adults 55 and older). OADS Review Team is going out and reviewing all consumer charts to ensure appropriate and needed therapeutic interventions are being provided. If a consumer wants or needs to be at a lesser restrictive environment, such as assisted living or other community setting OADS is connecting with the facility to purse their options. OADS is utilizing the Pre-admission Screening and Resident Review (PASRR) as required and recommend initial specialized services. PASRR is a required process before any admission to a nursing facility. Screening is required regardless of the source of payment and whether or not mental illness, intellectual disability or other related condition is known or suspected.

If the consumer is in need of PNMI Services as a step down when they no longer meet NF, SAMHS is contacted for PNMI referrals and services. If the consumer needs additional community mental health need while in a NF, then the NF arranges that service. To address the SMI/SED and co-occurring substance use disorders in rural or homeless populations, SAMHS administers the PATH program (Projects for Assistance in Transition from Homelessness). The PATH statewide program has been re-designed to more effectively target the rural SMI literally homeless populations in the state. Conducting outreach to the extremely rural homeless populations and ensuring access to services among the same population is a complex issue, and has been reorganized within SAMHS under Resource Development to align it with SAMHS housing resources, the state funded Bridges for Rental Assistant Program (BRAP) and HUD Shelter plus Care Programs. The PATH program measures the following resources on individuals enrolled in the program: housing, medical, behavioral health or mental health resources or a veterans Administrative Service resource as well employment/education. Maine’s PATH program mandates utilization of Homeless Management Information System (HMIS), an electronic data system which tracks and documents homelessness across the United States and in Maine.

Maine’s PATH program mandates utilization of this system for all persons who receive both Outreach/engagement services as well as PATH Enrolled services. Maine’s PATH program is supported by the current administration at a rate of more than 10 times the required federal match—the highest ratio in the country. Maine’s PATH program has been redesigned to focus on the literally, unsheltered, most vulnerable homeless with mental illness and co-occurring substance use disorders first. Maine is committed to ending homelessness, especially among individuals with SMI, with $ 1,833,830.00 committed as a state match to the $300,000 PATH Block Grant Funds.

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

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

? 5% set aside to support clinical assessments (this eliminates the provider risk by allowing payment for persons who did not categorically meet Medicaid coverage—those who do meet eligibility requirements receive payment through Medicaid for the assessment.)

? HMIS mandate participation of all PATH providers

? Data sharing between all PATH providers (each PATH provider can now ‘see’ other PATH provider clients)

? Outcome Measures Development

• Housing as a measure for a homeless program, PATH

• Health Care as a measure for PATH

• Behavioral Health (already a measure)

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

OCFS currently has six contracts with homeless youth providers throughout Maine--two contracts in each Region of the State. Services provided are: Homeless outreach and drop in, shelter services and transitional living programs--as well as MH and SA treatment to homeless youth. Youth who are runaway or homeless are eligible for services, and can walk into any homeless provider to request assistance. The outreach providers in each region are aware of rural areas that homeless youth congregate, and practice hot spotting techniques to reach youth.

Resource Coordinators are constantly monitoring the wait lists for services and will reach out to providers to request that they serve children who are eligible and waiting for services. They have made arrangements for providers to work together in rural areas, to meet a youth’s need, i.e.: for Home and Community Treatment, the Resource Coordinator was able to have one provider have their clinician involved with a family, with another agency’s BHP. This outside the box thinking is critical for our rural state, and helps families get served in a timely manner.
Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state’s management systems.

To support Maine’s System of Care, SAMHS has contracted with a training partner, AD-CARE, to provide the following trainings to all providers of the Behavioral Healthcare System:

- 110 trainings to an estimated 2600 people in Maine on the following issues: Co-Occurring Disorders, EPBs for adolescents/young adults, Workforce Retention, Working with adolescents, Criminogenic issues, Cultural Competency, Gender Responsiveness, Domestic Violence, Ethics for treatment professionals and supervisor, HIPAA, Prevention and Ethics, CIPPS (Certified Intentional Peer Support), Motivational Interviewing, Training topics for Recovery Coaches, Trauma Informed Care, Telehealth, Pregnancy and Substance Use, Sex and Human Trafficking, Substance Use Disorder and elders, Rural Issues, etc.

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

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

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

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

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

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

- the individual community support planning process, if applicable;
- the mental health service system;
- the family support services;
- the role state and private psychiatric hospitals play in relation to the agency;
- adverse reactions to psychoactive medications, if applicable;
- child development and children’s educational needs for staff who work with children and/or adolescents;
- For staff working with individuals over the age of 60,
- psychogeriatrics and communication techniques with elderly persons; and
- training in the inter-relationship of co-occurring conditions and referral and treatment processes for staff members who work with individuals with co-occurring conditions.

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

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

It is up to each individual provider to ensure that their employees are in compliance with the licensing standards/training requirements. Some of these trainings may be provided by AD-CARE, while others would have to be provided at the expense of the licensed agency.
OCFS has worked with Disability Rights Maine to create the Children’s Rights of Recipient’s Training, which was provided to community agencies. Also, the Children’s Behavioral Health Training will be provided to community agencies in 2017. For some contracts with community agencies, OCFS provides in-service training for the staff, this is the same 10-day training that new child welfare workers working for the State of Maine receive.

For FY18-19, SAMHS and OCFS believe that the training resources listed above currently meet the workforce development training needs, as identified by the State and Community. Training plans are developed based on the needs of the State, with input from the community and QIC. As the core training needs as outlined by Maine State Community Mental Health Licensing standards change, OCFS and SAMHS will reassess the need for training enhancements.

Funding is determined by budget allocations and contracts. For the FY 18/19 contract, SAMHS utilizes our workforce development contract to make training available within available resources. SAMHS braids their funding for the workforce development contract in order to support these efforts to greatest extent possible and the changing needs of the behavioral Health environment.
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.

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

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

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

The Maine Department of Education provides education and related services to Maine’s students with disabilities through school subsidy, contractual and federal funding through IDEA, the Individuals with Disabilities Education Act. These services include the following:
• Certified Educational Personnel which include: Administrator of Special Education, School Education Consultant, School Psychological Service Provider, Vocational Education Evaluator, Speech and Hearing Clinician, School Nurse, Teacher of Students with Disabilities, Teacher – Severe Impairments, Teacher-Hearing Impairments, Teacher – Visual Impairments and Adapted Physical Education.
• Licensed Contractors which include persons licensed by appropriate state agencies to provide supportive services to students with disabilities, including: Audiologists, Interpreter/ Translator, Licensed Clinical Professional Counselors, Occupational Therapists and Physical Therapist Assistants, Psychologists, Social Workers, Speech-Language Pathologists, Speech-Language Pathology Aides and Assistants, and Attorneys.
• Auxiliary Staff which include Educational Technicians I, II, and III approved by the Office of Certification and assigned full or part time to provide special education services.
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

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

Maine’s PATH program is supported by the current administration at a rate of more than 10 times the required federal match—the highest ratio in the country. Maine’s PATH program has been redesigned to focus on the literally, unsheltered, most vulnerable homeless with mental illness and co-occurring substance use disorders first. Maine is committed to ending homelessness, especially among individuals with SMI, with $1,483,830.00 committed as a state match to the $300,000 PATH Block Grant Funds.

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

- 25% set aside for persons with lived experience (Peers) to do the actual outreach
- 5% set aside to support clinical assessments (this eliminates the provider risk by allowing payment for persons who did not categorically meet Medicaid coverage—those who do meet eligibility requirements receive payment through Medicaid for the assessment.)
- HMIS mandate participation of all PATH providers
- Data sharing between all PATH providers (each PATH provider can now ‘see’ other PATH provider clients)
- Outcome Measures Development
  - Housing as a measure for a homeless program, PATH
  - Health Care as a measure for PATH
  - Behavioral Health (already a measure)
- Requirement that PATH provider must be a licensed Community Based Mental Health Agency to ensure and assist in the transition from literally homeless with mental illness to a supportive housing arrangement.
In FY17, PATH has expanded its rural presence and targeted funding to the Projects for Assistance in Transition from Homelessness (PATH) program to outreach the literally homeless in rural counties. Maine similarly supported an expansion of the First Episodic Psychosis (FEP) program in F17 to rural counties through outreach, education and training of agency clinicians in components of the Coordinated Specialty Care Model. For FY 18, SAMHS is targeting Androscoggin, Franklin, Kennebec, Oxford or Penobscot Counties for FEP education, information and outreach to service providers. SAMHS will also work with two (2) identified provider agency teams from Kennebec County to complete a year-long supervision and certification program for Coordinated Specialty Care. A FEP agency provider team was established in Androscoggin County in FY 17 and can outreach other rural areas such as Oxford and Franklin counties.

To address the unmet need of older adults with Serious Mental Illness (SMI), The Office of Aging and Disability Services (OADS) administers the contract and oversight of the Geri - Psych Services and Specialized Nursing Level of Care. This contract covers three facilities: Mountain Top in Fairfield with 18 Nursing Care Beds and 16 Residential Care beds (16 beds are utilized by Adults 55 and over); Hawthorne House in Freeport with 17 Beds (16 being utilized by Adults 55 and older) and Gorham House in Gorham with 18 Beds (15 beds are being utilized by Adults 55 and older). OADS Review Team reviews all consumer charts in the facilities to ensure that appropriate and necessary therapeutic interventions are being provided. If a consumer wants or needs to be in a less restrictive environment, such as assisted living or other community setting, OADS works with the facility to in order to assist the consumer in pursuing their options. OADS is utilizing the required Pre-Admission Screening and Resident Review (PASRR) in order to recommend initial specialized services. A Federal requirement, PASRR is a required process before any admission to a nursing facility. Screening is required regardless of the source of payment and whether or not mental illness, intellectual disability or other related condition is known or suspected.

If the consumer is in need of Private Non-Medical Institution (PNMI) Services as a step down when they no longer meet the above-mentioned Nursing Level of Care, SAMHS is contacted for PNMI referrals and services. If the consumer needs an additional community mental health need while in a Nursing Level of Care, then the nursing facility arranges that service.

The table below reflects the Adult SMI population 55 years of age and over in Maine:

- SMI is defined as using the following community services: Adult Behavioral Health Home (BHH), Community Integration (CI), Crisis Response Services (CRS), Assertive Community Treatment (ACT) and Adult PNMI.
- The table below shows unique people who used any of these services from July 1, 2016 through June 20, 2017, (nearly a complete state fiscal year).
- It includes people in grant-funded services as well as MaineCare (Medicaid) services.
- KEPRO, SAMHS’ contracted prior authorization service provider, does not have Medicare data, so people using Medicare to fund a service (such as Adult PNMI) would be excluded from the table.
- Older adult is defined as age 55 and over.
Maine SAMHS has adopted Maine CDC’s definition of “rural” for the purposes of this document, which is based on the US Census definition of rural counties. 11 of Maine’s 16 counties are classified as rural in this case.

The table is based on the total population for each rural county.

Based on the following percentages of persons with SMI - Adults age 55 years and over - in defined rural areas of Maine, the data suggests the SMI older adult population represents a small percentage of persons in each county. The total percentage of Older Adults with SMI in the 11 rural counties is .23%. The Department is addressing this older adult SMI population in rural counties through contracted, licensed Mental Health agencies and Behavioral Health Homes that are located in a major towns or hub areas accessible by public transportation.

SAMHS is exploring other ways to connect rural and older SMI populations with mental health services through methods including, but not limited to: educating agencies on the benefits of increased
utilization of telehealth services, funding consumer-based transportation services for the purposes of clinical care when other public resources are not available, and the promotion of the Recovery Model, where connections are encouraged with a person’s natural support system such as family, friends and peers. These natural supports help the person connect/access mainstream services and are identified through the Individual Support Plan (ISP) process. DHHS/Office of MaineCare Services (OMS) also provided up to 2 million rides in FY 16 for MaineCare recipients which includes Section 17 Community Integration and Behavioral Health Homes, and OMS has recently written peer recovery and telehealth services into their Rule chapters.
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?

   SAMHS Quality Improvement Plan
   The mission of the Quality Department is to ensure excellence in the services provided by the Maine Office of Substance Abuse and Mental Health Services.
   The Maine Office of Substance Abuse and Mental Health provide these core services:
   • Federal Grant Administration
   • Contracted Mental Health, Substance Abuse, and Housing Services
   • SAMHS-administered programs to include:
     o Driver Education and Evaluation Program
     o Intentional Peer Support Specialist Training and Certification
     o Levels of Care Utilization System Certification
     o Prescription Monitoring Program
   • Subject Matter Expertise
   • Substance Abuse and Mental Health Data Reporting

   The Quality Department is focusing its 2017 efforts on the following systemic improvements to ensure excellence in the services provided by SAMHS:
   • Data integrity audit to determine data availability and accuracy of information;
   • Quality Management Plan to analyze core services and implement process improvement measures;
   • Standard operating procedure development for all internal processes;
   • Strategic plan review to ensure it accomplishes its purpose as a guidance document for determining SAMHS services; and
   • Workforce development.

   The OCFS developed and spent two years implementing a Quality Review process for each of the following Medicaid billable services: Rehabilitative and Community Services, Home and Community Treatment, Medication Management, Outpatient Treatment and Targeted Case Management. The QA Unit was able to review every contracted provider, and obtained a baseline of all contracted services for youth and families. The QA process included a chart review of randomly selected records, followed by a telephone conversation with the parent/legal guardian. Program Staff met with each provider reviewing their QA Report and supported them in making any needed improvements. Program Staff provide ongoing technical assistance and support to Providers and address issues as they arise. The will conduct random reviews of records, as necessary.

   OCFS uses a Reportable Events System to monitor how agencies are functioning as a whole and to track the number of restraints, med errors and serious behavioral issues that occur while a youth is being served. A Reportable Event form that is filled out electronically by contracted providers into a state information system to notify the OCFS of critical incidents that occur while the contracted provider is serving a child/family. All incidents are reviewed and followed up on as appropriate to ensure any action steps necessary are taken and to provide guidance for recognizing antecedents which could prevent a future incident from occurring.

   OCFS has created and new single CANS Assessment Tool which will be used as both an assessment and later on as a quality measure. It is currently being used for Targeted Case Management and HCT services, but it is expected to be used with other OCFS contracted services in the future. The assessment is completed at the initiation of service and provides a baseline of need--this determines the frequency, intensity and duration of service authorized. The CANS will also be completed quarterly to measure progress and continued need for service.
OCFS is in the process of reviewing the entire Children’s System of Care looking at all policies, to identify gaps in service, and if families are being strengthened as a result of our current services. OCFS is working with Disability Rights Maine and other State Departments with DHHS and will be creating expanded stakeholder groups in the future.

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 affects 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](Yes) ![No](No)

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?  

   ![Yes](Yes) ![No](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](Yes) ![No](No)

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  

   ![Yes](Yes) ![No](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 provided.
- 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),
- Developed 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,
- Developed 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 overseen by 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 resilience 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 M M C/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. HBG funding has funded the addition of youth with lived experience to the FEP Program to: integrate youth voice, experience and expertise in developing training and educational materials, provide one to one youth peer support for eligible youth, receive training on and lead on Multi Family Groups, co-present at outreach training’s and conferences, and to develop a Youth Leadership Council.

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. 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?  
   - Yes 
   - No

OCFS and DOC are committed to collaborative system approaches in an effort to individualize treatment/service plans for all youth. For some youth that may mean diverting them entirely from the juvenile justice system, and for other youth it will mean joint planning to target both behavioral health needs and criminogenic risk factors.

A large percentage of children in the juvenile justice system have identified mental health/behavioral health issues. Youth in this system may not have had access to behavioral health services for a variety of reasons, and, in some cases, may have been confined in juvenile facilities. The goal is to assure that all youth under the jurisdiction of DJJS will be screened for and have behavioral health service needs identified, be appropriately evaluated, and receive needed services. Services will be provided in the least restrictive environment that ensures safety of the youth, the family and the community. The youth and their family will be involved in the planning process. Treatment plans will be youth guided, family driven, culturally competent, strengths based, trauma informed, and apply the principles of effective intervention for youth in the juvenile justice system.

OCFS has 4 CBHS Program Coordinators/DOC Liaisons who spend time in the DOC Offices ensuring that youth with behavioral
health issues who have committed a crime are assessed and referred to appropriate community treatment. These staff also train Juvenile Corrections Officers on Children’s Behavioral Health Issues.

NAMI Maine offers CIT Training:

Crisis Intervention Team (CIT) training consists of 40 hours of specialized training for uniformed patrol law and correctional officers, as well as emergency medical service providers, emergency room staff, and other first responders. Law enforcement and corrections officers learn how to respond to calls and situations concerning persons with mental illness in crisis. CIT is not just training—it transforms how the entire community responds to psychiatric crisis by creating on-going collaboration that ensures a more dynamic response and increases the likelihood of a successful diversion from the criminal justice system.

In 2010 Sgt. Jonathan Shapiro M.A in York County created a Protocol “An improved Police Response to Juveniles in Crisis” to address a growing issue of youth with mental health issues displaying “out of control behavior” that includes
• Education/training of Police Officers
• Development of a Police Juvenile Reporting Form
• Partnering with mental health organizations and Crisis
• Guaranteed follow up services
• Case Tracking to assure progress

SAMHS has collaborated and supports treatment drug courts for Adults with Mental Health and Substance Use Disorders (co-occurring disorders) and Veteran population through contracted programs such as Adult Treatment Drug Court, and Co-occurring Disorders and Veterans Drug Courts.

Adult Treatment Drug Court—Implemented in 2001, the ADTCs are specialty dockets given the responsibility to manage cases involving high risk/high need individuals with serious substance abuse and co-occurring disorders involved with the criminal justice system through rigorous judicial monitoring, community supervision, drug testing, specialized and comprehensive treatment services, and immediate sanctions and incentives. In exchange for a guilty plea an individual may enter the ADTC and following graduation expect a greatly reduced sentence. However, if unsuccessful in the Court, the previously agreed upon sentence associated with this outcome will be imposed.

Adult Drug Treatment Courts have been in existence since 1989 and have expanded across the United States and abroad. Every state and territory has a drug court. Rigorous research has demonstrated that, when operating with adherence to best practices for the drug court model, there are significant reductions in recidivism, improved treatment retention leading to strengthened recovery, improved public safety, and associated cost savings. Evaluations of the Adult Drug Treatment Courts in Maine have replicated these results

Co-occurring Drug Court & Veterans Drug Court—The Maine Co-Occurring Disorders began admitting adults with significant substance abuse disorders and mental illnesses and serious criminal charges in 2005. The Honorable Nancy Mills of the Superior Court founded this docket in collaboration with the Kennebec and Somerset County District Attorney and numerous other community and state partners and has continued to preside since its inception. This docket provides intensive judicial monitoring, case management, specialized treatment, and other services. Its goals include promoting recovery from substance abuse and mental illness, the development of prosocial skills, and improving public safety through reducing future criminal behavior. Although located at the Capital Judicial Center in Augusta, as the only specialty docket of its kind in Maine it accepts referrals from throughout the state.

For military veterans, criminal conduct as well as behavioral disorders may be attributable to their service, particularly if they were exposed to traumatic circumstances such as combat. The majority of these veterans have no history of criminal behavior or co-occurring disorders prior to their service. There is increasing recognition that these factors must be taken into account when veterans become involved with the criminal justice system in order to achieve better outcomes than result from traditional adjudication and incarceration.

It is the mission of the Maine Co-Occurring Disorders and Veterans Court to support the recovery of defendants from drug and alcohol abuse and psychiatric disorders in order to reduce the risk of recidivism, enhance public safety, and improve the quality of life for defendants and their families through early, continuous, and intensive judicially supervised integrated treatment and other appropriate rehabilitation services. Goals of these courts are to:
• Reduce alcohol and drug abuse dependency among criminal defendants;
• Reduce criminogenic risk while addressing related needs;
• Enhance community safety by reducing criminal recidivism;
• Reduce the severity of psychiatric symptoms;
• Increase personal, familial and societal accountability of defendants;
• Develop in offenders the necessary personal, familial and societal assets and skills to become productive citizens through, for example, employment, positive community activities, and healthy and safe family relationships;
• Coordinate case processing and monitoring of participants in CODVC who have multiple contacts with the legal system, including cases involving child protection, domestic violence, and other related family cases;
• Hold offenders accountable for crimes; and
• Support the recovery of veterans from any era or type of service through the provision of services, the utilization of peer mentors, and close coordination with the Veterans Administration.

Currently SAMHS has one Intensive Case Manager (ICM) under the Forensic Department who is considered a ride along with the Augusta Police Department, and have ICM’s in many of the jails across the state. SAMHS also has contracted with Mental Health Crisis Providers who provide Crisis Services in the community, which can mean a jail or emergency departments, along with ride along services with law enforcement in other major populated areas of the state. We also have contracts with NAMI (The National Alliance for the Mentally Ill) to provide CIT training and Mental Health First Aid to law enforcement, mental health providers, jails and other entities which request the training’s.
Please indicate areas of technical assistance needed related to this section.

CBHS does not provide cross trainings for behavioral health providers and juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the juvenile justice system. Perhaps TA could provide guidance/recommendations on how to incorporate this practice.

Footnotes:
Question 4: The JJAG-Juvenile Justice Advisory Group, is an inter-agency committee, a multidisciplinary team of professionals and youth with the mission "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". The JJAG’s current strategic plan involves the following priorities:
~To promote effective, system level responses that further the goals of the Juvenile Justice Delinquency Act;
~To promote the development of gender specific services for Maine's juvenile justice system;
~To ensure that youth are not detained for lack of appropriate alternatives;
~To reduce delinquency and youth violence by providing community members with skills, knowledge, and opportunities to foster a healthy and nurturing environment that supports the growth and development of productive and responsible citizens;
~To provide information and training to legislators, juvenile justice professionals, and the general public to benefit youth and all those involved with Maine's juvenile justice system; and
~To maintain compliance with the core requirements of the JJDP Act and to monitor the compliance of JJAG grantees.
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?
   
The state has recently implemented Opioid Health Homes which provide comprehensive and integrated care to individuals diagnosed with OUDs. We also enacted Ch.488 An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program. The State has recently designated over $2 million to increase access to MAT for uninsured individuals in areas identified as high-risk communities.

   Please indicate areas of technical assistance needed to this section.

   *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.

Footnotes:
The SABG funds and The State Targeted Response (STR) grant funds purchase Methadone, Buprenorphine & Naltrexone.
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.64 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 Crises65,

"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:

64 http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

Please respond to the following items:

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

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

3. Post Crisis Intervention/Support
   a) e WRAP Post-Crisis
   b) b Peer Support/Peer Bridges
4. Does the state have any activities related to this section that you would like to highlight?

1) Maine’s current system consists of Crisis Intervention Telephone Response, Mobile Response, and Crisis Stabilization-Residential Service.

Crisis intervention services has a statewide toll free crisis hotline number as the telephone response component. This is the client’s first point of entry with crisis services, where they are connected to needed resources at the time of the call. If the caller’s needs cannot be resolved over the phone, then they are connected to Crisis Mobile response. Crisis Intervention-Mobile Response services are immediate, crisis-oriented, on-scene services positioned toward stabilization of an acute emotional disturbance to ensure the safety of a consumer, and the community, in the least restrictive setting with an emphasis that emergency rooms are to be used as a last resort for crisis response.

The goal of Mobil Response is to provide on-scene interventions, de-escalation, stabilization, recovery, and follow-up services within a short-term treatment modality. Mobil Response workers have access to psychiatric consultation during the initial assessment 24 hours a day, 7 days a week.

Crisis Stabilization/Residential services are short term, highly supportive, supervised residential settings for individuals experiencing psychiatric crisis. These facilities are utilized for clients experiencing acute psychiatric episodes who require a step-down level of care; alternative to inpatient hospitalization. These services are also provided 24 hours per day, 7 days a week, with access to psychiatric consultation.

Maine is working on enhancements to each program for better quality service and performance outcomes by implementing SAMHSA’s “Core Elements in Responding to Mental Health Crisis” and through implementation of problem solving intervention models.

2) A description of Maine’s Warm Line is as follows (excerpted from the current agreement): The purpose of this Service is to operate the toll-free Warm Line. The Provider shall operate the Warm Line twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. The Warm Line shall target support towards people sixteen (16) years of age and older, living in Maine, and experiencing issues related to mental illness or co-occurring substance use disorders, emotional distress, and trauma, who are not in Behavioral Health Crisis.

Client Services included in the agreement are as follows:

1. Provide live response to individuals calling the Warm Line, an opportunity to be placed in a queue, or an opportunity to leave a message with a call back from Warm Line staff within thirty (30) minutes.
2. Determine when a caller needs immediate support beyond the scope of the Warm Line. A caller with more intensive services needs shall be connected to the appropriate service using a Warm Transfer. Callers shall never be forwarded without a Warm Transfer. Warm Line Operators shall stay on the phone with the caller during the transfer process as long as the caller requests they are involved.
3. Maintain Crisis protocols that have been approved by the Department, and ensure they are understood and implemented by Warm Line Operators. Minimally the protocols shall address:
   a. Specific actions required by staff when caller requires immediate support beyond Warm Line; and
   b. How to reach those services, such as crisis services.
4. Provide targeted attention to individual callers who utilize Warm Line services an average of thirty (30) times a month for a six (6) month period or greater frequency. These frequent callers will be engaged in a Wellness and Recovery Conversation.
5. Give new callers the option to participate in a survey that focuses on the caller’s experience. The information derived from the survey shall be utilized in quality assurance activities related in the provision of this service. Survey data will inform the New Callers Conversation Report
6. Promote the Warm Line to ensure consumers of behavioral health services, providers, and the public are aware of what the service is and how to access the service when in need. Promotional efforts shall include, but are not limited to, on-going engagement with crisis services providers to educate about services, presentations to Peer centers and agencies

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

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery.
Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
   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. SAMH5 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 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 Zeland 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:
Report to:
Maine Department of Health and Human Services

Olmstead Evaluation
January 23, 2017

Contact: Kirsten Smith
ksmith@bloomconsult.org
406.570.0058
bloomconsult.org
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Executive Summary

The Maine Department of Health and Human Services (DHHS or Department) updated its response to the Olmstead decision in 2016. The Department’s Olmstead goals are:

1. Support individual choice so individuals can effectively make decisions about issues that are important to them.
2. Improve community integration so individuals are able to meaningfully participate in community life.
3. Promote continuous quality improvement so individuals receive high quality long term services and supports.

This evaluation defines DHHS progress in achieving outcomes and performance measures associated with the Department’s Olmstead goals.

Purpose

The evaluation provides data on Olmstead performance measures to guide DHHS in understanding progress toward achieving Olmstead goals. The evaluation answers the following questions:

- To what extent were goals achieved?
- What strategies contributed to achieving the goals?
- What factors facilitated or hindered progress?

The Olmstead evaluation analyzes and aggregates work being done across DHHS offices associated with the Olmstead roadmap’s goals related to choice, meaningful community integration, and high quality long term services and supports.

Definitions

Similar terms can be used in various evaluation contexts with different meanings. The following terms and definitions are used in the Olmstead evaluation:

- **Goal.** Broad statement of what the project or initiative hopes to accomplish – a broad primary outcome or specific target.
- **Outcome.** Result or consequence of an action or intervention; the conditions of well-being we want for people using long term services and supports we hope to influence through programs, agencies, or service systems.
- **Performance Measure.** A measurement of how well a program, agency, or service system is working to support the outcome; an outcome stated in measurable and observable terms to help stakeholders assess achievement toward the intended outcome.
- **Baseline.** What the measures show about where we’ve been and where we’re headed.
- **Performance Target.** Specifies the level of outcome hoped for, expected, or intended based on data of what is possible.
Methods and Data Sources
Evaluators worked with DHHS offices to gather status updates related to Olmstead strategies as well as retrospective data to define the baseline for performance measures, which will allow for the impact of strategies to be seen in terms of changing the trend line. DHHS will set performance targets for each performance measure based on the baseline data. Evaluators will conduct key stakeholder interviews and review administrative and secondary data sources to further contextualize the evaluation.

Performance Measure Summary
The table below summarizes outcomes and performance measures associated with Maine’s Olmstead goals. Additional internal systems strategies supporting progress toward these goals are contained in the full body of the report.

<table>
<thead>
<tr>
<th>Goal 1: Support individual choice so individuals can effectively make decisions about issues that are important to them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1.1: People access the long term services and supports they need</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2: Improve community integration so individuals are able to meaningfully participate in community life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2.1: More people access peer natural supports</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Outcome 2.2: More people live in home and community based settings</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Outcome 2.3: More people are employed</td>
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<tr>
<td></td>
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<tr>
<td>Outcome 2.4: More people get where they want to go when they want to go</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3: Promote continuous quality improvement so individuals receive high quality long term services and supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 3.1: Providers use evidence-based/informed practices</td>
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</tbody>
</table>
Maine's Long Term Services and Supports Population

Maine’s Olmstead roadmap impacts all Mainers receiving long term services and supports (LTSS) through Medicaid, called MaineCare. LTSS assist diverse individuals in Maine, including older people, and adults and children with physical, intellectual, mental, or substance use disabilities or disorders. The following table illustrates the Medicaid expenditures for LTSS in FY2014.

Table 1: Medicaid Expenditures for Long-Term Services and Supports FY 2014

<table>
<thead>
<tr>
<th>Medicaid Program</th>
<th>Expenditure FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Institutional</td>
<td>$427,022,211</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>$258,418,797</td>
</tr>
<tr>
<td>ICF/IID</td>
<td>$76,585,676</td>
</tr>
<tr>
<td>Mental Health Facilities and Other Institutional LTSS</td>
<td>$92,017,738</td>
</tr>
<tr>
<td>Total HCBS</td>
<td>$520,855,946</td>
</tr>
<tr>
<td>1915(c) Waivers</td>
<td>$355,648,624</td>
</tr>
<tr>
<td>Personal Care</td>
<td>$77,468,687</td>
</tr>
<tr>
<td>Other HCBS</td>
<td>$87,738,635</td>
</tr>
<tr>
<td>Total</td>
<td>$947,878,157</td>
</tr>
<tr>
<td>Percent HCBS</td>
<td>54.9%</td>
</tr>
</tbody>
</table>

Maine’s total LTSS expenditures per state resident were $712.64 in FY2014. Maine ranked 9th among all states for total LTSS expenditures per resident, and expenditures grew by 6.4% between FY2013 and FY2014. Average annual growth in national Medicaid LTSS expenditures between 2013 and 2014 was 3.7%. Maine’s percentage of LTSS expenditures that were spent on home and community-based services (HCBS) was 54.9%; it ranked 18th in FY2014 among all states for percentage of expenditures spent on HCBS. The percentage of total LTSS spent on HCBS across all states in FY2014 was 53.1%.

Expenditures by member population varied across service type, as shown in the following table. In FY2014, total LTSS expenditures were 38.4 percent of total Medicaid expenditures in Maine.

Table 2: Medicaid Expenditures for Long-Term Services and Supports by Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY2014 Expenditure</th>
<th>FY2014 Expenditures Per State Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total-Older People, People with Physical Disability</td>
<td>$384,176,737</td>
<td>$289.16</td>
</tr>
<tr>
<td>Total-People with Developmental Disability</td>
<td>$402,617,570</td>
<td>$303.04</td>
</tr>
</tbody>
</table>

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1 Steve Eiken, Kate Sredl, Brian Burwell, Paul Saucier, Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, April 15, 2016.

2 Ibid.
Maine increased spending on HCBS by 8.8% between FY2013 ($478,848,578) and FY2014 ($520,855,946), and is ranked 10th nationally in terms of HCBS expenditures by state resident ($391.59). Much of that increase is driven by the increase in 1915(c) waiver expenditures which grew by 8.2% from $328,845,437 in FY2013 to $355,648,624 in FY2014. Maine’s 1915(c) waivers for people with developmental disabilities are the largest cost drivers in this category (92% of overall 1915(c) expenses go to people with developmental disabilities), with the state ranking #1 nationally in this category of spending per state resident. Health homes for people with chronic conditions, personal care, case management, Money Follows the Person Demonstration project, and private duty nursing expenditures also increased during this timeframe.

Maine provides Medicaid funded LTSS primarily through three offices at DHHS: 1) Office of Aging and Disability Services (OADS); 2) Office of Substance Abuse and Mental Health Services (SAMHS); and 3) Office of Child and Family Services (OCFS). Looking at member

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY2014 Expenditure</th>
<th>FY2014 Expenditures Per State Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total-People with Serious Mental Illness or Serious Emotional Disturbance</td>
<td>$104,677,170</td>
<td>$78.79</td>
</tr>
<tr>
<td>Total-Other/Multiple Populations</td>
<td>$56,406,680</td>
<td>$42.46</td>
</tr>
<tr>
<td>Total LTSS</td>
<td>$947,878,157</td>
<td>$712.64</td>
</tr>
<tr>
<td>Total Institutional LTSS</td>
<td>$427,022,211</td>
<td>$321.05</td>
</tr>
<tr>
<td>Total HCBS</td>
<td>$520,855,946</td>
<td>$391.59</td>
</tr>
<tr>
<td>Total Medicaid (all services)</td>
<td>$2,466,101,031</td>
<td>$1,854.09</td>
</tr>
</tbody>
</table>

*Figure 1: FY2014 Expenditure (Total Medicaid Expenditure $2,466,101,031)*
data for the three offices shows varying stories. Generally, OADS and OCFS served more MaineCare members in SFY2016 compared to SFY2014, while SAMHS served fewer.

OADS served 34% more members through its five waiver programs in SFY 2016 compared to 2014. Participation grew across all waivers. The largest increases were 755 new members served in Section 29 services, 482 in Section 19, and 233 in Section 21.

OADS Serves Growing Numbers of People in Waiver Programs

Figure 2: OADS Member Participation by Waiver Program, SFYs 2014 – 2016

SAMHS services and supports can be used over the long term or short term depending on the member’s needs. This data is inclusive of all services. SAMHS provided services and supports to 5,757 fewer members in SFY2015 (32,176 total unduplicated members) compared to SFY2012 (37,933). The declines occurred in outpatient comprehensive assessment and therapy (-5,907), medication management (-2,579), and crisis services (-1,451).

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3 Unduplicated total members served, point in time data from June 30 of each SFY. 2014 data for Sections 19, 21, and 29 waivers is from Muskie School. Section 18 waiver began January 1, 2015. Section 19 waiver merged with Section 22 and began in December 2014. Section 20 waiver began November 1, 2013.
Many OCFS services are not considered long term services and supports, but rather are intended to support children and families in the shorter term. However, children and youth may very well need longer term services and supports, sometimes continuing into adulthood. OCFS served a larger number of members through its Home and Community Based Treatment and Basic Rehabilitative and Community Support services between SFYs 2014 and 2016. There was a slight decrease in the number of members served with Specialized Rehabilitative and Community Support services in the same timeframe.

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\[ Data \text{ is based on MaineCare incurred claims from DSS. Age: 18 and above. Crisis Residential (CSU) includes procedure codes H0018. Residential (PNMI) includes procedure codes H0019, T1020-HE. Patient counts for individual procedures are unduplicated and the total is unduplicated across all procedures; summing of patient counts in each service category will produce a duplicated count since patients often use multiple services.} \]
OCFS Serves More Children and Youth

Figure 4: OCFS Member Participation by Program, SFYs 2014 – 2016

Unduplicated total members served, point in time data from January 1 of each SFY.

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5 Unduplicated total members served, point in time data from January 1 of each SFY.
Goal 1: Support individual choice so individuals can effectively make decisions about issues that are important to them

What This Means
People using long term services and supports exercise choice in how they plan for and use services. Choice is supported by having a robust menu of services available to members without waiting lists or other obstacles delaying or preventing access. Choice is central to person-centered planning and self-direction, where services and supports used are defined by the person’s preferences and whole life context, not driven or limited by professional opinion or available service options. The Maine Olmstead roadmap sees individual choice as foundational to supporting people’s ability to engage fully in their communities.

Outcome 1.1: People can access the long term services and supports they need
Access to services is central to choice. When individuals are restricted in the service options available because of waiting lists or insufficient staffing, their choice in services and ability to appropriately address their needs is hindered. Maine provides home and community based services through a combination of waivers and State Plan services. Individuals may have to wait to access services because of funding limitations for waiver services/slots creating waiting lists or from insufficient staffing to provide services/supports in member’s plans.

This outcome is measured through two performance measures:
- Performance Measure 1.1.1: Reduced percentage of members on waiting lists
- Performance Measure 1.1.2: Increased percentage of members with full staffing

Performance Measure 1.1.1: Reduced percentage of members on waiting lists
This measure looks at waiting lists in 1915(c) home and community based services waivers, specifically:
- Adults with brain injury (§18)
- Elderly and adults with disabilities (§19)
- Adults with other related conditions (§20)
- Members with intellectual disabilities or autistic disorder (§21)
- Support services for adults with intellectual disabilities or autistic disorder (§29)

Additionally, this measure analyzes members waiting to enter mental health treatment.
What We Have Achieved/Dashboard

Section 21 Waiver Services Have Growing Waiting List

Figure 5: OADS Waiver Waitlist Trend, SFYs 2014 – 2016

![Waitlist Trend Chart](chart1.png)

Figure 6: Section 21 Waiver Waiting List and Members Served, SFYs 2014 – 2016

![Waiting List and Members Served Chart](chart2.png)

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6 Point in time data from June 30 of each fiscal year.
Mental Health Waiting Lists Have Reduced

Figure 7: SAMHS MaineCare Mental Health Services Waitlist Trend, SFYs 2012 – 2017

Figure 8: SAMHS State-Funded Mental Health Services Waitlist Trend, SFYs 2012 – 2017

Story Behind the Data

Funding for waivers is not an entitlement, which means the state can set limits on the growth of these programs. Waiver waiting lists occur because waiver budgets are
limited by the amount the federal government approves in state waiver plans and the amount the state legislature approves for the state share of the service costs. A waiting list is created when people who are eligible for the service do not have immediate access because of funding limits.

Funding limitations are the reason for the waiting list in §21 comprehensive services waiver for people with intellectual and developmental disabilities. The waiting lists have grown from 957 people in June 2014 to 1,264 in June 2016. Despite an increase of 233 more members served in the §21 waiver in this timeframe, a growing relative percentage of people are on the waiting list for services (35% of the 2014 and 42% of the 2016 members receiving Section 21 services) because demand for these services exceeds the increasing investment.

Other waiver services (§18 brain injury, §19 elderly and physical disabilities, or §20 other related conditions) have not had waitlists over the past three state fiscal years. However, small waiting lists have started to form in SFY2017 for §18 brain injury and §20 other related conditions because of limited slots, limited funding, or limited direct service workers.

2015 was the peak for SAMHS waiting lists in State-funded services, and 2014 was the high point for MaineCare waitlists. There was a significant decline in the total number of members on waiting lists for SAMHS’ MaineCare and state-funded services between SFY2015 and SFY2016 (260 to 222 or 17% for MaineCare services and 220 to 122 or 80% for State-funded services). This decline in waiting lists occurred at the same time as a reduction in the number of members receiving SAMHS services, which decreased 17% from SFY2012 through SFY2015. The current downward trend in waiting lists is outpacing the decline in member numbers, showing the impact of the $5.7 million in consent decree funding SAMHS invested to reduce the mental health waiting list.

Policy changes made to State Plan community support services (§17) eligibility in April 2016 resulted in fewer people receiving services under this section of the State Plan. Some of these members have shifted to OADS waiting lists or State Plan behavioral health home services (§92) depending on their medical and functional needs. Waiting lists for OADS and behavioral health home services have increased since this change to community support services eligibility was implemented.

**Performance Measure 1.1.2: Increased percentage of members with full staffing**

This measure analyzes the number of members who are approved and funded to receive long term services and supports, but do not receive them because there is no direct care worker available to provide the services. This measure looks at the percentage of members who do not have staffing, using a numerator of unstaffed members and a denominator of the total number of members served in the program area.
What We Have Achieved/Dashboard
Improved Staffing for OCFS Services

Figure 9: OCFS Inservice and Unstaffed Members, SFYs 2014 – 2016

Story Behind the Data
Insufficient direct care worker staffing, particularly in rural areas and able to work with members with complex needs, creates delays for members to access both waiver and State Plan long term services and supports services. The Department completed a series of rate studies to provide additional funding to providers so they could hire more direct service workers. The Department funds services based on the cost of paying full time workers with benefits. However, the Department does not have control over how providers use the increased reimbursement rates.

OCFS has decreased the number and percentage of unstaffed members, or, said conversely, increased the number and percentage of members with full staffing, even while providing services to an increasing member population. Home and Community Based Treatment unstaffed member percentages declined from 18% to 13% from SFY2014 to SFY2016. Basic Rehabilitative and Community Support unstaffed members decreased from 7% to 5% and Specialized Rehabilitative and Community Support unstaffed members declined from 61% to 60%.

Most of OCFS’ services are provided in the home. Families generally want to receive services before or after the school and work day and/or on weekends to accommodate their schedules. Mental health providers and clinicians who provide these services often want full time jobs in typical business hours. Unstaffed hours are a workforce

7 The OCFS data represents a point in time measurement on January 1st of each year. There is no 2014 data for Rehabilitative and Community Support services.
issue in that providers struggle to find qualified staff willing to work atypical, and possibly part time hours. Staffing Specialized Rehabilitative and Community Support is particularly challenging since these children and youth have more complex needs. OCFS makes referrals to other services for children and youth impacted by staffing shortages to ensure they are receiving needed care. OCFS works closely with Kepro to monitor referral management lists, and actively works on resource development collaboratively with providers.

Goal 1 Internal Systems Strategies
In addition to the work related to reducing waiting lists and increasing staffing, DHHS is implementing strategies internally to support increased choice for members.

- **Increased person-centered planning.** DHHS is extending person-centered planning to the children’s system, and enhancing processes in the adult system through additional training and process changes. Developmental Services is replacing the Supports Intensity Scale (SIS) with a new person-centered planning tool.

- **Expanded conflict free assessment.** DHHS offices are implementing new standardized assessment tools in 2017, including the Child and Adolescent Needs and Strengths (CANS) assessment for child and youth services and the Adult Needs and Strengths Assessment (ANSA) for mental health services. Developmental Services is replacing the SIS with an alternative assessment. DHHS is in the process of analyzing alternatives with a broad group of stakeholders. Offices are also expanding conflict free case management through contractual requirements that create a wall between assessing agencies and providing entities.

- **Increased communication and outreach.** The Department is enhancing resource and referral services through Maine211 changes. DHHS offices are also working closely with schools, Veterans Affairs, Labor, and other agencies to increase communication and coordination.
Goal 2: Improve community integration so individuals are able to meaningfully participate in community life

What This Means
People with disabilities have the right to live, work, learn, and socialize in the settings that they choose. In order to support people to participate meaningfully in community life, the state is committed to:

- Supporting community engagement through peer relationships and natural supports.
- Providing meaningful options for people about where to live.
- Ensuring people with disabilities have choices for competitive, meaningful, and sustained employment in the most integrated setting.
- Changing expectations and beliefs about the integration of people with disabilities into the competitive workplace.
- Supporting accessible transportation options to help people get where they want to go, when they want to be there.

Outcome 2.1: More people access peer natural supports
The Department wants to see members leveraging natural supports and generic community resources in their local communities. This will support increased community integration for members. Peers can provide vital support to members as they navigate their local communities’ resources.

Performance Measure 2.1.1: Percentage of members participating in peer to peer programming
The Department supports peer to peer services throughout the long term services and support programs. This measure analyzes the usage of these services in terms of the unique number of members using peer to peer programming provided by grantee agencies.
What We Have Achieved/Dashboard

Mental Health Block Grantees Provide Workshops and Peer Support to Youth

Figure 10: GEAR Members Served, SFYs 2013 – 2016

Figure 11: Thrive Youth Served as Percentage of Total Youth Served in Mental Health Block Grant, SFY 2016

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8 GEAR grantee reports
9 Thrive grantee reports
Story Behind the Data

Disability organizations across the state have worked to develop natural supports, particularly through development of peer to peer infrastructure and engagement with broader community activities. DHHS often supports peer services through grant funding to partner agencies. OCFS contracts with two grantees with Mental Health Block Grant funds: 1) GEAR Parent Network, which is the Maine chapter of the Federation of Families for Children’s Mental Health; and 2) Thrive, Maine’s trauma-informed system of care initiative. Figure 10 shows an increasing number of people using GEAR services (+88% in workshop attendance and +57% in support group attendance between SFY2013 and SFY2016), and Figure 11 shows Thrive reaching a significant percentage of youth served through the Mental Health Block Grant with its services.

SAMHS was not confident in their accuracy of data from their peer service grantees, however, in an ongoing effort to build natural supports, SAMHS has funded Adult Peer Support in Maine as part of social club and drop-in center programs for over twenty years. SAMHS and OCFS recently started providing peer services to youth and adults through contractors with the goal of improving functioning and well-being, enhancing relationship and social connections, and increasing engagement and participation in meaningful community activities.

To encourage use of natural supports, DHHS began a peer-led self-help facilitated group called Maine Can Work in 2014, where peers are changing the conversation around employment. This curriculum is being implemented in psycho-social clubhouses. Additionally, peer centers providing day services for individuals with intellectual and developmental disabilities are less isolated and are increasingly working to engage members in community activities to further develop natural supports. DHHS has also contracted with Youth Move, a youth-led organization that ensures that young people are involved in their own planning and decision making, to provide peer support under the Transition to Independence Process (TIP) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Person-centered plans for members using OADS services contain a service called building unpaid relationships, which means a member is receiving peer support to help them connect to the broader community. This service is included under the heading of community supports, and there is no way to analyze data on how many members use the unpaid relationships service within community supports unless it is manually pulled from each plan.

Outcome 2.2: More people live in home and community based settings

Ensuring members are living in the least restrictive setting appropriate to their needs is a fundamental aspect of Olmstead.
Performance Measure 2.2.1: Percentage of members living in home and community based settings
This measure analyzes the number of members receiving long term services and supports living in home and community based settings compared to the number living in institutional settings.

What We Have Achieved/Dashboard
Number of Aging Housing Units Has Remained Relatively Unchanged
Figure 12: OADS Aging Housing Units, SFYs 2014 – 2016

Slight Decrease in the Number of Disability Private Non-Medical Institutions
Figure 13: OADS Disability Housing Units, SFYs 2014 – 2016
Majority of SAMHS Members Live in Home and Community Based Settings

Figure 14: Housing Status of SAMHS Members (7/16-9/16)

Key:
- NH/NIF: Living in a nursing home
- Riverview: Currently hospitalized at Riverview Psychiatric Center
- Dorothea Dix: Currently hospitalized at Dorothea Dix Psychiatric Center
- Psych Inpatient: Currently hospitalized at other psychiatric inpatient unit
- Hospital: currently hospitalized for medical reasons
- Incarcerated: Incarcerated in a state prison or county jail
- Homeless: Living in homeless shelter or on the street
- Home/Apt: Living in own apartment or home
- Staying with Others: Temporarily staying with others
- Supp Apt: Living in a supported apartment
- Comm Res Fac: Living in a community residential facility
- Res Tx (Group Home): Living in a residential treatment facility (group home living)
- ALF: Living in an assisted living facility
- Res Crisis: Currently in a residential crisis unit
- Rent Subsidy: Has rent subsidy
- Other: Housing Other

Printed: 9/1/2017 2:28 PM - Maine - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
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Story Behind the Data

Overall, Maine continues to increase its focus and spending on home and community based services and supports compared to institutional LTSS.11

Figures 12 and 13 above show the number of members living in OADS units for people who are aging or have disabilities. Institutional settings (nursing homes and ICF-IDDs) have remained constant, meaning the number of members living in these settings has not grown over the past three years. However, the number of units and members have dropped significantly since 2010, when there were more than 8,300 people MaineCare members living in nursing homes. The number of members in private nonmedical institutions (PNMIs) has also remained constant over the last three state fiscal years.

An increasing number of members are living in waiver homes associated with:

- 1915(c) waiver home and community benefits for members with intellectual disabilities or autistic disorder (§21).
- 1915(c) waiver support services for adults with intellectual disabilities or autistic disorder (§29).
- 1915(c) waiver home and community based services for adults with brain injury (§18).
- 1915(c) waiver home and community based services for adults with other related conditions (§20).

There have also been slight increases in the number of members living in affordable assisted living and adult family care homes.

The state is working to increase housing options for individuals with intellectual disabilities and autistic disorder. The state is looking to technology to meet the safety needs previously requiring staff, in addition to emphasizing the dignity of risk for individuals. This may allow more individuals to remain home and not need to live in group homes.

Figure 14 shows that 94% of members with mental illness or substance use disorder live in the community. This continued success of supporting the clear majority of members with mental illness and/or substance use disorder is a result of the state’s dedication to its housing first philosophy.

Seven percent of the 94% of members in home and community based settings are people experiencing homelessness. The state continues to increase funding for its Shelter Plus Care housing vouchers from the US Department of Housing and Urban

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Development (HUD); Maine has more vouchers per capita than any other state in the nation. SAMHS is also continuing to grow the Bridge to Recovery Program (BRAP) overall, and expanding BRAP to more rural locations in the state to increase early identification of participants to build relationships with local service providers and prevent migration to city centers. Half of BRAP funds are dedicated to homeless individuals, and the other half are used for individuals transitioning from institutional settings.

**Outcome 2.3: More people are employed**

The Department is committed to having integrated, community-based employment as the first and preferred service option for all members.

**Performance Measure 2.3.1: Increased percentage of members competitively employed**

This measure looks at the percentage of members who are competitively employed. This is calculated using a numerator of the number of members who are employed and a denominator of the total number of members receiving long term services and supports. SAMHS employed numbers include members who report status of self-employed, competitively employed full and part time, or supported employment full and part time.

**What We Have Achieved/Dashboard**

More OADS Members Served in Integrated Employment

*Figure 15: OADS Employment Outcomes for People with IDD, SFYs 2012 – 2015*[^12]

11% SAMHS Members Employed in 2016

*Figure 16: SAMHS Employment Outcomes for People with Mental Illness, 2016*\(^{13}\)

![Employment Bar Chart]

**Story Behind the Data**

Multiple ongoing efforts, including staff training and community outreach, support the transition to competitive employment for individuals with disabilities. Maine passed the Employment First law in 2013, and has had six workgroups advancing implementation since then that are focused on DHHS, Department of Labor, and Department of Education. The Workforce Innovation and Opportunity Act (WIOA) has continued the state’s focus on interagency efforts to increase competitive employment for individuals with disabilities. The Youth in Transition Steering Committee includes improving employment as a key activity in the short term.

A steadily increasing percentage of OADS members with intellectual and developmental disabilities are being served in integrated employment (21% in 2010 compared to 31% in 2015).

Approximately 11% of SAMHS members reporting status are working either part of full time in supported employment, competitive employment, or are self-employed. Maine has one of the lowest competitive employment rates of individuals with mental illness in the nation. SAMHS is working hard to change this by adopting the national standard of 19% employment, with interim benchmarks to assess progress toward this goal. SAMHS is working collaboratively with the Department of Labor, Bureau of Rehabilitation Services, Division of Vocational Rehabilitation to support individuals in connecting to educational and training opportunities. The state agencies are collectively updating

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\(^{13}\) Employment data collected from ACT, CI, CRS, and BHH case management services. Based on Clients with Status Reported. Employed means reported employment status of self-employed, competitively employed full and part time, or supported employment full and part time. Data from 7/1/16 and 9/30/16.
procedural directives for clubhouses. SAMHS is also using the Employment Services Workforce Development System to provide facilitator training for peers for the Maine Can Work curriculum as well as to provide training about access to and use of assistive technology in employment.

Additionally, SAMHS and OADS continue to work closely with the Maine Leadership Business Network, which is aimed at employing individuals with disabilities (including intellectual, autistic, and physical). Because some of the highest costs to employers are related to mental illness, SAMHS is working with this network to relay the value of investing in employees with mental illness, particularly in a graying state. Continued community outreach, development of employer incentives, and creation of employer-provider partnerships can increase access to and participation in competitive employment across all disability groups.

**Outcome 2.4: More people are able to get where they want to go when they want to go**

The Department is committed to supporting members in accessing transportation so they can participate in community activities. Maine is a rural state with a small population, making transportation an inherent challenge.

**Performance Measure 2.4.1: Percentage of members using transportation services**

This measure demonstrates the percentage of members using Medicaid transportation services, using a numerator of the unique count of members transported and a denominator of the total number of members eligible for transportation services at the end of the fiscal year.
What We Have Achieved/Dashboard
Slight Increase in Use of Transportation Services

Figure 17: Non-Emergency Transportation Utilization Rate, SFYs 2014 – 2016

Story Behind the Data
The number of members using non-emergency transportation services has remained very stable over the last three state fiscal years, reducing slightly from 32,602 in SFY2014 to 32,150. However, the eligible caseload for these services has reduced by 7.5% in the same timeframe, meaning a slightly higher percentage of members are using transportation services in SFY2016 compared to SFY2014.

Goal 2 Internal Systems Strategies
In addition to the work related to peer supports, housing, employment, and transportation, DHHS is implementing other strategies internally to support meaningful community integration for members.

- **Support seamless transitions.** The Department looks at transitions broadly, including transitions from youth services to adulthood, and transitions between services and programs for adults. Youth transitions are a primary focus of the Youth in Transition Steering Committee. The Department is ensuring that processes are in place to connect youth to services and supports they need to support their goals as they transition to adulthood. SAMHS is developing discharge planning protocols to support hospitalized individuals in transitioning home or to community placements when discharged.

- **Effectively manage complex cases.** The Department works collaboratively to manage complex cases, supporting members to remain integrated in the community.

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14 Office of MaineCare Services
Goal 3: Promote continuous quality improvement so individuals receive high quality long term services and supports

What This Means
The state is committed to ensuring that members receive high quality services to best support individual’s goals as defined in person-centered plans. DHHS engages in continuous quality improvement processes to meet this goal. The Department creates an environment where management, workers, and contractors are constantly improving quality. A culture exists of using data and research to continually analyze what is working and determine how to make improvements.

Outcome 3.1: Providers use evidence-based/informed practices
The Department is promoting the use of evidence-based and informed practices through provider contracts and oversight.

Performance Measure 3.1.1: Increased percentage of programs providing evidence-based/informed practices
This measure looks at the number of provider programs using evidence based or informed practices.

What We Have Achieved/Dashboard
Growing Percentage of LTSS Are Evidence-Based/Informed

Table 3: Evidence-Based Practices Used by DHHS Providers, SFY2017

| OADS       | • Individual Placement and Support (IPS) for employment services  
|            | • Matter of Balance  
|            | • Chronic Disease Self-Management  
|            | • Evidence-Based Practice Meal Program  
| SAMHS      | • Outpatient Evidence-Based Practices  
|            | • Adult Community Integration (ACT)  
|            | • Supported Housing  
|            | • Supported Employment  
|            | • 15 (78%) Mental Health and 10 (83%) Substance Abuse Services Use Evidence-Based Practices  
| OCFS       | • Multi-systemic Therapy for Problem Sexual Behavior (4 out of 35 HCT agencies)  
|            | • Functional Family Therapy (2 out of 35 HCT agencies)  
|            | • Treatment Foster Care Oregon (1 residential agency)  
|            | • Maine Enhanced Parenting Project (2 agencies)  
|            | • Cognitive Behavioral Therapy for Anxiety, Depression, Behavioral |
Story Behind the Data

DHHS is making progress in increasing the degree of evidence-based and best practice-based programming and participation.

All SAMHS outpatient programs are evidence-based. SAMHS requires evidence-based or best practices in all substance abuse contracts. MaineCare/SAMHS adopted national evidence based best practice of a seven-day requirement for face-to-face contact from time of referral to clinical visit. SAMHS is also promoting and enhancing the use of evidence-based interventions such as SBIRT (Screening. Brief Intervention. Referral to Treatment) with opioid prescribers.

OCFS has an evidence-based practice advisory council to guide the office’s work on integrating evidence-based/informed practices throughout service and support delivery. OCFS is developing an approach to track outpatient trauma-focused evidence-based practices, which occur broadly. Some innovative evidence-based practices are being tried with OCFS agencies, including Treatment Foster Care – Oregon, which is focused on hard to serve, older youth in foster care, and Maine Enhanced Parenting Project, which works with children and parents who are connected to Child Welfare and includes substance use treatment and parent programming.

Some provider agencies are requesting additional funding to sustain evidence-based practices.

Goal 3 Internal Systems Strategies

In addition to the work related to evidence-based/informed practices, DHHS is implementing other strategies internally to support high quality services and supports for members.

- **Increase use of data in decision making.** The Department is leveraging information technology resources to better determine the costs of care, volume and costs of service delivery, eliminate duplication of services, and determining hot-spots or outliers.
- **Increase capacity of service delivery in remote areas.** The Department is committed to increasing access to services in remote areas, so in turn members living in these regions can receive quality services. An island rate study was conducted as a part of these efforts.
- **Promote provider quality.** The Department’s efforts to increase quality include developing and prioritizing performance measures in contracted services, supporting a sustainable training infrastructure for families and caregivers, implementing quality improvement measures with direct caregivers, ongoing
efforts to implement rate study recommendations, and increasing enforcement and consequences.
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.66 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 24.67 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.68

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 21.69 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.70

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).

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

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED? [Y] Yes [N] No
   b) The recovery and resilience of children and youth with SUD? [Y] Yes [N] 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? [Y] Yes [N] No
   b) Juvenile justice? [Y] Yes [N] No
   c) Education? [Y] Yes [N] No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization? [Y] Yes [N] No
   b) Costs? [Y] Yes [N] No
   c) Outcomes for children and youth services? [Y] Yes [N] 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? [Y] Yes [N] No
   b) Mental health treatment and recovery services for children/adolescents and their families? [Y] Yes [N] No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult behavioral health system? [Y] Yes [N] No
   b) for youth in foster care? [Y] Yes [N] 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 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.

OCFS is also connected with other state agencies and entities that are not directly involved with services for children and their families, but are important potential, future service providers for some youth as they begin to transition to adulthood. These agencies include SAMHS, which may be a provider for young adults with Serious Mental Illness (SMI), and the Office of Aging and Disability Services (OADS) that could be a provider for high needs youth whose emotional, physical and behavioral needs require intensive and long term attention and support that would be available under the Home and Community-based Waiver offered...
OCFS has a close and productive working relationship with the DHHS Office of MaineCare Services (OMS), the Maine Center for Disease Control and Prevention (MCDC), and the Office of Continuous Quality Improvement (OCQI). These units of the Department provide essential subject matter expertise to OCFS, and they have been long standing partners in key areas within the behavioral health services program.

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

The Maine Office of Child & Family Services (OCFS) has created the Maine Enhanced Parenting Project (MEPP), a demonstration project that pairs the Matrix Intensive Outpatient Program and Positive Parenting Program (Triple P). Matrix is a four component treatment that blends 6 therapeutic approaches into 16 weeks of intensive treatment. Matrix has over 20 years of research demonstrating positive outcomes. Triple P - the Positive Parenting Program is an intensive parent education intervention proven to work in families experiencing moderate to severe behavioral or emotional difficulties. Triple P is supported by over 35 years of evaluation research that demonstrates significant child welfare and child/parent well-being outcomes.

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

20. Suicide Prevention - Required MHBG

Narrative Question

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

Please respond to the following items:

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

2. Describe activities intended to reduce incidents of suicide in your state.
   • In FY16, the Maine Suicide Prevention Program (MSPP) trained over 1800 individuals on evidence-based suicide prevention practices, including basic suicide awareness, Gatekeeper training (focused on identifying and referring individuals at risk of suicide), suicide risk screening, assessment, and intervention.
   • The MSPP provides training and technical assistance to health systems, schools, and community organizations to develop suicide prevention and response policies and protocols.
   • The MSPP responds to schools, organizations, and communities after a death by suicide, to provide postvention services and support.
   • The MSPP provides professional development opportunities to professionals across the state, including the annual Beyond the Basics Suicide Prevention Conference.

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?  
   - Yes  
   - No

If so, please describe the population targeted.

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

The MSPP continues to provide extensive training and professional development to schools, health systems, and behavioral healthcare providers. The MSPP continues to provide support for the implementation of Maine State Law LD609, which requires that all school staff receive suicide awareness and Gatekeeper training.

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

Footnotes:

Footnotes to:
Question 3 : Yes, The MSPP has worked with health and behavioral health systems to improve suicide risk screening, assessment, and intervention for youth and adults.

Question 4 Yes. The MSPP has worked with health and behavioral health systems to improve suicide risk screening, assessment, and intervention for youth and adults.

Question 5: No. • For the FFY 2016-FFY 2017 plan, most of what is described in Question 2 are ongoing efforts, and no specific initiatives have begun since the last report.
Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions or consultation on the benefits available to any Medicaid populations; work with the state, local, and tribal justice systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

Please respond to the following items:

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

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

   If yes, with whom?

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

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

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

   In rulemaking, to enable consumers to function outside of inpatient or residential institutions, MaineCare Rule established an initial face to face intake/assessment visit within seven calendar days of referral, regardless of referral source. It will provide timely...
access to services to our most vulnerable adults. SAMHS has shifted the monitoring of the Community Integration waitlist to internal staff. This has resulted in a functional zero waitlist for Community Integration Services as of July 2017. The OCFS has organized its’ Referral Management processes for HCT and RCS28 in such a way as to ensure that clients presenting with the highest acuity level (e.g. discharging from hospital or residential treatment) are provided with priority status to the next available community provider. This helps reduce the risk or re-entry into the highest level of service and assists with community re-integration.

Targeted Case Management and Behavioral Health Home agencies play a significant role in the coordination of care for Maine’s children entering our behavioral health system of care. They are responsible for helping to assess needs and refer children to the most appropriate treatment. Maine’s treatment continuum includes outpatient treatment in an office, as well as in-home treatment to be provided directly in the member’s home. MaineCare rule making establishes guidelines around member eligibility for residential and inpatient level of care. In order to access the higher levels of care, outpatient and or in-home treatment must be tried first, or be deemed an emergency. Access to day treatment programming at school or in special purpose private school is available for children living at home. This allows flexibility in being able to deliver the most appropriate service, and they do not have to be in tandem.

OCFS / Children’s Behavioral Health Services partners on an ongoing basis with providers to encourage expansion into low service coverage areas of our State. CBHS Resource Coordinators, through their relationships with providers, have been successful in having services expanded too hard to reach clients in rural parts of the State.

CBHS has also constructed it’s Referral Management lists in such a way as to support provider expansion planning. The lists are updated weekly and made available to providers to view where the need for service is highest in the State.

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

1. SAMHS has partnered with State and county Correctional facilities and diversion courts to provide housing vouchers for individuals who meet criteria for mental health community services prior to them leaving the facility. This work will allow these individuals to go directly to their own living space and not return to homelessness while providing the chance for them to access support services for stable living.

2. SAMHS has partnered with State Housing Authority and community housing agencies, to identify individuals who have been homeless the longest and assess their needs in order to connect them with the appropriate housing resource and support services.

3. SAMHS has partnered with the HUD COC program to develop a coordinated entry system serving any person who may be homeless throughout the State of Maine and direct them to the most appropriate resource available for housing.

4. SAMHS receives the federal SYT-I grant.

5. SAMHS has collaborative initiatives with the Department of Labor to improve and expand employment services for joint consumers and implement the Consent Decree Plan.

6. SAMHS is part of the Overdose Prevention Response Team – a collaboration with CDC and Public Safety (DEA and EMS) for prevention, treatment and law enforcement targeting opioids and overdose deaths.

7. The Department of Health and Human Services in collaboration with 2-1-1 Maine and the United Ways of Maine unveiled a new texting service in an effort to facilitate communications for those seeking access to opioid treatment services. When you text your zip code to 898-211, a Maine-based Information Specialist will be notified that a new transaction has been received. The person requesting assistance will receive an automated “Thank you for contacting 2-1-1” response and can immediately begin their dialogue with the trained and friendly Specialist. Initially, the text line will be available from 8am-5pm, Monday-Friday. If an individual is in need of assistance outside of those hours, they will receive a text response encouraging them to dial 2-1-1 and speak with an Information Specialist. DHHS launched the 24/7 Opiate Help line in April of 2016 through a contract with 211 Maine with a focus on pregnant women and young mothers seeking treatment.

Training and certification infrastructure: Maine has an employment Workforce Development System that jointly funded by DHHS (SAMHS, OADS OCFS) and DOL/BRS. This provides infrastructure for coordinating employment specialist trainings, webinars and advance topical trainings as well as maintaining a database of certified employment specialists.

Maine Business Leadership Network: SAMHS and OADS contract with the Maine State Chamber of Commerce to maintain a state Business Leadership Network (BLN) affiliate. The Maine BLN is focused on assisting businesses in attracting and retaining new employees and customers with disabilities, developing business leaders who value diversity and actively work to promote strong communities that include individuals with disabilities, and increasing opportunities for businesses to expand their diversity recruiting efforts, not as a social model but as a business case to recruit talent and better serve their customers.

Certification of Employment Services Staff: SAMHS and OADS collaborate with DOL/BRS to utilize the same certification process for employment services. Employment providers must be Certified Rehabilitation Providers with DOL/BRS and both DHHS and DOL require the same ACRE certification for employment specialists. This allows providers to serve individuals through both systems, providing greater continuity as well as an increased workforce.

Community Work Incentive Coordinators (CWICs) are available statewide to provide all Social Security beneficiaries with disabilities access to benefits planning and assistance services free-of-charge. These staff can answer questions about how work will impact benefits, and how to utilize the SSA work incentives. They can also assist in the development of return-to-work plans and connect clients with needed employment services. The contract for CWIC services is held by the Department of Labor/ Bureau of
Rehabilitation Services. SAMHS provides additional funding to increase the capacity beyond the funding available from the Social Security Administration and collaborates with DOL and OADS to support the availability of the service.

The OCFS/CBHS highly values and utilizes ongoing collaboration with providers and other State entities for system improvement, planning, and solution seeking. Some of these collaborations are in the form of formal focus groups, work groups, advisory groups, etc....Some of the recent collaborations include:

- Multi-stakeholder workgroup for the creation of a new Home and Community Treatment draft MaineCare rule with service providers, MaineCare, MH Licensing, DOC, Child Welfare
- Multi-stakeholder workgroup for the drafting of a new CBHS Planning Process with providers and the Office of Adult Aging & Disability (OADS)
- Multi-stakeholder advisory group for the creation of a new Child Adolescent Needs Strengths assessment (CANS) with multiple service providers and MaineCare.
- Multi-stakeholder advisory group consisting of EBP service providers to discuss the use of Evidence based Practices throughout the system and address barriers of access and implementation.
- Ongoing work by CBHS Resource Coordinators with Providers to expand services into hard to reach rural areas.
- Focus group with Dept. of Education and community educators to update and create a single Behavioral Health professional training that will allow providers to utilize BHP staff in multiple services and setting.
- Ongoing multi-stakeholder workgroup, in collaboration with the Office of MaineCare, to discuss and improve the Behavioral Health home services in Maine.
- Ongoing collaboration with the States Administrative Services Organization (ASO) to address issues of access to services by MaineCare clients.
- OCFS has partnered with MaineHousing, the State Housing Authority, to participate in a pilot program to ensure that homeless youth who have been in the foster care system receive appropriate housing and support. Another pilot program underway seeks to ensure that homeless young adults/families in need of education or job training receive appropriate housing and support to further their training and education goals. Both of these pilots have been successful and will continue into the next fiscal year.

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

Footnotes:
Environmental Factors and Plan

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

Narrative Question
Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.72

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

72 http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
      The Maine Office of Substance Abuse and Mental Health Services develops a strategic plan to map out the programs and services to accomplish its mission to promote appropriate access to efficient and effective substance abuse and mental health services in order to achieve improved outcomes for those with substance abuse disorders and mental illness. SAMHSA uses treatment data collected from treatment providers via contract performance measures, hotspotting and geomapping techniques, as well as input from consumers via the Disability Rights Maine SNAPSHOT: Maine’s Mental Health System and the Lewin Group’s Adult Mental Health and Wellness Survey to formulate the Office’s strategic plan.
      Incorporated into the strategic plan is the requirement of using evidence-based data gathered by the state’s subject matter experts as well as guidance from SAMHSA. Integrating primary care and substance abuse treatment, as well as the evidence-based practice of Medication Assisted Treatment led to the formation of the Opioid Health Home model being implemented throughout Maine.

      Federal and State dollars available for prevention are funneled through the Maine Centers for Disease Control. Interagency collaboration between SAMHS, the CDC, and the Department of Public Safety forms the membership of the Opioid Response Team to gather syndromic data to determine unmet needs for substance abuse treatment.

      Maine is currently undertaking a request for proposals for an organization to oversee the formation of Substance Abuse Peer Recovery Centers, as well as a separate RFP for Substance Abuse Peer Recovery Centers in the rural regions of the state where resources are inadequate.

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

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, etc.)?
   jn Yes jn No
3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

We monitor and advise on the block grant allocations and other mental health and substance use issues. Everyone brings to the council any issues and successes of persons with lived experiences. We have written letters on issues that have been important to advocate for. The council has also gained relationships with the legislatures. The council and state representation also did federal site reviews on all the services paid for by block grant funding. The council also added three questions to the site tool.

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

Most of the money allocated by the block grant goes to peer supports which is something the council feels very strongly about. The federal site visits were also an accomplishment especially since a member of the council was there at all of them.

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

We have been part of several TA activities

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.73

Footnotes:
The council still is working towards increasing membership especially in ethnic and cultural areas.

73There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.
August 16, 2017

Dear State Planner,

The Statewide Quality Improvement Council (QIC) has met monthly primarily around issues regarding the Community Mental Health and Substance Use Block Grant Application and its operations. We have discussed and provided input into the State Application. The council members were provided with visual copies of the Application on WEBB GAS to review. Some of the issues that were addressed:

1. The council is now a Behavioral Health Council.
2. The council along with state planners did federal site review of all agencies receiving block grant funding.
3. The council participated in technical assistance with SAMSHA.
4. The state planners and council chair attended the SAMSHA block grant conference.
5. The council introduced themselves to the Health and Human Services committee in the legislation.
6. The council did a meet and greet with the State legislators.
7. The council has increased membership greatly.
8. The council has great collaborations with its state planners.
9. The council hired a facilitator to come up with a clear strategic plan.
10. The council did wide community outreach, such as having an exhibit table at community events to increase our visibility.

The council feels that they were really engaged in the Application process to the best of everyone’s ability and look forward to continuing our work with the State Planners in meeting the expectations of the Mental Health and Substance Use Block Grants.

Thank you

Diane Bouffard, Chair
Statewide Quality Improvement Council
10 Caldwell Rd
PO Box 558
Augusta Me 04332
(207) 612-8996
maine qic chair@gmail.com
## Behavioral Health Advisory Council Members

**Start Year:** 2017  
**End Year:** 2019

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diane Bouffard</td>
<td>Parents of children with SED</td>
<td>GEAR Parent Network</td>
<td>10 Caldwell Rd Augusta ME, 04330 PH: 207-612-8996</td>
<td><a href="mailto:maineqicchair@gmail.com">maineqicchair@gmail.com</a></td>
</tr>
<tr>
<td>Samuel Chamberlain</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Youth Move Thrive</td>
<td></td>
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</tr>
<tr>
<td>Genevieve Doughty</td>
<td>Federally Recognized Tribe Representatives</td>
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<tr>
<td>Karen Evans</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Consumer Council System of Maine</td>
<td>145 Spring St Apt N Portland ME, 04101 PH: 207-772-7140</td>
<td><a href="mailto:kazgirl927@gmail.com">kazgirl927@gmail.com</a></td>
</tr>
<tr>
<td>Karen Frasier</td>
<td>State Employees</td>
<td>Dept of Labor Vocational Rehabilitation</td>
<td>150 State House Station Augusta ME, 04330 PH: 207-624-7961</td>
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<tr>
<td>Dan Hemdal</td>
<td>State Employees</td>
<td>State of Maine - Department of Education</td>
<td></td>
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<tr>
<td>Virigina Jewel</td>
<td>Parents of children with SED</td>
<td></td>
<td>279 Browns Corner Rd Canaan ME, 04924</td>
<td></td>
</tr>
<tr>
<td>Michele King</td>
<td>State Employees</td>
<td>DHHS Office of Substance Abuse and Mental Health Services</td>
<td></td>
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<tr>
<td>Richard Ladd Sr.</td>
<td>Parents of children with SED</td>
<td></td>
<td>118 Ladd Rd Barnard Twp ME, 04414</td>
<td></td>
</tr>
<tr>
<td>Vickie Mc Carty</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Consumer Council System of Maine</td>
<td>82 Willow St Apt 3 Augusta ME, 04330</td>
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</tr>
<tr>
<td>Bruce Mcclenahan</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
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</tr>
<tr>
<td>Cynthia McPherson</td>
<td>State Employees</td>
<td>Office of Substance Abuse and Mental Health Services</td>
<td>32 Blossom Lane Augusta ME, 04333-0011 PH: 207-592-2279 FX: 207-287-2156</td>
<td><a href="mailto:cynthia.mcpherson@maine.gov">cynthia.mcpherson@maine.gov</a></td>
</tr>
<tr>
<td>Anne Osolinski</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
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<tr>
<td>Susan Parks</td>
<td>Family Members of Individuals in Recovery (to include family members)</td>
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<td>Amy Pease</td>
<td>Individuals in Recovery</td>
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<td>Tara Pelotte</td>
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<td>Malory Shaughnessy</td>
<td>Family Members of Individuals in Recovery</td>
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<tr>
<td>Ryan Thornell</td>
<td>State Employees</td>
<td>Dept of Corrections</td>
<td>25 Tyson Drive Augusta ME, 04333 PH: 207-287-2711</td>
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<tr>
<td>Jeff Tiner</td>
<td>Providers</td>
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<tr>
<td>Karl Vigue</td>
<td>Individuals in Recovery</td>
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<td>Jessica Wood</td>
<td>State Employees</td>
<td>Office of Child and Family Services</td>
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**Footnotes:**
There should be more drop down selections in the member type. We do have representation from LGBTQ population.
### Environmental Factors and Plan

#### Behavioral Health Council Composition by Member Type

Start Year: 2017  
End Year: 2019

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<td>Vacancies (Individuals and Family Members)</td>
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<td>Others (Not State employees or providers)</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
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</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?  
   b) Posting of the plan on the web for public comment?  
   c) Other (e.g. public service announcements, print media)

   If yes, provide URL:

Footnotes: