**Maine Department of Health & Human Services**

# Children's Behavioral Health Services

# Performance Partnerships Block Grant

# Application and Plan

## Fiscal Year 2005

**Application and Plan as Reviewed and Approved by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services**

**January, 2005**

**CHILDREN'S SERVICES STATE GENERAL FUND EXPENDITURES**
**SFY 2002-2004 BY PROGRAM AREAS**

| PROGRAM AREAS | FY02 | FY03 | FY04 |
|---|---|---|---|
| CASE MANAGEMENT | 6,733,159 | 7,936,385 | 7,467,230 |
| COMMUNITY SUPPORT | 3,085,312 | 4,579,801 | 5,656,941 |
| HOME BASED FAMILY SVCS | 1,046,343 | 1,926,089 | 1,927,446 |
| IN-HOME SUPPORT Sec. 24 | 3,151,400 | 4,651,771 | 3,238,845 |
| IN-HOME SUPPORTS Sec. 65* | (See note) | (See note) | 4,834,917 |
| RESPITE SERVICES | 1,254,011 | 2,382,641 | 2,143,710 |
| FAMILY SUPPORT** | 919,645 | 734,916 | 542,971 |
| WRAPAROUND/FLEXIBLE | 966,115 | 1,678,448 | 1,396,048 |
| CRISIS SERVICES | 3,193,064 | 3,282,759 | 3,482,977 |
| OUTPATIENT/MEDICATION | 6,995,609 | 6,485,901 | 7,190,055 |
| RESIDENTIAL | 7,276,839 | 4,609,264 | 5,818,564 |
| RESEARCH & TRAINING | 341,950 | 484,825 | 184,762 |
| OTHER | 207,408 | 260,932 | 191,320 |
| PERSONAL SERVICES | 3,742,924 | 3,810,083 | 3,901,432 |

* Funded by BCFS/DHS in FY02-03
**Includes Family Support, Mediation, Social/Recreation, Information & Referral in FY02-03;
Includes Mediation and Social/Recreation in FY04 (other family support funded through Block Grant)

| | | | |
|---|---|---|---|
| **TOTAL** | **38,886,788** | **42,823,994** | **47,977,218** |

**Children's Mental Health Services**

Children's Mental Health Program of the Department of Health & Human Services expends CMHS Block Grant funds through contracts to community nonprofit service provider agencies. In FY2004, Children's Services allocated CMHS Block Grant Funds to fourteen community mental health centers and community-based agencies in Maine, for the following services. Financial data is for actual expenditures at the end of the fiscal year, reported as of 7/31/04. Most programs listed below also receive state general funds.

**CHILDREN'S MENTAL HEALTH BLOCK GRANT FY04**
**Expenditures by Region and Service**

| Agency | Service Funded | Amount | Number Served |
|---|---|---|---|
| **REGION I** | | | |
| S. Maine Parent Awareness | Information & Referral | $ 44,000 | N/A |
| Youth Alternatives | Family Mediation | $ 10,938 | 168 |
| Outright | Peer Support | $ 33,000 | 345 |
| **Region I Total** | | **$ 87,938** | **513** |
| | | | |
| **REGION II** | | | |
| Child Health Center | Family Support | $ 10,705 | 20 |
| Crisis and Counseling Center | Family Support | $202,000 | 1,052 |
| Mid-Coast Mental Health Services | Outpatient/ Medication | $ 25,000 | 404 |
| Sweetser | Outpatient | $ 50,200 | 1,103 |
| Tri-County Mental Health Services | Outpatient/ Medication | $ 41,950 | 1,121 |
| Maine Parent Federation | Information & Referral | $ 31,900 | N/A |
| NAMI Maine | Information & Referral | $18,500 | N/A |
| Spiral Arts | Public Education | $ 25,000 | N/A |
| Diana Scully | Public Education | $ 8,453 | N/A |
| **Region II Total** | | **$413,708** | **3,700** |
| | | | |
| **REGION III** | | | |
| Aroostook Mental Health Center | Outpatient | $ 41,416 | 450 |
| Community Health & Couns. Svs. | Crisis Services | $161,926 | 390 |
| Community Health & Couns. Svs. | Outpatient/ Medication | $ 61,348 | 900 |
| Helping Hands | Information & Referral | $ 45,604 | N/A |
| **Region III Total** | | **$310,294** | **1,740** |
| | | | |
| **BLOCK GRANT EXPENDITURES - STATE TOTAL** | | **$811,940** | **5,953** |

## PART C
## CHILDREN'S MENTAL HEALTH SERVICES

## SECTION I. DESCRIPTION OF THE STATE SERVICE SYSTEM

### Introduction to the FY 2005 Block Grant Plan for Children's Services

This year's State Plan for Community Mental Health Services is submitted as a single year plan for the Fiscal Year 2005. The plan incorporates updated planning data and related information, and continues to report on State of Maine developed Performance Indicators as reported in the FY04 application. This year's application also adds 3 CMHS Core Performance Indicators that apply to children's services in Maine, as well as administrative goals that are quantified in the Goals, Targets and Action Plans section of the Children's Services application. This plan also describes Maine's mental health service system for children with mental health, emotional and behavioral needs, and for their families.

In June, 2004, State Planning Council members representing the interests of Maine's children, adult consumers of mental health services, and state agency planning staff attended the Center for Mental Health Services' National Technical Assistance Mental Health Block Grant Conference "Transforming Mental Health Care to Achieve Lasting Recovery", held in Washington, D.C.

### Sources of Data and Information in this Application

Because the FY05 Block Grant Application and Plan represents a significant change from plan requirements in previous years in that statistical data and information are emphasized as important tools to indicate performance, consumer outcomes and benchmarks to represent progress in an action plan, it is useful to state at the beginning of this application the specific data sources that Maine employs for these purposes in the current application.

**Year End Contract Reports** Children's Services 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. Year end reports are not always available in August of the reporting year; in this instance some data may be estimated for the year based on third quarter reports. Contract reports show unduplicated counts of children served for the particular service under contract. However, when different types of services are added together, the total number is a duplicated client count.

**MaineCare (Medicaid) Data** The department has access to the MaineCare Decision Support System (MDSS), which captures Medicaid claims data, by service provided under the program. This system is able to process large numbers of claims and provide valuable planning reports on the utilization of services at any point in time. The MDSS reports unduplicated counts of children within service areas, and this data source is employed as a major planning and monitoring tool.

**Enterprise Information System (EIS)** This is an information system that is being developed by the Office of Information Systems in the former Department of Behavioral & Developmental Services. The system is designed to capture consumer information for persons who are receiving services from Children's Services, adult mental health services and adult mental retardation services. Each unit is developing an information capacity that will serve the specific needs of the unit. EIS at present is the key data source for the enrollment of children who are referred seeking in-home children's behavioral health services and children's habilitation services, as well as targeted case management services.

The EIS generates reports that are legally required by the Risinger Settlement Agreement on a monthly and quarterly frequency. These reports provide information specific to monitoring the agreed upon terms of the settlement. This information covers: 1. children waiting over 180 days for targeted case management services; 2. children waiting over 180 days for children's behavioral health and children's habilitation services; 3. children waiting over 120 days for an individual treatment plan.

**The Maine Financial and Administrative Information Systems (MFASIS)** This is an automated financial management system used by state agencies. Because the children's service system is heavily financed through service provider contracts, the accounting and reporting capabilities of MFASIS are increasingly used by Children's Services management. This system is able to generate a variety of fiscal reports which can be organized according to program and geographic needs. MFASIS is the primary tool which is queried in order to determine the status of and to track all children's services budged programs, current expenditures and obligations. MFASIS is frequently used to report on the sources of funds and the uses to which the funds are targeted. Other historical detail (previous fiscal year data) stored within the financial accounting system can be accessed through the Financial Warehouse.

**Performance Indicator and Outcome Data** The FY05 Application incorporates at least one Performance Indicator per criterion as required by CMHS. The primary data source for performance indicators is material submitted to the Office of Quality Improvement from contract agencies, specifically State Performance Indicators that are reported to regional offices quarterly. Other Performance Indicators draw from fiscal and programmatic data collected by the Department from budget and expenditure spread sheets, as well as service utilization from non-contracted sources, particularly the MDSS. CMHS Core Performance Indicators are included for service access, evidence based practices and client perception of care. Maine does not provide capacity for children or adolescents in a state operated psychiatric hospital.

## EXISTING STATE SERVICE SYSTEM

### 1. Focal Point of Responsibility for Children's Mental Health

The state mental health authority is the Department of Health & Human Services, (formerly known as the Department of Behavioral and Developmental Services (BDS). The focal point for children's mental health is the Children's Services Program within DHHS. The statutory authority for the Children's Mental Health Program is cited in PL1998, Chapter 790.

Children's Services supports and serves children, age birth through 5, who have developmental disabilities or demonstrate developmental delays, and children and adolescents, age 0-20, who have treatment needs related to mental illness, mental retardation, autism, developmental disabilities, or emotional and behavioral needs.

Children's Services statutory mission includes a strong family support focus. It is mandated to "strengthen the capacity of families, natural helping networks, self-help groups and other community resources to support and serve children in need of treatment" (M.R.S.A. Title 34-B. section 2604.1.A.) and to "(provide) in-home, community-based, family-oriented services." (34-B. section 6203.1.B.)

The focal point for responsibility for children's mental health is shared between the central office and three regional field offices. Over the past 4 years the Children's Services central office team underwent change, adding new staff resources and was reconfigured as a Children's Systems team. Under the Children's Services Director, staff were assigned from within the Department to include a Children's Systems Manager, a Children's Quality Improvement Manager, a Children's Information Systems Administrator, a Mental Health Program Specialist and a Grievance Coordinator. In FY01 a full time Child Psychiatrist was hired as the Children's Medical Director. In FY02 Children's Services staff added a Social Services Program Specialist for Resource Development. In November, 2003, a Children's Finance Director was assigned to oversee contracting, rate setting and financial reporting activities. These positions have significantly increased the capacity and ability of the Children's Services Team to manage and coordinate the Children's Mental Health Program, as required under Chapter 790.

Regional staffing also has undergone important changes as the Children's Services field mission changed from the provision of direct services (case management) to that of providing program oversight, contract monitoring, client enrollment and quality improvement functions. Initial stages of this transition began in FY00, and were completed during FY03.

**2. <u>Target Population</u>**

The Children's Services Program has three operational target populations:

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

b. Children and adolescents, age 0-20, who have emotional/behavioral needs including children with serious emotional disturbance;

c. Children, age 0-20, who have mental retardation, autism or pervasive developmental delay

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

## 3. Child Mental Health Services - Children's Services Program Current Operations

* Units: The Children's Services Program operates three (3) regional offices located in Portland, Augusta and Bangor and three (3) sub regional offices located in Presque Isle, Thomaston and Lewiston, Maine.

* Number Served ( FY'04) Source: Year End Contract Reports from Community Providers; MaineCare InHome Supports and Residential: 50,504 total services provided to children; Estimated unduplicated number of children served: 20,201

* Expenditures (FY04) $47,977,218 (State General Funds, not including federal funds or match; MaineCare Match $68,981,908) Budget (FY05) $48,282,459 (All Sources includes State General Funds and Federal Funds; MaineCare Match estimated $55,696,775)

a. Early Childhood, Mental Retardation, and Autism Services. Regional Supervisors oversee staff who perform program management, oversight and quality improvement functions. Direct services are purchased through contracts with local providers. These contractors provide identification and assessment; habilitation services, residential and personal supports under the MR Home and Community Services waiver, case management; crisis services; in-home supports; infant/toddler group services; preschool integrated support; family support; respite, social and recreation services, infant mental health and flexible funds for children with developmental delay, autism and mental retardation.

b. Children's Mental Health Services. Regional Mental Health Program Coordinators and Resource Coordinators oversee regional program development; facilitate interagency case collaboration and wraparound services; conduct information, referral and case advocacy and education and public awareness activities for children who have neurobiological and other serious emotional disabilities and their families. The Children's Services Program contracts with community agencies that provide case management; crisis services; flexible funds; information and referral; family and community integration; in-home supports; family mediation; outpatient counseling and therapies; home based family services; respite services, medication management; day treatment; social and recreational programs, and residential treatment services.

**c.** Facilities. Elizabeth Levinson Center, Bangor is the only state operated ICF/MR Nursing Facility that provides both residential (16 beds) and respite care (4 beds) for up to 20 children, birth through 20, who are medically fragile and who have severe or profound mental retardation.

## 4. State/Local Administrative Structure

As is the case in other New England states, Maine's sixteen county governments are not an administrative vehicle for state funded social services. Services are primarily funded by State contracts to local non-profit service providers. Services are administered through a mix of statewide, regional, and sub-regional entities. The Children's Services Program field operations are organized within three service regions that contain a total of seven Local Service Areas.

**CHILDREN'S SERVICES OPERATIONS STRUCTURE**
**Local Service Areas (LSA)**

| | |
|---|---|
| **Region III** | |
| Aroostook LSA | (Aroostook County) |
| Northeastern LSA | (Penobscot, Piscataquis, Hancock, and Washington Counties) |
| **Region II** | |
| Kennebec-Somerset LSA | (Kennebec-Somerset Counties) |
| Coastal LSA | (Sagadohoc + Brunswick, Lincoln, Knox and Waldo Counties) |
| Western LSA | (Androscoggin, Oxford and Franklin Counties) |
| **Region I** | |
| Cumberland LSA | (Cumberland County) |
| York LSA | (York County) |

**Significant Achievements in FY04**

In the previous year Application (FY04) Children's Services established specific priority areas meriting attention in the upcoming year (FY05). Among those noted at the beginning of the year were the following:

1. **Merger of BDS and DHS.** In the spring of 2003, the 121st Maine Legislature enacted PL 2003, Chapter 20, Part K, directing that the Department of Human Services and the Department of Behavioral and Developmental Services merge into a single department and that the departments commence merger activities immediately. Under Executive Order 13FY03, Governor Baldacci appointed a 14 member Commissioner's Implementation Advisory Team (CIAT) to advise the Commissioner on issues regarding creation of the new Department. BDS and Children's Services staff will assist the CIAT's Integrated Services - Children and Families Subcommittee during the course of its work. The CIAT will advise the Commissioner as he develops recommendations to the Legislature on the specifics of the bureau structure, administrative structure and function, and various program and service delivery functions. The Commissioner will report his recommendations and plan to the first regular session of the 122st Legislature in January 2005.

- **Results** The merger of the two departments was accomplished by the Maine legislature in which passed PL 689 in May, 2004. A new Commissioner was nominated by the Governor and confirmed by the Legislature. Under the current restructuring plan Children's Behavioral Health Services is organizationally located within the DHHS Bureau of Child and Family Services. The merger achieves a significant first step in the integration of state services for children and families in that Children's Behavioral Health Services is administratively co-located with the former DHS Child Welfare Services that includes child protective and substitute care services.

2. **Sundram Report Recommendations.** Pursuant to an agreement between BDS and plaintiffs under the Risinger Settlement Agreement, Clarance Sundram was retained as an independent expert consultant to advise the department on how to achieve full compliance with the Settlement Agreement and to make recommendations regarding timely access to case management and in home support services covered by the Settlement Agreement. Mr. Sundram's July, 2003 Final Report identified barriers or impediments to compliance and offered recommendations for removing those barriers. Recommendations focus on Expanding Service Capacity, Utilization of Existing Resources and Administrative Recommendations. BDS will respond to the consultant's recommendations and move forward to selectively implement changes that will improve its ability to provide services in the timeliest fashion.

- **Results**: Over the past year the majority of the recommendations of the Sundram Report have been fully implemented and two alternative strategies to specific recommendations were undertaken. Of particular significance are the results shown in the decrease in the number of children who are waiting for in-home behavioral health and habilitation services, case management services and the development of an individual treatment plan. Data reported through the Enterprise Information System indicate that over the past fiscal year the average number of children waiting more than 180 days for in-home services decreased from 240 in FY03 to 54 in FY04; the average number of children waiting more than 120 days for an individual treatment plan decreased from 267 in FY03 to 128 in FY04 and the average number of children waiting more than 180 days for case management services decreased from 8 in FY03 to 4 in FY04.

3. **MaineCare Re-Write** In a multi departmental collaborative effort led by BDS and the Bureau of Medical Services are engaged in reviewing all existing MaineCare policies that provide funding for BDS Children's Services. The participants also include representation from the Departments of Education, Corrections and Human Services along with service providers, parents and plaintiff's attorney under the Risinger Settlement. The rewrite will focus on incorporating common eligibility, treatment plans, licensing and training requirements where possible. The goal is to better meet the needs of children by maximizing utilization, reducing barriers to access, and improving the comprehensiveness of services especially as individual policies relate to one another. A second objective is to relocate all MaineCare children's policies in a single coherent section of State Plan that is easily identifiable and accessible to users**.**

- **Results** This goal continues although with a less comprehensive focus due in large part to a strategic change in the overall priorities of the Bureau of Medical Services (MaineCare) based on serious financial realities imposed by increasing Medicaid costs in the State of Maine. Instead, the administration supported a more focused effort to redesign key MaineCare Children's Mental Health policies under Section 65(g) and (h) of the MaineCare Benefits Manual. These two policies represented approximately $30 million in expenditures in FY04. The redesigned benefit will address Child and Family Behavioral Treatment Services and Community-Based Treatment Services for Children without Permanency. The redesigned service is also a critical part of the Department's initiative to reduce MaineCare costs with specific targets in FY05, as directed by the legislature.

4. **Independence PLUS Waiver**. In FY04 the department intended to apply for an Independence PLUS waiver from the federal Centers for Medicare & Medicaid Services. Initial consideration of the content for Maine's proposal is based on a recently approved effort by the State of New Hampshire's Medicaid InHome Supports Community Care waiver. Services not covered under existing MaineCare policy, such as therapeutic day care, will be included, and cover all diagnostic populations served by BDS. The consumer directed model employed in New Hampshire allows families the flexibility they need to arrange for in home supports in a manner that best fits their unique and individual situations.

- **Results:** Work on this goal was suspended due to the MaineCare fiscal challenges. However, the Department restored priority to consideration of a federal waiver under the condition that funding for this initiative be cost neutral. Accordingly, the department arranged for a comprehensive consultation with an established expert consultant on federal waivers, especially for children's services. Children's Services will move forward in FY05 and apply for a 1915 Waiver.

5. **Strategic Planning for Children's FY 05 Budget**. Considerable effort is anticipated in the coming months to address the fiscal situation facing Children's Services beginning in July, 2004. Presently the biennial budget for FY05 reflects a decrease in state general funds of approximately 9 million dollars. An initial statewide meeting of children's service providers and representatives from family organizations has been scheduled for early August. This meeting is being held jointly by BDS, key members of the 121st Legislature and representatives from the Governor's office. A central objective of this initial strategic planning is to discuss the budget's targeted reductions. One approach in dealing with this problem recommended by the legislature during appropriations hearings in the spring was the development of a sliding fee schedule applicable to respite services as a means to reduce the impact of a planned $500,000 reduction in this service. The Department will complete a study on the potential advantages of implementing a sliding fee schedule based on data now being collected by respite providers on family income, size and severity of a child's needs.

- **Results**: A formal report and recommendations concerning implementation of methods to achieve cost savings in the respite program was prepared by the department in collaboration with the 3 statewide respite provider agencies. The key recommendation was to uniformly reduce by 25% the number of hours available to families, based on the disadvantages providers associated with the administration of imposing and collecting fees for services. However, legislation (PL2003 c. 673) was passed late in the session to require the development of a sliding fee scale to be applied to case management, outpatient, home-based family services and respite care services paid for with state general funds. Children's Services, in collaboration with DHHS TANF program developed the fee schedule based on the legislature's specific instructions, initiated the formal rule-making process necessary to implement the law and established a September 1, 2004 effective date for the rule.

6. **Expanded Training and Certification of Habilitation Services Workers** A MaineCare rule change for Section 24 services delivered in the child's home will require equivalent training and certification that currently applies to Behavioral Health Services provided to children with mental health needs. Habilitation services are delivered to children with mental retardation or autism. A training curriculum originally developed for the BSI was modified to cover habilitation services specific to the needs of the population to be served. Training will be delivered primarily by agencies through the train the trainer model. The Behavioral Health Services Institute certifies individuals who successfully complete training.

- **Results**: The expanded training curriculum to cover individuals providing services with mental retardation and autism was developed and is now being implemented primarily through provider agencies with certified trainers.

7. **Implementation of Licensing Standards for MR Community Providers**. Effective with MaineCare rule changes in August, 2003, new licensing regulations will apply to community agencies providing services to children with mental retardation or autism. Licensing will be carried out through the BDS Division of Licensing and will effect all providers of habilitation services and case management services serving these populations.

- **Results**: Licensing rules were completed and providers supported the extension of client rights to the MR population. Due to fiscal constraints, specifically regarding the costs associated with provider training, this initiative was suspended by the Commissioner, in February 2004 for at least this fiscal year.

8. **Rate Setting for Children's MaineCare Services.** The Department will complete an analysis of MaineCare rates for Children's Services providers in the first quarter of FY04. Rates will be established for all of Section 65, Mental Health Services, which include: Emergency, Crisis, Outpatient, Medication Monitoring, Child and Family Community Support, Behavioral Health Services and Children's ACT Team. Rates will also be set for Section 37, Home Based Family Services and Section 24, Habilitation Services.

- **Results:** Within the past year, this activity has continued but under a new policy direction. While rate setting approaches initially focused on negotiated rates, the current policy is capping of rates; the second phase will be moving to standardized rates.

9. **Inpatient Services for MR/DD/Autism.** In conjunction with the DHS Bureau of Medical Services, BDS Utilization Review has worked with Hampstead Hospital in New Hampshire to develop a new inpatient unit for children with mental retardation, developmental disabilities or autism. This development will allow children from Maine to be treated much closer to home, as the nearest facility currently is Bradley Hospital in Rhode Island.

- **Results:** Hampstead Hospital opened the specialty unit for children and adolescents with autism (primarily) and has served 22 individuals to date. This facility offers an attractive alternative to other specialty facilities due to its proximity to Maine and successes experienced by children placed in the program to date. In addition, collaboration and consultation over the past year with a Maine inpatient hospital, Spring

Harbor in South Portland, resulted in development of a 12 bed specialty unit for children with MR/Autism.

## New Developments and Issues

Several of the primary new developments and issues that affect mental health service delivery in Maine are noted in the context of significant achievements during the previous fiscal year. In addition there are other, more global factors that will influence the children's system of care in the coming year (FY05). They include:

## Merger: Creating the Department of Health & Human Services (DHHS)

The creation of the new department from the former Department of Human Services and Behavioral & Developmental Services has been a priority for the Administration in order to restructure state government to enhance the provision of quality services in an effective and cost-efficient manner. The rationale for the merger includes objectives to improve the care and assistance provided to Maine citizens; to improve fiscal accountability for tax dollars spent; recognition that BDS and DHS have similar missions and services to help Maine citizens; and that overlapping programs using similar funding and service providers creates administrative duplication and conflicting administrative requirements resulting in unnecessary expense for Maine taxpayers.

## Litigation

A class action lawsuit (Risinger v Concannon – D. Me. CV-00-116-B) was filed in June, 2000 in the United States District Court against the former Department of Human Services and the Department of Behavioral and Developmental Services (the 2 Departments have now merged to form the Department of Health & Human Services).

The lawsuit was filed on behalf of Medicaid (MaineCare) eligible children who were on waiting lists for case management services or in-home behavioral health and habilitation services. The Complaint requested the Court to order the Defendants to eliminate waiting lists and provide adequate, timely and reliable case management and in-home behavioral health services to Maine children. The federal court approved the case as a class action. Members of the class are: All current or future recipients of Medicaid in the State of Maine who are under 21 years of age who are not receiving or will not timely receive in-home mental health or behavioral services. In May, 2002 the parties agreed to settle the lawsuit and in June, 2002 the federal court approved the agreement.

The key elements of the settlement are that the Department will comply with timeliness standards to ensure that case management services and in-home behavioral health and habilitation services "will commence promptly in accordance with reasonable standards of behavioral health practice, generally within an outer limit of 180 days." Over the past year the Department, following the specific recommendations of a court-appointed expert independent consultant, Clarance J. Sundram, Esq., completed a plan of implementation addressing report recommendations on expanding service capacity, utilization of current resources and administrative recommendations.

The department has developed a system (Enterprise Information System) that allows it to track whether the timeliness standards are being met for each class member and submits monthly data and a quarterly report to attorneys. The U.S. District Court has maintained jurisdiction over the case in order to enforce compliance with the terms of the settlement agreement.

The terms of the Risinger Settlement agreement continue to be applicable in current fiscal year. While reporting data regarding the timeliness of services has shown significant improvement over the past 2 years, the department must prioritize its efforts to further reduce the number of children waiting for services with the goal to eliminate waiting lists for these services altogether.

**Reduction in Children's Services Grant Funding for FY05**

As in many other states, Maine is faced with serious economic conditions that have impacted state government's fiscal capacity with direct consequences in FY05 as regards the Children's Services biennial budget. This impact has registered in a reduction of appropriations in state general fund grant dollars from $16.1 million in FY04 to $12.0 million in FY05, or approximately one-third (34.2%), reflecting a greater degree of client eligibility for services and reliability on the MaineCare program. State grant general funds are used to provide services that are not covered under the MaineCare program, such as respite care, information and referral, family support groups, family mediation and flexible funds used for individualized wraparound services. These dollars are also used to provide services that are covered under MaineCare for children and families that are not eligible under MaineCare. The Department was instructed to develop a sliding fee methodology for some grant funded services with an intended fee recovery target of $700,000.

**MaineCare Cost Savings in FY05**

In the last session ending in May, 2004, the Maine legislature directed the Department of Health & Human Services to achieve targeted cost savings in the MaineCare program. One million dollars is to be saved through managing the system of care more efficiently by employing prior authorization, utilization review and quality improvement activities as tools. Children's Services was specifically charged to achieve an additional $1 million cost savings in mental health treatment services under MaineCare policy Section 65, which included child & family community support services and in-home behavioral health services. The Department is currently designing a new benefit under Section 65 that will address this fiscal requirement while providing focus and emphasis on medically necessary treatment services for the child and family.

**Children's Habilitation Waiver**

Over the last several years Children's Services has been increasingly aware of the needs being experienced by families with children and adolescents who require highly specialized and often expensive individualized treatment services in order to keep their child in the home and community. In previous years some of these children were able to be served through the Mental Retardation Home and Community Based Waiver, administered by DHHS Adult Mental Retardation Services. In the past year MR Services amended its Waiver and established a new priority population for these services, specifically persons with mental retardation or autism who

require adult protective services under the MR Guardianship program. The consequence of this change is that children no longer have access to residential training and personal support services offered through the MR Waiver. The Department recognized the potential impact of that change and in light of an accumulating need for these services, authorized Children's Services to initiate planning for a children's waiver with the understanding that the plan be cost neutral.

**Katie Beckett Waiver**

The Bureau of Medical Services, DHHS, administers the Katie Beckett MaineCare Option. BMS has informed families that currently qualify for MaineCare under the Katie Beckett Option that the Department has requested changes in Maine's program through a Waiver from the Center for Medicaid and Medicare Services that would establish a system of co-pays based on family size and income. Some families that will be affected if the Waiver is approved believe that the financial burden on them will be excessive and they will not be able to continue coverage for their child. If the Waiver is approved and implemented, Children's Services believes that it will be directly impacted by families seeking services and funding through the mental health and behavioral health services offered through the children's services mental health program. Many of the families that may be negatively impacted by premiums that they may not be able to afford have children with exceptionally high needs.

**How the State Mental Health Agency Provides Leadership in Coordinating Mental Health Services Within the Broader System**

The recent DHHS merger affords Children's Services, through its Director, an opportunity to directly participate with peers from the Child Welfare system at the highest administrative levels in the new department. Children's Services is represented on the DHHS Commissioner's Executive Team and the Senior Management Team.

Children's Services is also an active participant in the bi-weekly meetings of the Children's Cabinet Senior Staff. This group consists of designees of the Commissioners who serve as the Governor's Children's Cabinet from the Departments of HHS, Corrections, Education, Public Safety and Labor. The senior staff focus on the operational aspects of the children's overall system of care. This is a forum that is a vehicle to promote interdepartmental coordination.

**SECTION II: Identification and Analysis of the Service System's Strengths, Needs and Priorities**

The strengths of Maine's children's system of care were recently documented by a review team from the University of South Florida, Research & Training unit which is supported by the Center for Mental Health Services. Maine was one of five states selected for this visitation due to its reputation for inter-agency collaboration at the state and local level. The review team's debriefing validated the existence of strong collaboration among the child serving agencies and highlighted the extensive working relationships developed between Children's Services and the Department of Corrections, Juvenile Services. Other strengths noted were the presence of wraparound values in the planning and delivery of services, parent employees in regional offices

serving as Family Information Specialists, and strong relationships with statewide family organizations. System strengths include respite services, which have been a cornerstone of family support since the beginning of the Children's Services in 1985, and the use of flexible funding, connected with the wraparound process, to meet both simple and complex needs of children and families. In an earlier visit to Maine, John Van DenBerg noted many of the same strengths. However, he did point out, and Children's Services agrees that there is a need to build on the greater community and natural supports.

**Service Gaps and Unmet Needs**

The Department's information systems provide data upon which service gaps, unmet needs and individuals waiting for services are determined. Currently the Enterprise Information System generates data to track children who have requested and are waiting for Case Management Services, In-home Behavioral Health Services and Habilitation Services.

Other sources of identifying needed services are from regional resource development activities and from discussion among Maine's child-serving state agencies. Some examples of the identification of needs and services that were developed over the past 3 years resulted from discussions with the service provider community and through interdepartmental collaboration were: crisis services for children with mental retardation and autism, transitional services from hospitals to home and local schools and development of specialized inpatient capacity for children with mental retardation or autism.

In August, 2003, Spring Harbor Hospital announced its plans to open short term inpatient capacity for young people with autism or other developmental disabilities who experience psychiatric crisis. This program has been operational for nearly a year and has a capacity to provide services for 12 children and adolescents. This new resource provides a local alternative for Maine families whose children might otherwise be hospitalized in an out of state facility.

Children's Services has focused on extensive service development to address waiting time issues in the area of case management and in-home supports over the past two years, and these services will continue to be a priority in FY05. Other needs, such as respite care and therapeutic day care may be addressed through efforts to include these currently non-reimbursable services under a new Children's Waiver.

**Service Needs and Critical Gaps Within the Current System**

**Priorities for FY05**

Children's Services establishes its priorities for each fiscal year based on an understanding of the critical needs of the behavioral health service system. These priorities are established from a variety of sources including legislative direction or mandate, knowledge of the service system obtained through input from service providers and families and needs that are addressed through rule or policy change. Priorities are also derived from data obtained from the Children's Services information systems that include Performance Indicators as reported by the DHHS

Office of Quality Improvement, from monitoring of fiscal expenditures and projections, and from administrative goals set by the Department and the Children's Services Director. The priorities that follow represent the major elements of the Children's Service's work for FY05 as they are known at the time of submission of the Block Grant Application for FY05, and they are addressed in the Children's Services action plan.

1. **Risinger Settlement Agreement Compliance** Achieving full compliance with the Risinger Settlement Agreement is the highest priority for Children's Services in this fiscal year. Compliance entails the elimination of waiting lists for children of greater than 180 days for in-home behavioral health services, in-home habilitation services, and case management services, and greater than 120 days waiting for an individual treatment plan. Full compliance will require ongoing efforts by the service provider system in order to maintain and to build additional capacity as needed.

2. **Section 65 Redesigned Services (M) and (N)** The department, in collaboration with service providers, parents, attorneys, staff from the Bureau of Child & Family Services and the Bureau of Medical Services, is preparing proposed new services to be incorporated in the MaineCare policy related to the service needs of children with mental health needs, mental retardation or autism. These services are:

- **Child and Family Behavioral Health Treatment Services (65M**) for children who need intensive mental health treatment and who live, or will live, with a parent or caregiver who will participate in the treatment. The treatment will be provided by a team that will include the parent/caregiver, a clinician who will provide therapy or counseling directly to the child and family in the home, and a child and family services professional who will provide intervention services to the child and family under the supervision of the clinician.

- **Community-Based Treatment for Children Without Permanency (65N**) are services for children who need treatment for their mental health needs and do not have permanency, i.e., they are homeless; legally emancipated; or have voluntary service status with DHHS. The treatment team for this service includes the child, a clinician who will provide therapy or counseling directly to the child, and a community-based services professional who will provide services to the child under the supervision of the clinician.

3. **Home-Based Services for Children with Mental Retardation or Autism** This proposed new rule will create a new section (Section 28) in the MaineCare manual for Home-Based Services for Children with Mental Retardation or Autism. A public hearing was held in July as required by the Administrative Procedures Act. Currently the Bureau of Medical Services and the Children's Services are working collaboratively to respond to the numerous comments from the public, advocates and providers. Children up to the age of 21 with diagnoses of mental retardation and/or autism will be able to receive treatment services in their home and community, or in a center based setting, or under an applied behavior analysis model, according to the treatment needs of the child.

4. **Cost Containment for MaineCare Seed** Children's Services is directed by the legislature to achieve cost savings in its MaineCare program of $2 million in FY05. The department's primary strategy to reach this target is through the implementation of the new Section 65 (M) and (N) services. The new rule will include elements of care management such as a determination of medical necessity, targeted service timelines, prior authorization and concurrent review for the continuation of services. In order to achieve this target the department will rely heavily on utilization review nurses and quality improvement personnel.

5. **Sliding Fee Rule- Implement & Report** Children's Services will implement the sliding fee rule applicable to grant funded services covering case management, outpatient, home-based family services and respite care beginning September 1, 2004. A major legislative intent of this rule is for providers to recover a portion of the cost of these services when the recipient's income is greater than 250% of the federal non-farm poverty level. At the end of the fiscal year a report will be issued specifying the dollar amounts of fees received by agency providers and the impact of the fees with regard to continued participation of families that are subject to fees.

6. **Collaboration with TANF – Access to Block Grant for Respite** In FY05 the legislature replaced $1 million in Children's Services grant funds with $1 million in TANF Block Grant prevention services funds. Children's Services will work with the Bureau of Family Independence and the 3 Respite programs to create a billing system for respite care services that are delivered to eligible families under this program.

7. **Children's Waiver – (Supports and Comprehensive**) With departmental approval to go forward with a cost neutral Waiver proposal, Children's Services will focus on two types of Waiver under the 1915 c Home and Community Based Waiver. The Supports Waiver is for persons living in their own homes with parents/caregivers; persons who can be safely maintained in their current living situation with supports and who are at risk of out of home placement without this level of support. The Comprehensive Waiver is similar to the Supports Waiver with an increase in the intensity, frequency and duration of the services and supports and/or some residential training and need for 24/7 services.

8. **Stakeholder Collaboration** Children's Services will continue to benefit from the active involvement of stakeholders in the development of budget and policy initiatives, such as input for the development of service models, staff qualifications and training, that are key elements in the continuing development of services for the system of care. Stakeholder groups involved in the development of the new Section 65 mental health services included a statewide provider association, attorneys, providers, parents and advocates and representatives of the child-serving state agencies. Smaller workgroups made up of stakeholders have been helpful contributors in the development of policy in the areas of central enrollment, staff qualification and training, transition parent involvement and rate-setting. Children's Services regional staff participate with providers and other stakeholders on a regular quarterly meeting schedule.

9. **Statewide Family Organizations Collaboration** The Statewide Collaborative of Family Organizations perform important services to families through their information and referral activities. Children's Services will continue to engage with these providers to explain new developments in the system of care that affect families so that these organizations will be able to accurately inform consumers and other interested parties of these changes. This information covers policy changes and explains service eligibility and how to access services, especially those that are new or are undergoing change.

10. **Partnerships for Youth in Transition Grant** This activity is one of 5 grants awarded on a nationally competitive basis to the Maine Medical Center from the Substance Abuse and Mental Health Services Administration. The purpose of this project is to identify and resolve barriers in the system of services which prevents a smooth transition of young people with mental illness from the children's service system to adulthood; and secondly to create a model of services for these transitioning youth which, when implemented will be successful in helping them to achieve the life goals that all young people have; continuing or completing their education; living stable lives in the community; finding employment; and, managing their mental illnesses. Children's Services will continue to support this effort in the two pilot sites located in Portland through the involvement of the Children's Team Leader and in Washington County through support offered by Children's Services Quality Improvement Specialist staff.

11. **Merger Activities** Children's Behavioral Health Services is looking forward to the opportunity to more fully engage and integrate with its child-serving counterparts in the Bureau of Child & Family Services, specifically with Child Welfare, Foster Care and Post Adoption Services. The merger presents an important opportunity for the Department's child-serving partners to exchange information to obtain a better understanding of their mission, values, populations served and resources available to carry out their roles and responsibilities. The context of these discussions will be in the framework of increasing accessibility for all children and families to obtain needed supports and services, enhance efficiency and reduce duplication of effort or services where that is evident and addressing ongoing strategies to enhance the quality of services being provided to Maine's children and families.

## Recent Significant Achievements that Reflect Progress toward the Development of the System of Care

In addition to the priorities established for the past fiscal year that are reported in earlier section of this Application, Children's Services has been involved on several levels (policy, program development, collaboration) in order to move ahead in the development of the behavioral health system of care. These activities encompass the following:

- A crosswalk for Medicaid billing purposes was developed by a group of stakeholders including clinicians, reimbursement staff, Children's Services and the Bureau of Medical Services. This crosswalk, from the Diagnostic Classification: 0-3 (DC:0-3) system to the International Classification of Diseases –9 (ICD-9), will allow clinicians to use the DC: 0-3 to diagnose very young children and to bill MaineCare. The professionals who work with the very young recognize the Diagnostic And Statistical Manual of Mental Disorders' (DSM-IV) criteria do not always adequately describe the symptoms of the very young. By developing the crosswalk, clinicians now have an alternative diagnostic system for very young children.

- Children's Services Quality Assurance activities are seeing positive results. Results of the Family Empowerment Scale '04 saw an increase in the percentage of parents who responded Mostly True or Very true to the statement "I understand how the service system for children is organized". Following the '03 survey, Children's Services provided training to the family organizations, GEAR, and to case management agencies, who in turn did a better job of imparting information to families.

- Quality Assurance staff conducted a record review of in-home behavioral support services high end users. Recommendations based on the data collected support an expansion of quality assurance activities both at the state and provider level. Specific quality assurance activities should include structured case record reviews, program site visits, and interviews with family, youth and program staff. Future practice, including training, will be guided by the results.

- The Behavioral Health Sciences Institute, contracted by Children's Services to develop, implement and track the quality of in-home behavioral support training, is expanding the current training curriculum to include two new services that are more intensive and can include delivering direct therapy/counseling to the family in the home.

- Collaboration with Spring Harbor Hospital in the development of MR/DD/Autism unit for children. Children's Services supported staff development and training and brought Dr. Brian King from Dartmouth to consult on this development.

- Continued reduction in the out of state census for children. Data reported for July, 2004 indicate 55 children are in out of state treatment placements. This is a reduction of 15 children over the course of the past year, or a difference of 27%.

- The Children's Services Medical Director participated in a planning grant from the Maine Health Access Foundation with the Maine Center for Public Health in assessing how best to address the difficulty of access to mental health services for children. Opinions were solicited from primary care physicians and multiple stakeholder meetings were held. It was decided that integrating mental and physical health offered the most promise for both physical and mental health care, allowing earlier intervention, prevention, improved communications and increased follow up rates. Children's Services is actively exploring next steps to support this process.

- Children's Services participates in a planning grant from SAMHSA to evaluate evidence-based practices in Maine, and to develop two further grants to pilot an evidence based practice. ADHD treatment protocol is one of the possible areas for a continued year grant application.

- More providers of in-home support services in the Northern Maine and Aroostook County have come on board to provide these services in rural areas of Maine, decreasing the number of children waiting for in-home supports as well as decreasing the waiting time for services to begin. Other providers already serving in Region 3 have expanded their catchment areas and are inquiring about additional service needs in the region.

- DHHS/MADSEC Collaboration in central Maine is bringing Children's Services and Special Education together under the Central Maine Inclusive School initiative. DHHS is designing a train the trainer program to open communication between school in the central region of the state and community case management agencies in the same area. The focus of this project will be to achieve a better understanding of services offered by schools and case management agencies to the children and families they serve in common. Parents will participate in the design of the training as well as in training for other parents. This is a pilot project that is being designed for use statewide.

## VISION FOR THE FUTURE: A PLAN FOR CHILDREN'S MENTAL HEALTH

For almost a decade, Maine's Children's Services Program operated under a Ten-Year (Year 2000) Strategic Plan for program and service development, which was designed under P.L. 99-660. While that Plan served the Department and Maine's children and families well for many of those years, the direction and vision for the future continues to be based on a comprehensive document created by families, service providers and child-serving state agencies in 1997, titled A Plan for Children's Mental Health Services. This Plan established the essential values for the system of care and outlined a comprehensive approach for community based children's mental health services that has served as the template for subsequent resource development and defined the six core services that the department has continued to develop over the past six years: crisis intervention, outpatient, home-based family services, in-home behavioral supports, case management and respite care services. Statistical data showing the historical growth of these core services are presented under Criterion 1: Comprehensive Community Based Mental Health Services for Children.

The mission of the Children's Services Program is to institute statewide and regional systems of care that are imbued with family strengths and family support values and principles. Systems of care are guided by a model which incorporates federal Child and Adolescent Service's System "system of care" principles, along with a wraparound, individualized approach to services, utilizing flexible funding and natural supports.

The Children's Services Program's long-range vision is to implement a "child and family centered" approach to system of care development. "Family centered" means more than developing and providing services that focus on families. Family centered means that parents participate in needs assessment, planning, developing, implementing and evaluating services and the administration of services.

In a family centered approach, there is a full partnership between parents, providers and the State. Parents define the strengths and needs of their families; support staff assist families to identify or create resources that will best help parent and child to achieve their stated goals and meet their needs. This is an ongoing process that requires continued contact, maximum flexibility and creativity on the part of parents, resource coordinators and service providers joined in a common effort.

The operational framework for the present and future system of care is based on fundamental principles that include: ease of access to services for children and families; cost effective services and supports; high quality services; avoidance of duplication and redundancy; avoidance of parallel systems of care and the development of a fully integrated system of care for all children and their families.

## SECTION III.

## PERFORMANCE GOALS and ACTON PLANS to IMPROVE the SERVICE SYSTEM

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

**Structure of the System of Care.**

Maine's mental health authority for children's mental health services is the Children's Mental Health Services program unit within the new Department of Health & Human Services (the Department). Children's Services central office provides leadership in policy, interdepartmental relations, legislative initiative and systems advocacy on behalf of children with emotional and behavioral needs and their families. The proposed organizational structure is that Children's Behavioral Health Services (Children's Services) will be located in the Department's Bureau of Child & Family Services. The 122nd legislature will make the final decision regarding the new Department's specific structure.

**Children's Services Central Operations**

The Children's Services Director oversees all operations of Children's Services from the central office level, implements policies relevant to the delivery of a system of care, acts as liaison for the department in issues effecting Children's Services, and directs staff within the central office operations. These staff include the following:

Children's Systems Manager, who is responsible for communication and meetings with regional and central office staff pertinent to issues of operation, as well as meeting with staff representatives from other state agencies.

Children's Medical Director, a child psychiatrist who provides clinical expertise, consultation on clinical issues and promotes best practices in the field. The position consults with and supports field staff and provides clinical supervision to Children's Services Utilization Review Nurses.

Other personnel include an Assessment Data Specialist responsible for the accuracy and completeness of data entered regarding assessments submitted by all case management and crisis services agency staff and also acts as the Children's Grievance Coordinator. A Quality Improvement/ Assurance Manager, who is a liaison to the Office of Quality Improvement and responsible for implementing the Children's QI Plan, overseeing the staff training and certification process required for behavioral health services and habilitation services workers, and assisting with licensing efforts for Children's Mental Retardation Services. A Program Specialist responsible for preparation of reports required by federal, legislative or departmental personnel, analysis of non-clinical data and information, and program support/liaison with regions and central financial unit, as needed. Information Systems Administrator responsible for liaison work and communication between Children's Services and the Office of Information Services, and who is the lead team member overseeing the implementation of the Enterprise Information System, specifically as that system will support the needs of Children's Services. A

Behavioral Health Services Manager is responsible for the implementation of the delivery of mental health services to youth in Department of Corrections youth facilities and regional juvenile services offices. A Social Services Program Specialist performing interdepartmental collaborative work with other child serving agencies on the design and implementation of new and existing programs and services for children with behavioral health needs, including MaineCare policy and development of an application for federal Waiver services. A Children's Finance Director manages departmental contracts awarded to providers of children's services, and oversees regional management analyst/contract staff and is responsible for maintaining fiscal information on budgets and expenditures and participates in the rate setting process for children's services.

**Children's Services Field Operations**

Mental health services for children are delivered at the local level through a regional structure managed by a Regional Director who oversees Team Leaders having responsibility for Children's Services, and for adult Mental Retardation Services and for adult Mental Health Services. The Children's Services Team Leader manages all activities in the region pertaining to the delivery, development and oversight of children's services, supervises management staff in the region and is a member of the Regional Management Team.

Mental Health Program Coordinators address specific child and family issues and work with community providers around individual children and youth (or specific groups) to ensure access to services, including services outside of the home. Resource Coordinators work with community providers to develop or expand services needed in the region, act as local contact for collection of information on services and may act as liaison to other child serving entities of the state. Utilization Review Nurses track utilization of services to children placed out of state and in psychiatric settings within the state and review requests for out of home placements/ high intensity services. The purpose of these reviews is to assure the child receives the most appropriate yet least restrictive medically necessary level of care. UR Nurses assure that providers meet minimum requirements of clinical competency and that practice standards are met in caring for children. Management Analyst staff perform contract, fiscal oversight and monitoring functions and prepare related financial reports. The Department provides its mental health services almost exclusively through contracts with community providers.

Regional Supervisors are involved in daily regional operations, engage in issue/problem solving, participate in community meetings and select, orient and supervise the following front line staff. Enrollment Specialists responsible for documenting individual access to community services, manage the collection of information from community agencies regarding children receiving services, track information for accuracy, completeness and utilization of services. Quality Improvement Specialists are responsible for participating in site visits to community agencies in order to review operations and services that are funded by the Department. These tasks include reviewing service trends, incident reports and performance outcome data, providing technical assistance and obtaining feedback from consumers. Family Information Specialists are responsible for communicating with parents who seek access to services for their child/youth, provide information to parents about community services, and maintain updated information about services provided in the region. A Family Information Specialist is a trained parent employee who is knowledgeable of the local service area.

**Available System of Treatment, Rehabilitation and Support Services**

The Department, in concert with all other child-serving state agencies, parents, community service providers and legislators who participated in the 1997 planning process culminating in A Plan for Children's Mental Health Services, identified a full array of services and supports essential to the children's system of care. Funding sources identified in the Plan include sources available to and employed by any of the 4 child-serving state agencies.

Six core mental health service components were identified and are described below. Each core service is available in varying degrees of intensity, depending on the level of need. In addition to the core services, flexible resources - sometimes called flexible funds- are available to provide for individual needs identified through the individualized planning process, and cannot be addressed through categorical services or funding sources.

In Maine, the core service array is intended to provide a blueprint for developing service capacity in each geographic area of the state. The core service array with service components is summarized as follows:

**Prevention/Consultation Services** include identification of at-risk children, clinical consultation and information/education components. Services are designed to identify problems and intervene early. Information about health and emotional development can identify children "at risk" and trigger treatment services. Education activities inform the community about mental health problems; consultation services address individual cases and assist other agencies in handling mental health problems. In Maine, these services are funded by the General Fund, MaineCare EPSDT, Part B-IDEA, School Linked Mental Health Services, and pooled flexible funding.

**Crisis Intervention and Stabilization Services** are accessed through a single statewide, toll free 1-888 Crisis Telephone line. Services include crisis outreach services, crisis respite, short term crisis stabilization (both in home and out of home) and acute hospitalization. Crisis services provide support and stabilization services to children and youth in their home, school or other community settings. Services are available 24 hours a day, 7 days a week. Crisis outreach includes an assessment of risk, identification of immediate needs, development of a crisis stabilization plan, referral and follow up. Specific crisis interventions may involve a variety of in-home support services, short term out of home placement in the community, or short term hospitalization. In Maine, these services are funded by the General Fund, MaineCare - Crisis Services, MaineCare -Emergency Services, MaineCare - Outpatient Services and the Mental Health Block Grant.

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

**Family and Child Supports** include respite care, parent support services, family mediation and social & recreational services. These natural and extended supports are designed to strengthen the ability of families/caregivers to maintain children in their home and community. Services include in-home respite care, parent and sibling support groups and social and recreational services, including structured after school programs. Family support and respite provide relief from constant care giving, and support for each care giver's problem-solving, communication skills, behavioral interventions and advocacy. In Maine, these services are funded by the General Fund, Mental Health Block Grant, Family Preservation (federal) Grant, School Linked Mental Health Services, and Part B-IDEA.

**Community Outpatient and Treatment Services** consist of psychological/psychiatric evaluation, medication management, individual, group and family counseling, school-linked mental health services, day treatment and home-based 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 interventions to strengthen and stabilize the family living environment are designed to minimize the risk of out of home placement. School-linked mental health services provide a variety of educational/psychological assessment and referral, individual & family counseling, special education and other support services geared specifically to support the child or youth in the school environment. In Maine, these services are funded by the General Fund, MaineCare, Mental Health Block Grant, Substance Abuse Block Grant, School-Linked Mental Health federal Grant, Part B-IDEA, and pooled flexible funding.

**Residential Treatment Services** include therapeutic foster care, group homes and residential treatment. 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. Group homes provide a therapeutic living environment with a specific behavioral or treatment focus shaped in part by common treatment needs of residents with services available in the residence and the community. Residential treatment centers provide around the clock staffing, a therapeutic milieu, and address educational needs. In Maine, these services are funded by the General Fund, MaineCare-PNMI, Title IV-E, Substance Abuse Block Grant, Local Educational Administrations (educational costs), and Part B-IDEA.

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

**Expansion of Core Services**

During the most recent legislative session the Department prepared information about its progress in developing the system of care, and specifically with regard to growth in services for

children and families over the previous 6 years. This time frame coincided with planning effort and program information gathered for the Plan for Children's Mental Health during the summer of 1997; therefore, the baseline data was taken from that report and compared with Year End contracting report data for FY04. The results are shown in the table below:

**Children's Services – Core Services – Numbers Served**
**FY98 - FY04**

| Service Area | FY 98 | FY 04 | Increase | % Increase |
|---|---|---|---|---|
| Crisis Intervention | 2,144 | 5,838 | +3,694 | 172% |
| Outpatient* | 6,949 | 18,397 | +11,448 | 164% |
| Home Based Family Services | 539 | 1,338 | + 799 | 148% |
| In-Home Behavioral Supports | 90 | 2,614 | +2,524 | 2,804% |
| Case Management | 1,532 | 7,171 | +5,639 | 368% |
| Respite Care | 1,514 | 2,228 | +714 | 47% |
| | | | | |
| **Totals** | **12,768** | **37,586** | **+24,818** | **+194%** |

*Includes Medication Management

The expansion that has occurred over this six-year period was driven in part by the demand for specific MaineCare services and by pre-Risinger litigation that emphasized the need for In-home Behavioral Health Services (Section 65 h) and for In-Home Habilitation Services (Section 24). Targeted Case Management Services were also considered an integral service that would increase family access to the entire system of care, and was, therefore, a third service that increased prior to and during the present Risinger Settlement Agreement.

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

By FY04 this profile changed significantly. Children's Services now contracts with (32) Targeted Case Management Providers; (30) Outpatient Services providers, of which one-half (15) also provide Medication Management; (11) Home-Based Family Services providers; (24) Habilitation Services providers that offer In-Home Supports; (20) Behavioral Health Services In-Home Services providers (10) Crisis Services providers; (12) Child & Family Community Support providers; (10) Homeless Services providers and (14) Family Support Services providers that include Parent and Peer Support groups, Family Mediation Services, and Information and Referral Services. Many of these agencies serve more than one Region.

**Case Management Services for Children**

Case management services for children entail an individualized planning process. Assessment involves determination of an individual or family's strengths and needs, contributing factors, and existing assets and resources. An individual service plan is built on the results of

assessment, taking into account child and family strengths, needs, and preferences. Plans reflect services to be secured, with measurable goals and time frames, natural supports and service providers.

An individual plan is developed through a child and family centered wraparound planning process, with a Child and Family Team. Agencies and programs already involved with the child and/or family are included in the planning process. Case management involves brokering services, advocacy, insuring that an adequate treatment plan is developed and implemented, and reviewing client progress. Case management involves aggressive outreach to the child and family and working with a wide range of community agencies and resources.

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

Children's Services case management services are provided through contracts with local service providers. Mental health case management services for children have recently undergone a major redesign that recognizes the need for uniform screening and assessment tools that are used to establish the child's level of care needed for service. Case management services are delivered according to two levels of service, defined in accordance with the degree of needed service intensity.

Based on the initial screening assessment (CALOCUS, CAFAS, Family Empowerment Scale) and on clinical interpretation of other factors, a child and family will be assigned to the level that most matches their needs. There are two broad levels of case management: Level I case management generally focuses on resource coordination and provides for moderate to minimum needs. Level II - intensive case management provides for an intermediate care level that addresses moderate to extensive needs. The same screening instruments are readministered at 12 month intervals with corresponding adjustments in level of care determination. The department requires that if the child's level of need change, the case management agency will assure that the current case manager maintain continuity of services.

Nearly all Maine children receiving case management services are eligible for MaineCare, and are served through Targeted Case Management services under that funding mechanism. During the past 4 years, case management services for children with mental retardation and autism have been transferred to community provider agencies, as regional staff have assumed non-direct service duties. This change, coupled with a high demand for case management services from families who had not previously been served, has resulted in a dramatic expansion of both provider agencies and numbers of children served in the MaineCare funded program. The net effect of these developments over the past 2 years is shown in the following table.

# Targeted Case Management Services - Children's Services

**Number Served, by Provider FY2 - FY04**

| Provider Name | # Served FY02 | # Served FY04 | Change FY02-FY04 |
|---|---|---|---|
| ASSISTANCE PLUS | 53 | 129 | 76 |
| CATHOLIC CHARITIES ME | 254 | 444 | 190 |
| CHARLOTTE WHITE CTR | 16 | 111 | 95 |
| CHILD & YOUTH BOARD | 66 | 83 | 17 |
| CHILDRENS CENTER | 13 | 66 | 53 |
| COMMUNITY COUNSEL CTR | 326 | 293 | -33 |
| CRISIS AND COUNSELING | 31 | 46 | 15 |
| FAMILY FOCUS | 51 | 43 | -8 |
| INDEPENDENCE ASSOC INC | 29 | 60 | 31 |
| KATAHDIN FRIENDS INC | 24 | 40 | 16 |
| MAINE VOCATIONAL ASSOC | 0 | 17 | 17 |
| ME SPEC ED & MNTL HLTH | 25 | 27 | 2 |
| MID COAST MENTAL HLTH | 46 | 109 | 63 |
| MILESTONES FAMILY SVCS | 0 | 29 | 29 |
| MOBIUS INC | 6 | 17 | 11 |
| MORRISON DEVELOPMENTAL | 0 | 10 | 10 |
| NORTHERN MAINE GENERAL | 78 | 105 | 27 |
| PENQUIS CAP | 64 | 98 | 34 |
| PINE TREE SOCIETY | 107 | 110 | 3 |
| PROTEA BEHAVIORAL HLTH | 0 | 23 | 23 |
| RICHARDSON HOLLOW | 403 | 618 | 215 |
| SPECIAL CHILDRENS | 18 | 61 | 43 |
| SPURWINK SCHOOL | 114 | 253 | 139 |
| SWEETSER | 1,794 | 2,387 | 593 |
| TRI COUNTY MENTAL HLTH | 500 | 478 | -22 |
| UNITED CEREBRAL PALSY | 87 | 139 | 52 |
| WABAN PROJECTS INC | 98 | 147 | 49 |
| WABANAKI MENTAL HLTH | 24 | 0 | -24 |
| WALDO CNTY PRESCHOOL | 26 | 85 | 59 |
| WINGS FOR CHILDREN | 579 | 751 | 172 |
| WOODFORDS FAMILY SVCS | 98 | 137 | 39 |
| YOUTH & FAM SVCS INC | 300 | 337 | 37 |
| YWCA OF PORTLAND | 0 | 3 | 3 |
| | | | |
| TOTAL | **5,230** | ***7,256** | **2,026** |

Source: MaineCare Decision Support System (Children served under MaineCare) *Note: The statewide unduplicated count for MaineCare Case Management is 7,010. Duplication in the FY04 client count above is due to a client's changing to another agency (estimated at 3.5%).

## Inpatient Services and Hospital Utilization

As of August, 2004, the number of available beds for children and adolescents in Maine in inpatient psychiatric hospitals totaled 130 and were allocated as follows:

| | | | |
|---|---|---|---|
| Spring Harbor | (S. Portland) | Child = 12 Adolescent =28<br>MR/DD/Autism = 12 | Total = 52 |
| St. Marys | (Lewiston) | Child = 8 Adolescent =14 | Total = 22 |
| Maine General | (Waterville) | Child = 0 Adolescent = 8 | Total = 8 |
| N. Maine Medical Center | (Ft.Kent) | Serves age range from 4 to 17 | Total = 7 |
| Acadia | (Bangor) | Child = 17 Adolescent = 24 | Total = 41 |
| **Maine Inpatient Psychiatric Beds** | | | **Total = 130** |

## Children in Out of State Placement

LD 790 specifically directs the Department to report periodically on progress made in meeting schedules for transitioning children receiving treatment out of state back to care in the State of Maine. The legislation references a Memoranda of Agreement between the former BDS and the Department of Human Services. This document sets targets for returning children who are in out-of-state hospital and residential placements, as well as children who could be diverted from unnecessary placement out of state.

The Department of Health Human Services, Bureau of Child & Family Services, tracks out of state placements of children whose care is paid for by MaineCare funds, and children returning to Maine from these placements.

- The census of children living out of state in July, 2003 was 70 and the census of children living out of state in July, 2004 was 55, for a net reduction of 15 children and youth. (Note: the numbers of admissions and discharges do not yield the net reduction because a number of children have had multiple admissions and discharges).

- The census in out of state placements in July, 2004, was 28 for Child & Family Services, which is has responsibility for children in state custody, and 27 children for Children's Services, which has responsibility for children not in state custody.

- The census over the past four years represents a steady reduction in the utilization of out of state residential and hospital placements. Shortly after the passage of Chapter 790 in April, 1998, the census out of state was 260 children. Over the past 6 years the census has been reduced by over three quarters of that total, or by 205 children.
- The current census by placement type is Residential Treatment (39, or 71%) and Hospital setting (16 or 29%)

- Of the 55 youth currently in out of state placement the vast majority (46 or 84%) are placed in New England.

**Systems Access Program and Utilization Review**

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

The Department established a Children's Services Utilization Review Program several years ago to assess the quality and effectiveness of hospital care and residential treatment rendered to children and adolescents from the State of Maine. The focus of the program, supported through Children's Services Utilization Review Nurses and other personnel, is to ensure that the clinical care that is approved for children and adolescents with behavioral health needs is consistent with best practices and standards and meets generally accepted levels of medical necessity.

The Systems Access Program was initially developed by the former BDS and DHS, and is designed to streamline the admission process for children covered under MaineCare. The program allows for a single point of access to regional crisis services, without regard to whether the child is in DHS custody or being served by Children's Services. The protocol assures that children are assessed for the least restrictive level of care, and a psychiatrist reviews the circumstances for any child placed out of home.

**Housing Services: Intensive Temporary Out of Home Treatment Services (ITOOHTS) Policy**

ITOOHTS is defined as an intensive level of care that provides treatment for children and adolescents in a structured setting that includes 24-hour supervision. This program provides the necessary services, which cannot be instituted at home, but do not require a hospital level of care.

Intensive temporary out of home treatment will be provided to address the specific issues that necessitate the child needing to leave home, with the center of treatment being focused on returning the child home. Research has clearly indicated that the longer a child is out of the home, the more difficult it is for the child to successfully transition home. This "focal treatment" is intended to minimize the time that a child is physically out of the home. A basic premise of this program is the requirement that the family will be actively involved in the treatment of the child, and participate on the treatment team.

In FY04 a total of 365 children received intensive temporary out of home treatment services. Children who receive these services are monitored through the Children's Services Utilization Review Nurses and are also accounted for through the Department's financial support staff through the Room & Board account, which pays for the non-treatment costs of the child's placement.

**Legislative Initiatives: Mental Health Services**

Significant legislation was passed by Maine's 118th Legislature concerning children's mental health services. Chapter 790 focuses on mental health systems of care due to the interdepartmental nature of legislation. Therefore, discussion about Chapter 790 appears in Criterion 3: Integration of Children's Services of the Children's Mental Health Block Grant Plan.

## Co-Occurring/Dual Diagnosis Services

Services to children and adolescents with co-occurring mental health/ substance abuse needs are provided by the Department of Behavioral and Developmental Services through the Office of Substance Abuse. OSA reports in FY04 that 1,837 adolescent (under age 19) clients entered some form of substance abuse treatment during the year. Of those unduplicated clients, 624 or 34.0% were identified as dually diagnosed.

The following agencies have specific programs for youth that are funded through OSA to provide substance abuse treatment – **Residential** – Day One; Your Choice; Janus House. In June, 2003, Phoenix Academy of Maine opened a 14 bed residential treatment program for adolescents in Augusta – **Intensive Outpatient** - Open Door Recovery; Addiction Resource; Maine General Hospital – **Outpatient Program** – Day One. 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. Children's Services regional offices maintain an informal list of dental providers who are willing to take children with MaineCare insurance. Children's Services has provided for interpreter services to overcome language barriers between dental professionals and the child and family.

Medical Services for children are provided through MaineCare. Public health services are provided through the Department of Human Services, Bureau of Health. Children's Services does not provide medical services beyond those that are characterized as behavioral health services. Maine expanded medical coverage for many children beginning in 1998 through the Cub Care program.

## State Children's Health Insurance Program

In Maine, the State Children's Health Insurance Program (SCHIP) and the federal Medicaid program are known as MaineCare. MaineCare is administered by the Department of Human Services, Bureau of Medical Services.

With SCHIP funding, MaineCare provides coverage to (1) children ages 1 through 18 in families with income from 133% to 125% through 150% of the Federal Poverty Level (formerly known as Medicaid expansion), and (2) children from birth to 12 months of age in families with income from 186% through 200% of the Federal Poverty Level and to children ages 1 through 18 in families with income from 151% through 200% of the Federal Poverty Level (formerly known as Cub Care). In July 2004, there were 13,067 children enrolled in MaineCare with SCHIP funding. This count represents an increase of 1,322 children or 10.5% from the previous year.

Covered MaineCare services, both Title XIX (Medicaid) and Title XXI (SCHIP) funded, include: hospital, physician, therapies (OT, PT, Speech), medication, lab and x-ray, durable medical equipment, vision and hearing, ambulance, transportation, behavioral health, family planning and case management.

**Rehabilitation and Employment Services**

Children's Services works collaboratively with adult service systems regarding appropriate services and supports, including employment, during the transition planning phase – beginning usually two years or more before a young person enters adult services. Activities include an agreement with adult Mental Retardation Services to begin early collaborative planning for young people at age 16 so that the adult service system can begin resource planning for future needs. In addition a unique aspect of this agreement allows a young person to receive needed supports and services from either system or both systems as circumstances require and allow. As part of that agreement training was provided to children's services contracted case managers. Training included such topics as vocational rehabilitation, guardianship issues and consumer perspective.

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 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 child development sites. It reflects all students with Individual Educational Plans regardless of placement.

The Special Education Child Count lists 14 areas of Disability/ Exceptionality. Six specific areas among the total 14 categories represent a range of disabilities that suggest a level of severity or type that are likely to be included in the children's system of behavioral health care. These categories, with child count data are listed as follows:

**Department of Education - Special Education - Child Count Data**
**December, 2003**

| Disability/Exceptionality | Age 3-5 CDS* | Age 6-21 School Age | Total | % of All Child Count |
|---|---|---|---|---|
| Mental Retardation | 9 | 940 | 949 | 2.51 |
| Emotional Disability | 73 | 3,326 | 3,399 | 9.00 |
| Specific Learning Disability | 30 | 12,659 | 12,689 | 33.58 |
| Multiple Disabilities | 96 | 3,222 | 3,318 | 8.78 |
| Developmentally Delayed | 1,824 | 0 | 1,824 | 4.83 |
| Autism | 203 | 675 | 1,018 | 2.69 |
| | | | | |
| **TOTALS** | **2,235** | **20,862** | **23,197** | **61.39** |

## Child Development Services (CDS)

The Child Development Services System (CDS) is established for the purpose of maintaining a coordinated service delivery system for the provision of Childfind activities 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 CDS system currently serves over 5,000 children pursuant to federal and state regulation. The services that each of these children receives are determined by each child's early childhood team and are reflected on the child's Individual Family Service Plan or IEP.

## Services Provided by Local School Systems

The Maine Department of Education provides education and related services to Maine's students with disabilities through school subsidy, contractual and federal funding through IDEA, the Individuals with Disabilities Education Act. These services include the following:

Certified Educational Personnel which include: Administrator of Special Education, School Education Consultant, School Psychological Service Provider, Vocational Education Evaluator, Speech & Hearing Clinician, School Nurse, Teacher of Students with Disabilities, Teacher – Severe Impairments, Teacher-Hearing Impairments, Teacher – Visual Impairments and Adapted Physical Education.

Licensed Contractors which include persons licensed by appropriate state agencies to provide supportive services to students with disabilities, to include: Audiologists, Interpreter/Translator, Licensed Clinical Professional Counselors, Occupational Therapists and Physical Therapist Assistants, Psychologists, Social Workers, Speech-Language Pathologists, Speech-Language Pathology Aides and Assistants, and Attorneys.

Auxiliary Staff which include those Educational Technicians I, II, and III approved by the Office of Certification and assigned full or part time to provide special education services.

## Office of Substance Abuse Services

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

OSA provides support for residential substance abuse treatment throughout the state and support for individual and family services statewide. Contracted substance abuse counseling and evaluation network services are also provided statewide. In addition, contracted substance abuse services are available in the two juvenileYouth Development Centers, Long Creek located in South Portland and Mountain View located in Charleston. The Office of Substance Abuse Services is involved in Drug Treatment Court programs in Biddeford, Portland, West Bath, Augusta, Waterville, Bangor and Lewiston. This activity is supported by the Juvenile Accountability Incentive Block Grant, administered by the Department of Corrections.

In FY04, OSA provided the following unduplicated services to adolescents in Maine: Evaluations (136); Outpatient (1,365); Intensive Outpatient (187); Residential (119) and Other - shelter/ halfway house (30). **The unduplicated service count totals 1,837**.

**Department of Corrections**

Mental health services are provided to youth served in the Juvenile Justice Division through the Mental Health Program Collaborative. In FY04, case consultation and direct service hours were delivered to youth and DOC staff by Children's Mental Health Program Coordinators and Children's Psychiatric Social Workers.

Four (4) Mental Health Program Coordinators operate in Juvenile Services field offices. These coordinators screen all the correctional caseworker's caseloads to identify youth in need of mental health services. The coordinators also provide "flex funding" for mental health evaluations, treatment and support services. In FY04, the coordinators worked with their DOC counterparts to assist children who needed Intensive Out of Home Treatment Services to receive this service rather than possibly spending time in a locked facility. Other examples of the use of flex dollars included funding for home-based counseling (Muli-Systemic Therapy) for a limited time while families were pursuing MaineCare funding, individual sex-offender counseling with non-MaineCre providers, psychological examinations, transportation assistance, rental assistance and case management services. In FY04 the Mental Health Program Coordinators reported a total of $58,149 expended for these services which were provided to 153 children.

One Mental Health Coordinator is housed at Long Creek Youth Development Center in South Portland. The coordinator works to coordinate mental health services for youth while they are at Long Creek and Mountain View Development Center in Charlston. The coordinator also works to coordinate mental health services for youth leaving these facilities and returning to the community. In FY03 the coordinator helped and consulted on approximately 97 cases in both youth development centers. The coordinator also processed 43 requests for flexible funds totaling $24,800 for mental health evaluations, treatment and support services.

There are two psychiatric social workers that work at Long Creek Youth Development Center. These social workers work exclusively in the detention units. One is assigned in the girl's unit and one is assigned in the boy's unit. These social workers provided 1200 hours of direct clinical contact to approximately 540 detained boys and girls in FY04.

There are 2 psychiatric social workers that are assigned to Mountain View Youth Development Center. These workers provide case management services to male residents committed at the Center. In FY03 case management services were provided to 48 residents.

## CRITERION 2: MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

### Target Population Defined by Chapter 790

Maine's legislation for children's mental health, Chapter 790, defines a "child", for purposes of children's mental health services, as follows:

"Child. 'Child' means a person from birth to 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, 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 Block Grant State Plan.

### Maine Estimates of SED Population

New population estimates of Maine children with Serious Emotional Disturbance were prepared for this State Plan. In all previous Block Grant Applications the methodology used was guided by "Prevalence of Serious Emotional Disturbance in Children and Adolescents" Katz-Leavy, Manderschied and Sondheimer (October, 1997). In prior years the estimate of SED population was derived by using a prevalence rate of 11.0% and then applied to the total number of children and adolescents ages 0-20 years.

For the current Block Grant Application a different methodology to estimate the SED population was employed. Under methodological guidance from the Center for Mental Health Services, the Department's Office of Quality Improvement (OQI) developed the population estimates for children and adolescents with Severe Emotional Disturbance.

The Office of Quality Improvement is the unit that has responsibility for Maine's Data Infrastructure Grant and for developing a wide range of state-specific information, including basic and developmental data tables for both children with SED and adults with Serious Mental Illness. Basic Table 1 of the CMHS 2003 Uniform Reporting System estimates Maine's total population of children with SED at 18,862 for the current reporting year. This estimate includes children and youth ages 0 -17 years, and therefore represents the total population with SED at 6.3% of this population group.

Accordingly, the population with SED was further distributed by OQI among Department's seven defined Local Service Areas as follows:

**CMHS Data Infrastructure Plan**
**Maine Population Estimate for Children Under Age 18 with SED**

| Local Service Area | All Children Ages 0-17 Years | Estimate of SED (6.3% of Population) |
|---|---|---|
| | | |
| Aroostook | 16,720 | 1,047 |
| Northeast | 56,458 | 3,535 |
| Ken-Som | 40,490 | 2,535 |
| Coastal | 34,336 | 2,150 |
| Western | 44,999 | 2,818 |
| Cumberland | 61,962 | 3,880 |
| York | 46,273 | 2,897 |
| | | |
| **STATE TOTAL** | **301,238** | **18,862** |

## Children Receiving Publicly Funded Services

Children's Services accounts for the number of children served using departmental funds by three primary sources: (1) Year End Contract reports submitted to the Office of Quality Improvement by provider agencies; (2) information from internal accounting systems capturing services provided on a per diem basis (non-contract) for children served in residential treatment programs - known as Intensive Temporary Out of Home Treatment Services; (3) MaineCare only funded programs that provide In-home Supports for children who have emotional/ behavioral needs. Contract Services are listed below for FY04, using information reported to OQI from 4$^{th}$ Quarter Performance Indicator reports. MaineCare counts for services billed and paid in FY04 cover unduplicated services provided to children for Behavioral Health Services and Habilitation Services In-home Supports. Intensive Temporary Out of Home Treatment Services account for residential placements paid for through the Room & Board account processed by MaineCare.

## Children's Services
## Children Served, by Program Type
## Under Community Provider Contract FY04

| Type of Service | #Served | Type of Service | #Served |
|---|---|---|---|
| Case Management | 7,171 | Outpatient | 13,330 |
| Crisis Services | 5,838 | Medication Management | 5,067 |
| Early Intervention (0-5) | 1,033 | Parent Self-Help/Support | 1,052 |
| Assertive Community Treat. | 167 | Sibling/Peer Support | 541 |
| Family Mediation | 419 | Information & Referral | n.a* |
| Homebased Family Services | 1,338 | Respite | 2,228 |
| Homeless Services | 1,485 | Therapeutic Recreation | 1,745 |
| Child/Family Community Support | 3,941 | Wraparound/Flexible Services | 2,170 |

*Not reported due to inability to correct for duplication

**Total, Contract Services 47,525**

## MaineCare, Seed Only Contracts, In-Home Supports FY04

| Type of Service | # Served | Type of Service | #Served |
|---|---|---|---|
| Section 65, Children's Behavioral Health Services (Behavior Specialist I) | 1,791 | Section 24 Habilitation Services In-Home Supports | 823 |

**Total, In-Home Supports 2,614**

## Residential – Intensive Temporary Out of Home Treatment Services FY04

| Type of Service | #Served |
|---|---|
| PNMI Room & Board/ Non-Treatment Component | 365 |

**Total, Residential R&B 365**

## TOTAL SERVICES PROVIDED to CHILDREN - FY04 - 50,504

**Estimation of Unduplicated Count of Children Served**

Individual service categories reported above provide an unduplicated count of all children who received that service during FY04. However, when a series of individual service categories are added together, the total represents the number of services delivered to children, and not an unduplicated count of all children served because children are likely to receive multiple services.

Children's Services has employed a planning assumption that children and families in Maine receive an average of 2.5 different types of service over a year. Based on that assumption, then **it is estimated that the unduplicated count of children served was 20,201 in FY04**.

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

**Rather, Chapter 790 focuses on the mental health needs of children who are served by all child-serving departments, introduces the principle that there should be a system in place that addresses these needs, and designates DHHS to be responsible for coordinating that system.** The major sections of the law include:

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

### Section 15002: Children's Mental Health Program.

This program represents the structure that will coordinate children's mental health care provided by all child serving departments. The program is now under the supervision of the Commissioner of DHHS. The Children's Services Director has responsibility for the implementation, monitoring and oversight of the program.

This program will track the mental health care and services of all child serving departments, as well as the development of new resources and funds used to provide mental health services from each department's budget. This includes pooled funds that are blended with those of other departments. The program does not diminish any entitlements already in place that are the responsibility of the various departments by virtue of state or federal law, rule or regulation.

Fundamental values endorsed by the LD 1744 planning process are made explicit for all children and families. They include a child and family centered program and planning process, focusing on child and family strengths as the starting point for an individualized plan of services. There is paramount consideration given for the safety of the child, followed by mental health, emotional, social educational and physical needs that are to be addressed in the least restrictive, most normative environment.

Principles of care delivery stress local service provision, prevention and early intervention services, and choice of care through a case management system. The program must implement uniform intake and assessment protocols and identify a central location for obtaining information and access to the program. The system of providing care must be a functionally integrated, network based system, with Children's Behavioral Health Services as the single point of accountability.

**Section 15003: Responsibilities of the Departments**

Each department has entered into memoranda of agreement that recognizes DHHS as responsible for the implementation and operation of the Children's Mental Health Program, and specifies the other department's respective responsibilities.

DHHS Children's 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 need and the need for increased service capacity. The law instructs DHHS to adopt rules for mental health care to 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. Federal block grant monies are to be used for children who are not eligible for Medicaid. General funds will be used to maximize the use of federal funds, including Title IV-E and other federal funds for care of children living at home and in residential placements.

Management information systems must focus on care and support services delivered, needs and unmet needs for care, waiting lists, resource development and costs of the program. Information is to be kept by treatment need, region, care provided and department involvement. Information will cover children placed out of state who transfer to care in the state of Maine. Both internal and external evaluation processes of the program's effectiveness are required.

The law places considerable emphasis on regular reporting on the Children's Mental Health Program to an Oversight Committee and to the legislature's Joint Standing Committee on Health and Human Services. Reports are generated by the departments on a regular basis at the direction of the committee. The committee reports annually in October to the Maine Legislature on progress toward developing the system of care. Due to the resignation of the legislative chair of the committee in November and absence of legislative reappointments for this position and several other membership slots, the committee has been inactive since that time. The Department expects that a newly reappointed Oversight Committee will be reconstituted when the 122 Legislature convenes in December, 2004.

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

BDS, 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 mental retardation. In designing the service system, the department utilized the

framework of the Children's Mental Health Program. Children's Services has fully integrated children with autism and mental retardation into the system of services developed for children with mental health needs. Community case management and crisis services are examples of this integration. BDS received an allocation of funding to RFP augmented crisis services for children with autism or mental retardation. The agency awarded with the contract will conduct training and consultation to the crisis services providers. Consultation will also be provided to community treatment teams to assist with creating individualized crisis plans.

## Interdepartmental Collaboration

Chapter 790, beginning with Memoranda of Agreement linking Children's Services and each of the 3 child-serving state agencies, has promoted a high level of interdepartmental collaboration over the past 3 years. These collaborative efforts are summarized as follows:

*Note: Because these partnerships began prior to the merger of the Department of Behavioral and Developmental Services (BDS) and the Department of Human Services (DHS), the original Departments are cited in the discussion below*

### BDS Data Partnership with MaineCare (Medicaid)

In July, 2000, the Systems Infrastructure Development Initiative (SIDI) of BDS partnered with DHS, Bureau of Medical Services, in an effort to rebuild and enhance the Medicaid Claims Management System and adding a high-end financial application to assist with managing accounts and budgeting. The Department was included as a partner in this effort in recognition that BDS provides substantial funding for the State share of the federal Medicaid program. The project has significant positive impacts for the Department and the provider community from whom services are contracted and delivered to adults and children. The partnership adds a capacity to submit and track claims and reports of service encounters.

BDS, with DOE and DHS, continue to meet with BMS, MaineCare, on a regular basis. This collaborative process has been in place for the last 6 years and whose main purpose is to coordinate efforts pertaining to policy coordination and implementation. Issues and concerns from the field (local or regional level) and any new initiatives are discussed in this group. Information from these meetings is shared with regional staff. Regional provider meetings are held regularly to inform and clarify issues pertaining to MaineCare Services contracted through BDS.

### Department of Human Services/BDS

Both departments have worked closely on a number of initiatives. Children's Services and the Bureau of Medical Services (MaineCare), in accordance with their Memoranda of Agreement, jointly share responsibility for the development of policies for behavioral health care for children and adolescents. Once developed, these policies are formally promulgated by BMS, the state Medicaid authority. Meetings with providers following the release of a MaineCare policy change also include representatives from the Department of Education and Department of Corrections. Providers have indicated they find these meetings to be very helpful, which is both indicative of and reflects the excellent working relationships between the state agencies.

In the past two years significant changes have been made or are presently undergoing formal rulemaking that directly impact the children's system of care. Representative provider agencies participate in the process for proposed changes to MaincCare policies. These Medicaid policy areas include: Targeted Case Management, Homebased Mental Health Services, In-Home Behavioral Supports and Child and Family Community Supports. Both departments have worked cooperatively on MaineCare Targeted Case Management Services provided to children served by BDS.

The Bureau of Child and Family Services provides Child Welfare Services, tracks and monitors children in custody placed out of state, and provides case management services for children in protective cases at the local level. Both agencies have worked successfully to demonstrate the value of a clinical case management pilot, which is a positive outgrowth of the Memoranda of Agreement between the two agencies. The purpose of the pilot is to provide mental health clinical case management services to state wards. These services are provided by 2 MSW mental health staff who are co-located in regional DHS offices in Southern Maine.

**Interdepartmental MOU for Assisting Children At Risk**

The goal of this protocol is to establish a clear framework and process for meeting the behavioral health needs of children effectively and efficiently. This approach is one of collaborative and joint problem solving. The primary focus is to include and support parents in their efforts to continue nurturing their child and participating in their child's treatment in and out of the child's home. BDS and DHS expect all providers to have active family involvement components in their treatment programs and to encourage families to continue to actively participate in all aspects of their child's care and treatment in order to expedite the child's successful transition to their home and community. This protocol was signed in December, 2003.

**Interdepartmental MOU for Assisting Children At Risk -Post Adoption Addendum**

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

This agreement provides for information sharing between DHS Bureau of Child and Family Services Adoption Program (DHS) and the Department of Behavioral & Developmental Services-Children's Services (BDS), regarding children receiving adoption assistance who also access BDS grant funds for out-of-home treatment. Both Departments will facilitate coordination of resources to maximize utilization of appropriate funding & prevent duplication.

Adoptive parents applying for BDS's Intensive Temporary Out of Home Treatment Services will be informed of DHS & BDS coordination regarding children receiving Adoption Assistance through DHS. Families receiving post-adoption assistance, who have children with special needs, will be encouraged by BDS and its contracted providers to access appropriate services available through the DHS Post-Adoption Support program. Families receiving post-adoption assistance, who have children with special needs, will be encouraged by DHS Post-Adoption Support program to access assistance available through BDS and its contracted providers. BDS and DHS recognize there is a shared responsibility to provide adoptive families the most appropriate services that are supportive of their children's needs in a continuum of community-based services.

This amendment was finalized in June, 2004. In addition BDS and DHS Adoption Services are finalizing plans for statewide cross training activities for therapeutic foster care providers, BDS contracted community case management providers and BDS and DHS staff.

**Department of Corrections, Juvenile Services/BDS**

Over the past four years, Children's Services has, in collaboration with the Department of Corrections, been developing a mental health program for adolescents placed at former Maine Youth Center, now called the Long Creek Youth Development Center. New Children's Services mental health resources were committed to the Mountain View Youth Development Center in Northern Maine beginning in April, 2002. In addition to the facility based programs, Children's Services has placed Mental Health Program Coordinators (LCSW's) in each of the 4 regional Juvenile Services offices of the Department of Corrections. These staff consult with Juvenile Community Corrections Officers in their regional offices to assist in developing case plans and accessing appropriate mental health services. A primary goal of this collaboration is to divert potential future involvement with the juvenile justice system, and specifically new admissions to youth correctional facilities. Statistics on mental health services delivered within the Juvenile Services system are cited in Criterion 1 of this Application.

**Interdepartmental Protocol Concerning Title 15 Referrals to The Department of Human Services**

The purpose of this protocol is to establish a framework and process for meeting the needs of youth/children involved with the Department of Corrections (DOC) for whom remaining in their homes is contrary to their welfare or safety and may require Department of Human Services (DHS) custody. Because all departments [DOC, DHS, and Behavioral and Developmental Services (BDS)] recognize that there are consequences to removing children from their parents' custody, emphasis will be placed on making all reasonable efforts to secure alternative options before consideration of state custody. This agreement was effective in December, 2002.

**Department of Education/BDS**

Children's Services regularly participates with staff from the state Department of Education on a wide variety of policy level issues as well as specific operational initiatives. Included among these activities are Interdepartmental Resource Development Planning to identify priority needs for all children, to include new or enhanced program models, and an Out of State Facilities Review Group, which conduct a review of all children in out of state facilities for behavioral health care and treatment. DOE is a frequent collaborator with the other child serving state agencies, either as a participant or advisor to new initiatives which involve multiple agencies, such as the Systems Access program. BDS and the Department of Education recently concluded a new Memorandum of Agreement, as called for under Chapter 790.

**MADSEC/BDS Liaison Committee**

In an effort to support and implement the MOA with DOE (signed July 2002), a liaison committee was established in November of 2002 with statewide representation of the Maine Administrators of Special Education Services (MADSEC) and the Department of Behavioral and Developmental Services, Children's Services (BDS). The liaison Committee meets monthly and its primary focus is to enhance the communication and coordination among schools, BDS

contracted community case management provider agencies, and departmental staff on the local, regional, and state levels.

Major collaborative activities include cross training on the Wraparound Planning/Strengths Based model for service delivery, presentations on children's mental health and behavioral health systems of care at the annual Special Education Director's forum, and participation on regionally based special education director's meetings.

Currently, the Liaison Committee is finalizing a Cooperative training Grant through DOE to provide training modules on the respective departments/agencies legal mandates, statutes, and requirements, including information on the type, range, and access of services available. The training grant will be delivered via a train-the-trainer curriculum which will also include parents as presenters/trainers. The grant will be fully implemented by the end of the 2005 school year.

## Transitional Services for Adolescents and Young Adults

In October 2002 an interdepartmental protocol for the coordination and transition of children served by DHS and BDS was completed. This protocol covers youth with identified diagnoses of mental illness, youth with mental retardation and youth who are in need of adult protective services who will transition from youth services to adult services. This protocol also covers youth served by both DHS and BDS children's services systems.

The Department of Behavioral and Developmental Services (BDS)*[1] and the Department of Human Services, Bureau of Child and Family Services (BCFS) and Bureau of Elder and Adult Services (BEAS) are often serving people who are receiving supports from both agencies or who require a close collaborative working relationship to plan services for people leaving the BCFS children's service system and entering the BDS or BEAS adult service system.

In the first instance this refers to children who are in the care and custody of DHS but who also need services or supports offered through BDS Children's Services system. In the latter instance this refers to young people who are between the ages of 18 and 21 and in the care and custody of DHS and who require services from the adult system of BDS or BEAS.

Both Departments are committed to providing a close collaborative working environment in order to plan and work together and share common expertise to support children and youth who are consumers of State services. In setting forth this Protocol, the Departments reaffirm their commitment to providing the best services and supports possible by building on the strengths of their mutual work. This is a major challenge that will require attention in the coming year.

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

## Mental Retardation Services Transition

Strategies that were initiated in FY02 included work with BDS Adult Mental Retardation Services. These discussions resulted in agreement on a number of points. Youth should have

[1] BDS refers to Children's Services, Adult Mental Health Services and Mental Retardation Services.

flexibility in choosing which system to receive service from between the ages of 18 and 21 years. Information sharing between children and adult systems for planning purposes will begin at age 16. Adult services will provide advisory eligibility for young people so that planning can be done understanding the adult services that the young person is eligible for. There will be a collaborative financial planning process when development of resources for children will impact the adult services system. Training in the adult mental retardation services has been delivered for all children's services contracted case managers in all regions. Regional staff are meeting regularly to discuss planning efforts and on going collaboration. Finally, protocols for information sharing and resource development have been developed and agreed upon.

## The Children's Cabinet

The Children's Cabinet was established in 1995 to oversee and coordinate the delivery of services to children in Maine. The Children's Cabinet is composed of the departments directly related to children and families: Corrections, Education, Human Services, Behavioral and Developmental Services, Public Safety, and Labor.

The vision of the Children's Cabinet is that children's needs are best met within the context of relationships in the family and community,

The mission of the Children's Cabinet is to actively collaborate to create and promote coordinated policies and service delivery systems that support children, families and communities. The Children's Cabinet is chaired by the First Lady.

Children's Services is an active participant in the bi-weekly meetings of the Children's Cabinet Senior Staff. This group consists of designees of the Commissioners that serve on the Children's Cabinet. The Senior Staff focus on the operational aspects of the children's overall system of care. This is a forum that is a vehicle to promote interdepartmental coordination.

## Regional Cabinets and Local Case Resolution Committees

In 1996, the administration created Regional Children's Cabinets, mirroring the composition of membership at the state level. Regional Children's Cabinets are the vehicle through which the initiatives from the Children's Cabinet flow, and are managed and overseen at the local level. The Communities for Children is an initiative developed by the Children's Cabinet to support community determined priorities and community leadership that involve 72 sites in the State of Maine.

Local Case Resolution Committees (LCRC) originated through a CMHS Infrastructure Project, "Family Partnerships", beginning in 1993. These committees are comprised of local parents, service providers, professionals and other community based caregivers. The purpose of the LCRC is to review and, where possible, resolve issues of treatment, services and community supports that impact on complex cases that are interdepartmental in nature. The "review" function changed to "resolution" after each committee was given access to pooled, flexible funds. In FY04 there were 16 active LCRC'S statewide. The function of the Children's Regional Cabinet as it relates the LCRC is to coordinate, support and monitor the work of LCRC's, and to allocate flexible state funds to fill small service gaps when that is the only barrier to case resolution.

## CRITERION 4: TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

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

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

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

**PATH GRANTS SUPPORTING HOMELESS YOUTH FY04**

| Region | Area Served | Agency | #Served | Funding |
|---|---|---|---|---|
| Region I | York County | Sweetser Childrens Services | 95 | $36,500 |
| Region II | Waldo/Knox Counties<br>Lewiston/Auburn Areas | Home Counselors<br>New Beginnings | 69<br>155 | $36,500<br>$36,500 |
| Region III | Bangor area<br>Statewide Provider Training | Shaw House/Streetlight<br>Home Counselors | 542<br>na | $ 36,500<br>$ 4,000 |
| PATH Homeless Youth Totals | | | 861 | $150,000 |

**Expansion of Services to Homeless Youth**

In the spring of 1998, the Department issued Requests for Proposals for Mental Health & Support Services for Homeless Youth. New state funding combined with existing PATH dollars was made available for expanded services totaling $588,020 for FY99, thereby increasing financial support for homeless youth by nearly 300% in a single year.

The expansion funding for homeless services has allowed Maine to move from a single agency, outreach/case management model (PATH) to more creative, collaborative approaches to serve homeless youth. The addition of new funding levels are now able to support more than a single staff person.

| PROGRAMS SERVING HOMELESS YOUTH FY04 | | | |
|---|---|---|---|
| **Agency** | **Service Area Focus** | **Est.#'s Served** | **FY04 Funding** |
| YWCA of Portland | Cumberland County | 168 | $134,760 |
| Preble Street Resource Center | Cumberland County | 50 | $140,000 |
| Total Region I | | 218 | $274,760 |
| | | | |
| New Beginnings | Androscogin County | 9 | $36,500 |
| Home Counselors | Knox, Waldo and Lincoln County | Total all | |
| New Beginnings | Androscoggin and Franklin County | youth | |
| Youth & Family Services | Somerset and Kennebec County | Consort-ium | |
| Rumford Group Home | Oxford County | 180 | $268,000 |
| | | | |
| Total Region II | | 189 | $304,500 |
| | | | |
| Shaw House | Bangor area | 129 | $ 78,146 |
| Penquis Community Action Program | Penobscot, Piscataquis, Hancock and Washington County | 88 | $ 46,642 |
| | | | |
| Total Region III | | 217 | $ 124,788 |
| | | | |
| **STATEWIDE TOTALS, HOMELESS YOUTH SERVICES** | | 624 | $704,048 |

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

**Expansion of Services in FY01-FY03**

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

In FY03 the Preble Street Resource Center expanded its operations to include additional evening and weekend hours, as well as vocational services offered in the collaborative. The Homeless Youth Employment Project provides and promotes employment and education services. The Earn to Learn demonstration project provides 1 to 1 instruction in the areas of job expectations, job placement and on site support. In FY04 the program served 168 youth.

The YWCA of Portland provides outpatient mental health treatment for homeless youth. The agency also provides mental heath community support services through case management and supportive counseling. In FY04 the program served 50 youth.

A consortium of 4 agencies in central Maine provide outreach services throughout the region. These services are similar to the PATH model. In order to increase the prospects for family unification the model also focuses on early identification of youth who have left home. The consortium which includes Home Counselors, New Beginnings, Rumford Group Homes and Youth & Family Services served a total of 189 youth in FY04.

The Shaw House funding supports a Rapid Response approach in redesigning service delivery to homeless youth. The program focuses on youth, ages 10-17, who find themselves homeless for the first time. The objective is to identify this population and to deliver intensive outreach and case management services, outside of typical shelter services, which may result in reunification with the parent, family or relative. Rapid response relies on finding and delivering supports and services in the youth's community of origin. In this model, natural supports are an important ingredient for success. Shaw House participates in a HUD project through Acadia Hospital which provides evaluation and diagnostic services to homeless children via the Shaw House outreach services. In FY04 Shaw House programs served 129 youth.

The Penquis Community Action Program provides alternative dispute resolution and family mediation services to children and youth at risk of becoming homeless or for reunification with the family when the youth is homeless. Mediation was provided to 88 youth and their families in FY04.

**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 1,274,923** according to the **Year 2000 United States Census**, and the distribution pattern of the population within the geographic area. Given these conditions, for purposes of planning the term "rural" means any area of Maine not identified by the United States Census Bureau to be a Standard Metropolitan Area (SMA).

Maine has three SMA's within its border. Maine's SMA populations are centered in the Cities of Portland, Bangor and Lewiston-Auburn. The **Portland SMA totals 243,537**, the **Bangor SMA totals 90,864,** and the **Lewiston Auburn SMA totals 90,830**, for a grand total of **425,231 population, or 33.4% of the total Maine population**.

The areas of Maine located outside the three SMA's are clearly rural. **The population living outside Maine's SMA's totals 849,602, or 66.6% of the population**. A closer examination of the towns that comprise SMA's shows a respectable number of towns and villages that are rural in nature. When everyday standards of "rural" or "urban" are applied to the census data for SMA and Non-SMA, most Maine people would agree that the SMA total over represents Maine's non-rural population.

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

**Overcoming Rural Barriers**

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

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

In 2004, thirty-two (32) case management agencies were serving children and families, compared with six (6) community agencies and five (5) Children's Services regional offices providing those services in 1998. Many previously unserved areas in Maine, particularly smaller rural population centers, now have accessible case management services, due to service expansion and the location of case management personnel in rural areas. In the two year period between FY02 and FY04, Medicaid Targeted Case Management services increased by 2,026 children.

In-home behavioral support services were nearly nonexistent in 1998, and were provided primarily by individuals chosen by the family to do "one-to-one" supports for a limited number of hours, paid for through limited flexible funds. In 2004, twenty-nine (29) locally based agencies are delivering behavioral specialist services through trained and certified personnel, delivering these services in the family's home. Additional children are served under a separate in-home support program available under MaineCare Free Standing Day Habilitation. In FY04 thirty-six (36) agencies were providing Habilitation Services in the family's home. In FY04 these programs combined served 2,614 children. In-home supports represent the essence of addressing the rural problem, since the service comes to the child and family, in their own home and own community.

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## CRITERION 5: MANAGEMENT SYSTEMS

### Intended Use of CMHS Block Grant Funds

In accordance with the scope and requirements of PL 102-321 and Maine's Block Grant Children's Mental Health Services Comprehensive Plan, CMHS Block Grant funds are requested for community mental 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 Requests for Proposals for new services and awarding contracts for services which are funded in part through the Block Grant. Children's Services Program issues contracts with specifications for all services, including conformance with all PHS Act requirements and applicable service conditions of the CMHS Block Grant. Regional Children's Services personnel monitor contracts through quarterly and year end fiscal and narrative reports from service providers, as well as regularly scheduled face to face meetings with providers.

Program reports are reviewed and become part of the annual contract application and approval process. All programs are required to provide consumer satisfaction information. Licensing site visits are conducted and agencies have internal quality assurance systems per licensing standards. Beginning in FY00, all contractors report information on Performance Indicators and Performance Outcomes which apply to the services for which they receive funds. Selected Performance Indicators have been chosen for inclusion in the FY05 Block Grant Application.

### Maintenance of State Effort

As a condition of receiving federal CMHS Mental Health Block Grant funds, the State of Maine must demonstrate maintenance of effort by documenting that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the 2 year period preceding the fiscal year in which the State is applying for the grant. Support shall be documented by the actual dollar expenditures committed for services, which in this instance mean state general funds expended for the Children's Services unit of the Department of Health & Human Services. This information is presented in the table below:

**State General Fund Expenditures for State Fiscal Years 2002-2004**

| | SFY02 | SFY03 | Ave SFY02+03 | SFY04 |
|---|---|---|---|---|
| Children's Services | $38,886,788 | $42,823,944 | 40,855,391 | $47,977,218 |

The average of state fund expenditures for Children's Services in FY02-03 is $40,855,391. Expenditures for FY04 are $47,977,218 and exceed the two year average. **Children's Services expenditures therefore meet the criterion for Maintenance of Effort**.

Maine dedicates one-half (50%) of its Center for Mental Health Services Block Grant to address the needs of children who have serious emotional disturbance and their families. The allocation of FY05 Children's Services Block Grant funds, including unallocated FY04 funds are shown below.

**CHILDREN'S MENTAL HEALTH BLOCK GRANT FY05**
**Distribution by Region/Service Type**

| Agency | Service Funded | Amount | Estimated # Total Served |
|---|---|---|---|
| **REGION I** | | | |
| Youth Alternatives | Family Mediation | 10,938 | 200 |
| Outright | Peer Support | 33,000 | 600 |
| S. Maine Parent Awareness | Information & Referral | 44,000 | N/A* |
| Community Counseling | Targeted Case Management | 100,000 | 38 |
| Counseling Services, Inc | Crisis Services | 100,000 | 211 |
| Sweetser | Crisis Services | 100,000 | 200 |
| | | **387,938** | **1,249** |
| **REGION II** | | | |
| Child Health Center | Family Support | 10,705 | 20 |
| Crisis & Counseling | Family Support | 202,000 | 1,055 |
| Mid Coast MH Services | Outpatient & Medication | 25,000 | 195 |
| Sweetser | Outpatient & Medication | 127,200 | 560 |
| Tri-County MH Services | Outpatient | 41,950 | 315 |
| Maine Parent Federation | Information & Referral | 31,900 | N/A* |
| NAMI Maine | Information & Referral | 18,500 | N/A* |
| | | **457,255** | **2,145** |
| | | | |
| **Region III** | | | |
| Eastern Maine Testing & Counseling | Training | 14,365 | 135 |
| Comm. Health & Counseling | Outpatient & Medication | 45,677 | 1,100 |
| Comm. Health & Counseling | Crisis Services | 161,926 | 368 |
| Helping Hands | Information & Referral | 45,604 | N/A* |
| Aroostook MH Center | Outpatient | 41,416 | 475 |
| **Region III Total** | | **308,988** | **2,078** |
| | | | |
| **Total Funds Allocated** | | **1,154,181** | **5,472** |
| FY05 Allocation | | 882,202 | |
| Prior Year Available | | 356,435 | |
| Total Available | | 1,238,637 | |
| Total Unallocated as of 8/04 | | **84,456** | |

* Not subject to estimation due to extensive duplication.

The Department's FY05 budget for Children's Services from all sources totals $ 48,282,459. **The Block Grant funding available for children's mental health services in FY05 is $1,238,637 and represents 2.6 % of the Department's funds for this fiscal year.**

The ongoing FY05 Block Grant distribution among specific contracts are made at the central office level, using rationale that allocate federal funds for services that are not "matchable" to draw down federal Medicaid dollars. A second consideration in the allocation process is to identify programs that serve children and their families that are not covered by MaineCare and those which provide services to children who are not eligible for MaineCare funding.

## Limitations for Expenditure of Block Grant Funds

Distribution of FY05 CMHS Mental Health Block Grant funds are consistent with the Block Grant Agreement, Section 1916 (a). in that the State of Maine agrees that it will not expend the grant to provide inpatient services, make cash payments to recipients of health services, purchase land, facilities or major medical equipment or assist any entity other than a public or nonprofit public entity.

Recent Maine law, Chapter 790, offers further guidance on the distribution of these federal funds. Section 15003.5.C. states that "(all child serving) departments shall shift children's block grant funding toward the development of a community-based mental health system that includes developing additional community-based services and providing care and services for children who are not eligible for services under the Medicaid program. The departments shall maximize the use of federal funding, the Medicaid program and health coverage for children under the (Children's Health Insurance Program)."

## Strategies for Investment of Block Grant Funds

The Department fully endorses future Block Grant strategies for investment that are consistent with the resource development priorities contained in the Plan for Children's Mental Health Services, which is a stakeholder driven plan for developing a community-based children's mental health system, and by Maine legislation, Chapter 790, both of which were shaped with substantial parent and family input. In this context, the Department supports the following strategies for investment of block grant funds:

1. Use block grant funds within the parameters established under Chapter 790. Funding should be directed for services to children and families who are not eligible for MaineCare services.

2. Within the parameters of Chapter 790, use block grant funds to supplement services provided with state general funds, where the demand for service surpasses the current capacity to meet established needs. This strategy would identify current service areas that are of established high priority, and for which children and families are not being served, or are underserved, as shown by waiting lists for service or other documented sources of information. An example of this strategy was the allocation of block grant dollars in FY01 and in FY03 to address respite service needs for families on waiting lists.

3. Secure input from the State QIC Children's Committee with regard to service areas that are seen as a priority and should be considered for purposes of block grant investment. In FY02 the committee recommended family support and children's transition services as priority services, using block grant carry over funds. In addition to the family support initiatives noted above, these funds were also dedicated for implementing regional family support planning and to supplement respite care services in southern and central Maine.

As FY03 progressed, Maine was experiencing a budget shortfall common to many other states in the nation. In order to offset deficits caused by decreasing revenues, the Department was required to reduce general fund expenditures through a selective deappropriation of grant dollars. The Department utilized unobligated block grant funds to restore level funding for all family support programs affected by these reductions.

In April 2003, the Department briefed the state QIC on the budget situation facing Children's Services for FY04. The Department recommended that the Mental Health Block Grant funds available for FY04 be allocated to family support activities encompassing parent and adolescent support groups and family information and referral services in order to preserve these services, consistent with optimal usage of non-matchable federal dollars and consistent with the priorities established by the Children's sub-committee over the previous three years.

Block Grant funding for the family support activities noted above are continued in the FY05 allocation. These services total $396,647 and represent one-third (32.0%) of the available Block Grant funding for the current fiscal year.

**Training for Providers of Mental Health Services**

Children's Services is actively engaged in training for contract providers of children's services. This training is conducted by Children's Services staff with the assistance of the Office of Quality Improvement (Assessment Training), by consultants where there is an identified need (Wraparound Training for Case Managers, Training for Children's Behavioral Health Services (BS1) and Home Based Services for Children with Mental Retardation or Autism). Service providers also offer training for their staff that is supported as a cost in determining their service rate. Specific examples of training that has been initiated over the past 3 years and continues on a regular basis include:

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

- Use of Assessment tools (CAFAS, CALOCUS, Family Empowerment Scale and CHAT) for school age children and youth, delivered to all case management providers and all crisis services providers.

- Use of Assessment tools (AIMS and Ages & Stages Questionnaire) for the early childhood population (ages 0-5) delivered to case management agencies serving this group.

- Annual Crisis Services Conference, which in FY03 highlighted children with mental retardation and autism.

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

- Training for Department of Corrections staff on mental health in the juvenile justice system for youth.

- Ongoing training for providers of In-home Behavioral Support Services and Habilitation Services through the Behavioral Health Sciences Institute.

- Training children's case management service providers regarding transition to adult mental retardation services.

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

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

**Specific Training of Providers of Emergency Mental Health Services**

Emergency mental health services for children and youth with emotional or behavioral needs are provided primarily through contracts with a statewide system of crisis services providers. Crisis services programs offer integrated services for both adult and child populations. Crisis response personnel must meet Mental Health Rehabilitation Technician (MHRT) certification requirements in order to be approved as "other qualified mental health professionals" under MaineCare rules which is a condition for reimbursement.

MHRT certification requires emergency services (crisis) staff to receive training and to demonstrate knowledge of competencies deemed necessary to provide quality crisis response, intervention and stabilization services. Training geared to demonstrating core competencies include:

- Helping Theories and Techniques – covering a knowledge base focusing on Psychosocial Rehabilitation, Recovery and Empowerment

- Policy Knowledge – understanding Maine's laws regarding mental health recipient's rights, the Americans with Disabilities Act and benefit and entitlement programs.

- Medical Aspects Related to Mental Illness – knowledge of etiology, progression and treatment of major disabling conditions, understanding of interaction of co-occurring medical issues, consumer risk factors (e.g. suicide) and role of medications in symptom management.

- Diversity – cross cultural awareness and sensitivity, gender differences and differing sexual orientations, changing treatment needs for stages of transition, effective communication across cultures.

- Community Resources – understanding basic social service resources and entitlements, knowledge of community provider system, generic community resources including available natural supports.

- Professional competence - ethics and practices in a professional manner, contributing member of an interdisciplinary team, confidentiality, evaluating effectiveness of personal practice, use of supervision, interaction with community members and professionals, strategies that empower consumers.

**Department of Health & Human Services**
**FY05 Children's Behavioral Health Services Funding**

**Community Services**

| Services | General Fund | MaineCare Seed * | Block Grant MH Federal | PATH Federal | Total |
|---|---|---|---|---|---|
| | | | | | |
| Crisis | 2,316,956 | 1,217,225 | 361,926 | | 3,896,107 |
| Community Support | 0 | 4,363,521 | | | 4,363,521 |
| Case Management | 409,897 | 5,772,669 | | | 6,182,566 |
| Habilitation Services – In-Home Supports (Sec. 24) | | 5,319,237 | | | 5,319,237 |
| Day Treatment | | 183,354 | | | 183,354 |
| Family support – self help | | | 245,705 | | 245,705 |
| Home-Based Family Services | 220,625 | 5,612,782 | | | 5,833,407 |
| Behavioral Health In-Home Supports (Sec. 65) | | 4,579,232 | | | 4,579,232 |
| Outpatient Services | 1,257,395 | 959,913 | 381,243 | | 2,598,551 |
| Residential Services | 0 | 1,435,119 | | | 1,435,119 |
| Homeless | 557,000 | | | 150,000 | 707,000 |
| Early Intervention | 725,000 | | | | 725,000 |
| Room and Board | 3,115,793 | | | | 3,115,793 |
| Flexible Funds | 2,188,732 | | | | 2,188,732 |
| Respite | 705,531 | | | | 705,531 |
| Mediation | 220,000 | | 10,938 | | 230,938 |
| Training/Overhead/Other | 132,995 | 323,464 | 14,365 | | 470,824 |
| Prior Auth/Util Rev. contract | 125,000 | | | | 125,000 |
| Information & Referral | | | 140,004 | | 140,004 |
| **Total** | **11,974,924** | **29,766,516** | **1,154,181** | **150,000** | **43,045,621** |

*** Note** - The State General Fund seed is provided as matching funds that enable agencies to receive Federal Medicaid funds of approximately **$55,696,775**.

## Goals, Targets and Action Plans: Children's Services

### Performance Indicators

This section presents 7 Maine specific performance indicators for Children's Services that are useful for tracking improvements in the public mental health system, in addition to 3 Core Performance Indicators that are required by CMHS for the FY05 Block Grant Application/Plan.

The Performance Indicators are presented in the order of the plan's 5 Criteria that are applicable to children. Each Performance Indicator identifies the goal, the measures used to construct the indicator, the sources of information from which the indicator is derived and the significance of the indicator as regards improvement in the children's system of care.

**Administrative Targets and Action Plan.**

Following the presentation of each specific Performance Indicator, a bulleted summary outlines the approach that the Department and Children's Services are committed to address within the scope of that Criterion. These summaries include administrative actions that are planned to improve the quality and scope of the children's system of care, to expand access to children's behavioral health services, to coordinate, collaborate and integrate services with other state and local agencies, to address services to rural populations and homeless youth, and to maintain the State's level of financial commitment that is necessary to meet the federal requirements to continue to participate in the CMHS Block Grant program.

The administrative action plan summary identifies strategies and activities that appear in previous sections throughout this application. For example, administrative targets and action include, but are not limited to, specific Children's Services priorities for FY05 that are detailed in Part C, Section II of the application. These priorities represent the key administrative goals, targets and actions by which the FY05 Implementation Plan will be evaluated.

## CRITERION 1: Comprehensive Community Based Mental Health Services Systems

### Goal 1: Maintain or Expand Access to Crisis Services to Reduce Hospitalization.

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Target |
| Performance Indicator | 24.9% | <24.96% | 24.3% | <24.3% |
| Numerator | 1,437 | | 1,476 | |
| Denominator | 5,757 | | 6,073 | |

Performance Indicator: Percentage of face to face crisis outreach contacts resulting in a psychiatric hospitalization
Measure: Percent of children/youth hospitalized as a result of crisis intervention
Numerator: Number of children/youth crisis contacts resulting in hospitalization

Denominator: Total number of crisis face to face contacts in FY
Source of Information: Agency/Program Quarterly Performance Data (OQI)
Significance: Intervention by trained crisis workers who are aware of available community alternatives when a child is experiencing crisis, will decrease the potential for unnecessary hospitalization. The data show that in this scenario, disposition to hospitals decreased in the past year.

**Goal 2: Decrease Out-of-Home Placements**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 06.9% | <06.9% | 05.2% | <05.2% |
| Numerator | 440 | | 365 | |
| Denominator | 6,368 | | 7,010 | |

Performance Indicator: Percentage of children/youth enrolled in case management services placed out of home in the fiscal year
Numerator: Number of children/youth placed out of home in FY
Denominator: Total number of children enrolled in case management services
Source of Information: MMDSS data – case management unduplicated in FY
MFASIS data - number of children placed out of home based on payment from the Residential Treatment Room & Board account
Significance: Access to case management services will reduce the potential for out of home placement. The data show a decrease in out of home placement in the past year.

**Goal 3: Maintain the Appropriateness and Quality of Services Delivered**

| (1) | (2) | (3) | (4) | (50 |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 77.5% | >77.5% | 78.1% | >78.1% |
| Numerator | 293 | | 460 | |
| Denominator | 378 | | 589 | |

Indicator: Client Perception of Care (**PPG CORE Performance Indicator)**
Measure: Percentage of children/families who report satisfaction with services
Numerator: Number of children/families who report satisfaction with services
Denominator: Total number of children/families responding to satisfaction survey
Source of Information: OQI Satisfaction Survey
Significance: The Family and Youth survey reflects the experience and perception of individuals who receive services funded by Children's Services. Increased consumer satisfaction with services is a major goal of the children's system of care. FY04 data show a slight increase in the percentage of children and families that report satisfaction with service.

**Goal 4: Increase Crisis Outreach Interventions in Community Settings**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 27.0% | >27.0% | 28.2% | >28.2% |
| Denominator | 1,559 | | 1,712 | |
| Numerator | 6,076 | | 6,073 | |

Measure: Percentage of face to face crisis contacts that occur in a community location other than hospital emergency room or crisis office
Numerator: Number of crisis contacts that occur in a community location
Denominator: Number of crisis contacts in FY
Source of Information: Agency/Program annual performance indicator report (OQI)
Significance: The Children's Crisis Services program model emphasizes mobile crisis assessment and intervention. The data on actual location of the crisis assessment is an indicator of whether the mobile outreach model emphasizes face to face contacts where the crisis occurs within the range of natural community settings, such as home, school, or other community location. The FY04 data show a slight increase in the percentage of face to face contacts in community settings.

**Goal 5: Improve Functioning in Home, School, Community**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 53.8% | >53.8% | 67.8% | >67 .8% |
| Denominator | 265 | | 166 | |
| Numerator | 492 | | 245 | |

Measure: Improved functioning exhibited by youth
Numerator: Children exhibiting gains in functioning measured by the Child & Adolescent Functional Assessment Scale (Total Youth Score) over a 12 month period.
Denominator: Total number of children tracked over a 12 month period using the CAFAS to determine degree of functioning.
Source of Information: OQI Child & Adolescent Assessment and Outcome tracking project
Significance: The goal of treatment is to maintain or improve a child's ability to function in the normal life environments of the home, at school and in the community. FY04 data show a gain in the percentage of children who have improved functioning.

## Action Plan – Development of a Comprehensive Community Based Mental Health System for Children

- Integrate Children's Behavioral Health Services within the service components of Child Welfare, Foster Care and Post Adoption Services in the Bureau of Child and Family Services, DHHS

- Enhance the management of the Children's system of care through implementing prior authorization and utilization review across the range of treatment services.

- Enhance clinical aspects of services delivered under MaineCare for Children's Behavioral Health Services.

- Foster the active involvement of families in the planning and delivery of treatment services for their children.

- Maintain and expand stakeholder collaboration with service providers, parents, advocates, provider associations, attorneys, and representatives of statewide family organizations and child-serving State agencies in the planning, development and evaluation of the children's system of care.

- Expand the range of services available to children with mental retardation and autism through the development of a Home and Community Based Waiver application.

- Address the timeliness of service access that is necessary to achieve full compliance with the Risinger Settlement Agreement.

- Promote Quality Assurance activities with regard to In-Home Support Services and Case Management

- Continue to reduce the number of children with behavioral health needs who receive treatment services in out of home placements, both in and out of state.

- Complete comprehensive re-design of MaineCare Section 65 Children's Mental Health Services, to include part (M), Child & Family Behavioral Health Treatment Services provided by a clinical team with active participation of the parent/caregiver, and (N) Community Based Treatment for Children without Permanency that is also clinically based for youth who homeless, legally emancipated or in voluntary status in the Child Welfare system.

- Complete rule-making process for MaineCare Section 28, Home-Based Services for Children with Mental Retardation or Autism which will provide for these treatment services to be delivered in the child's home and community, or in a center-based setting, or under an applied behavior analysis model, according to the treatment needs of the child.

## CRITERION 2: Mental Health System Epidemiology

**Goal 1: Increase Access to Services for Children with Serious Emotional Disturbance**

**(CMHS CORE PERFORMANCE INDICATOR)**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | | | | |
| Measure | 23,835 | >23,835 | 15,511 | >15,511 |

Performance Indicator: Increased access to services for children with SED.
Measure: Number of children and youth ages 0-17 years with SED receiving MaineCare children's behavioral health services.
Source of Information: Maine Uniform Reporting System, Basic Table 2A
Significance: FY03 data includes all children accessing MaineCare behavioral health services, regardless of state agency funding source. The FY04 data focuses only on children whose services are paid for by DHHS Children's Services, which is a more meaningful measure. Behavioral health services are identified by MaineCare procedure codes that represent services that are appropriate to address the treatment needs of this population. Because there was not consistency in the methodology between FY03 and FY04, the target for FY04 is not measured, but more than 15,511 is established for FY05.

### Action Plan – Mental Health System Data Epidemiology

- Prepare current FY04 service utilization data that represents all components of the Children's Services system of care.
- Analyze and track specific service utilization and timeliness standards of services and individual treatment plans for Risinger Settlement Agreement, i.e.
    - In-home Behavioral Health Services and Home Based Habilitation Services
    - Targeted Case Management Services
- Identify current trends in service utilization with reference to previous FY data
- Prepare service utilization data related to financial expenditure data in order to inform:
    - Department of Health & Human Services Administration
    - Bureau of Child & Family Services
    - Office of the Governor
    - Relevant legislative committees – Joint Standing Committee on Appropriations and Financial Affairs and Joint Standing Committee on Health & Human Services
- Commit Children's Services staff to fully participate in the CMHS Data Infrastructure Grant activities carried out through the DHHS Office of Quality Improvement.

## CRITERION 3: Children's Services

**Goal 1: Increase Access to Evidence Based Practices (CMHS CORE PERFORMANCE INDICATOR)**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Therapeutic Foster Care &Child ACT programs (# practices | DHHS Licensed TFC ( 644 ) Children's ACT (2) | DHHS Licensed TFC (>644) Children's ACT (2) | DHHS Licensed TFC (700) Children's ACT (2) | DHHS Licensed TFC >700 Children's ACT >2 |
| # Persons Receiving Therapeutic Foster Care & Child ACT team services | TFC 800 Children's ACT 179 | TFC >800 Children's ACT >179 | TFC 815 Children's ACT 167 | TFC >815 Children's ACT >167 |

Performance Indicator: Increase Access to Maine Evidence Based Practices
Measure: Number of practices that are evidence-based: Therapeutic Foster Care (number of licensed practices) and Children's ACT practices
Measure: Number of persons receiving evidence-based practice services
Source of Information: ACT team reports on OQI Performance Indicator Report
TFC data available through Bureau of Child & Family Services licensing
Significance: Research evidence supports the development of Assertive Community Treatment (ACT) programs and therapeutic foster care treatment services to meet the needs of children with emotional and behavioral needs. Therapeutic foster care is funded and licensed through the DHHS Bureau of Child & Family Services. Some children served under the Children's Services Intensive Temporary Out of Home Treatment Services are placed in therapeutic foster care settings. Children's Services funds 2 ACT programs in southern Maine. Both ACT programs and therapeutic foster care programs have maintained services in FY04 at a relatively constant level.

**Goal 2: Increase Children/Youth Enrolled in Regular School Setting With and Without Supports**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 73.74% | >73.7% | 62.1% | >62.1% |
| Numerator | 3,915 | | 3,605 | |
| Denominator | 5,311 | | 5,759 | |

Measure: Average percentage of children/youth enrolled in case management services who attend school in regular integrated classroom setting

Numerator: Number of children enrolled in case management services who attend school in regular classroom setting in 4th quarter of FY

Denominator: Total number of children/youth enrolled in case management services in 4th quarter of FY

Source of Information: Agency/Program Quarterly Performance Indicator data (OQI)

Significance: Performance in a regular school setting with or without supports reflects a positive ability to function in an important community environment. This indicator represents coordination and collaboration between Children's Services contracted case managers and local school system educational personnel. Data for FY04 indicates a decrease of 11.6% in a single year. This data is being reviewed by the Office of Quality Improvement to assess possible reasons for the large decrease.

## Action Plan- Children's Services

- Promote within the present and future system of care fundamental principles that include ease of access to services for children and families, cost effective services and supports and high quality services.

- With other child serving agencies, work toward the development of a fully integrated system of care for all children and families while avoiding duplication and redundancy and parallel systems of care.

- Commitment to work for integrated children's behavioral health services with Child Welfare, Foster Care Services and Post Adoption Services in the Bureau of Child & Family Services.

- Promote and evaluate evidence-based practices for children in Maine through continued commitment to SAMHSA planning grant to pilot an evidence-based practice.

- Support the continued integration of children's behavioral health services within the Department of Corrections, Juvenile Justice community service system and Youth Development Centers through co-location of personnel, consultative support and flexible resources.

- Expand relationships with the Department of Education through full implementation of Memoranda of Agreement to include Child Development Services for age 0-5 children.

- Support and implement the practice of active family involvement in all aspects of their child's treatment.

- Within the Children's Cabinet and Senior Staff agendas, provide the voice for families and children who need and receive children's behavioral health services within the children's system of care.

- Continue support for the Maine Medical Center's Partnerships for Youth in Transition Grant through active participation of Children's Services regional staff in northern and southern Maine pilot sites.

## CRITERION 4: Targeted Services to Rural & Homeless Populations

**Goal 1: Maintain or Increase level of Services for Homeless Youth**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Performance Indicator | 29.17% | >0% -5.0% | +02.8% | 0% to +05.% >1,677 |
| Numerator | 1,638 | >1,638 | 1,677 | |
| Denominator | 1,268 | 1,638 | 1,638 | |

Measure: Maintain at Previous Level or Increase by 5% the percentage of homeless youth receiving services in FY
Numerator: Number of homeless youth receiving services in current FY
Denominator: Number of homeless youth receiving services in previous FY
Source of information: Agency Performance Indicator Reports (OQI)
Significance: Maine's geographic makeup and population distribution are essentially rural in nature. Therefore the children's behavioral health system of services are largely delivered in a rural context. Services to homeless youth are available in both urban and rural areas of the State.

### Action Plan - Targeted Services to Rural and Homeless Populations

- Maintain current level of funding for Children's Behavioral Health Services support for programs that serve homeless youth.
- Continue to expand access to services in rural areas of the State through resource development to address documented need for services such as Targeted Case Management Services and In-Home Supports
- Focus resource development activity in the State using geo-mapping techniques that identify known population that are waiting for services under the Risinger Settlement Agreement.
- Continue to promote and support the activities of "Keeping Maine's Children and Youth Connected". These 4 initiatives are examples of the child-serving state agencies working together in an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement and in-patient psychiatric care.

## CRITERION 5: Management Systems

**Goal 1: Maintain State Expenditures Sufficient to Meet Federal Maintenance of Effort Requirements in Children's Mental Health Block Grant**

| (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|
| Fiscal Year | FY03 Actual | FY04 Projected | FY04 Actual | FY05 Projected |
| Actual Expenditures Indicator | 42,823,944 | >40,855,391 | 47,977,218 | >45,400,606 |
| Expended Average of 2 Previous Fiscal Years (MOE) | 35,941,185 = average for FY01 and FY02 | 40,855,391= average for FY02 and FY03 | 45,400,606 average for FY03 and FY 04 | Average for FY04 and FY 05 |
| | | | | |

Performance Indicator: Fiscal year State expenditures for Children's Behavioral Health Services that are sufficient meet the federal requirement of Maintenance of Effort (MOE) in order for the State to continue to participate in the federal Block Grant program.

Measure: MOE for the fiscal year of measurement must equal the average of state general funds expended for Children's Services in the previous two fiscal years.

Source of Information: MFASIS financial warehouse; state expenditures by fiscal year.

Significance: Inability to meet the requirement for Maintenance of Effort may result in sanctions that affect continued participation in the Block Grant program, including suspension of funding in the next fiscal year. In FY04 Actual Expenditures of $47.9 million surpassed the MOE target of $45.4 million.

### Action Plan – Management Systems

- Advocate for finances adequate to meet the Department's commitments in support the operations of the Children's system of care.
- Achieve cost containment targets in the MaineCare seed account of $2 million in FY05 by employing techniques of good care management strategies including determination of medical necessity, targeted service timelines, prior authorization and concurrent review for continuation of services.
- Implement sliding fee policy by new rule, as directed by the Maine Legislature, for grant funded case management services, outpatient services, home-based family services and respite care services that target an additional $700,000 in FY05.
- Assist respite service providers to access funding up to $1 million in FY05 for families receiving respite care services through continued collaboration with the DHHS Bureau of Family Independence through the TANF Block Grant Prevention Program.