II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

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

Footnotes:

Office of Adult Mental Health Services

Overview
Maine's Department of Health and Human Services (DHHS), Office of Adult Mental Health Services (OAMHS) is the designated State Public Mental Health Authority. OAMHS is responsible for assuring the quality of services and supports to individuals with severe and persistent mental illness and the integration of mental health service into healthcare generally and through specific public health initiatives. OAMHS, in collaboration with its community partners, develops, monitors and improves adult mental health treatment, services and supports for individuals 18 years and older who have SPMI. Treatment, services and supports include crisis services, inpatient treatment, outpatient treatment, community integration services, ACT, peer support, medication management, housing, vocational and outreach services.

OAMHS works within DHHS to incorporate mental health into Maine's Homeland Security and Disaster Response Plan and in the state's health plan.

OAMHS is committed to ensuring that a full array of treatment, supports and services are available and equitably accessible throughout the state to sustain and enhance the quality of life for adults with SPMI.

Criteria 1:
OAMHS provides statewide leadership in defining, measuring and improving the quality of services and supports to adults with serious mental illness. Administratively, this function is accomplished through a Central Office, the Office of Adult Mental Health Services, two state- operated psychiatric inpatient facilities as well as state forensic services.

OAMHS contracts with community-based agencies for the provision of: tenant based supported housing, residential treatment supports and services, medication management, crisis services, ACT, daily living supports, peer supports and other services essential to recovery. All services and supports are designed to increase the ability of each consumer to live and thrive in his or her chosen community.

Based on a future needs analysis of block grant services we will incorporate the national best practice model that will utilize peers in the provision of services. Our target will include 25% utilization of peer based services and future contracts will see an increase of this percentage in years to come. This will be achieved through the Request for Proposal (RFP) process, which will be informed by the needs analysis mentioned above.

In addition to the two state-operated psychiatric facilities, six private hospitals with dedicated psychiatric units and two private psychiatric hospitals partner with OAMHS to provide inpatient treatment as close to an individual's home community as possible. The primary goal of inpatient treatment is to stabilize the person's psychiatric symptoms, resolve imminent issues and restore his or her capacity to resume life in the community.

Monthly webinars are conducted by leadership of OAMH to the provider community to provide an opportunity for bi-directional communication and establish uniform consistency of programs and applications.

Mental health service and support contracts are performance based and include:
• Assertive Community Treatment (ACT)
• Community integration, daily living supports and skill development;
• Crisis services, which include telephone support, mobile assessments and residential stabilization services and peer crisis supports
• Tenant based supported housing as well residential treatment programs
• Outpatient therapy
• Medication management
• Peer support services, including peer centers and social clubs, peer operated "warm lines," peer support in emergency departments, peer conferences, certified peer training, and support of the Consumer Council of Maine.
• Inpatient hospital care and treatment
• Vocational services and supports

DHHS/OAMHS contracts with APS HealthCare to serve as its Administrative Services Organization for prior authorization and continued stay reviews for certain services.

OAMHS provides Intensive Case Management (ICM) services to individuals with mental illness who are in jail or in homeless shelters. ICM services focus on those individuals who are homeless within the identified population who have historically experienced difficulty connecting with and maintaining other community services. The goal is to provide outreach, engagement and referral to mainstream resources. For those in jails, the ICMs focus on service linkage upon release.

Over the last few years OAMHS has incorporated national best practices of linking Substance Abuse and Mental Health Treatment into the contracting process with providers. Now, our standard rider language specifically includes the following language: "Co-occurring Mental Health and Substance Abuse Disorders. In support of the DHHS statewide initiative to create a system welcoming to clients with co-occurring mental health and substance abuse disorders, the Provider agrees to the following:
1.The Provider shall not deny services to any individual solely on the basis of the individual's having a known substance use/abuse disorder in addition to their mental illness;
2.The Provider shall maintain a written protocol or policy that describes its service approach to individuals with a co-occurring mental health and substance abuse disorder; etc.

Criteria 2:
The development of quality improvement and information systems, including data/information systems, monitoring, peer review, consumer satisfaction and

evaluation processes, is based on the commitment of all those involved with the provision of mental health services at every level. The responsiveness and effectiveness of Maine's mental health system can only be guaranteed by the collaborative input of consumers, families, the DHHS/OAMHS, other involved State departments, and all community providers.

As mental health services move toward increased community inclusion and increased consumer and family involvement, there is a need to better integrate information systems. With the additional impact of the Bates v. DHHS consent decree, the Mental Health Statistics Improvement Program (MHSIP), the U.S. Supreme Court's "Olmstead decision", statutorily mandated performance contracting, and other state and federal requirements, the development of a comprehensive information system that can capture client identifiable instances of service, assessments, and other demographic data is essential.

The Offices of Information Services and Quality Improvement efforts have focused on systems integration and restructuring, performance measures/indicators, and consent decree/settlement mandates. They play a significant role in the identification of needs and outcomes in the planning of mental health services and the service delivery system. Of significant note, OAMHS, CBHS and the Office of Quality Improvement, in conjunction with the QIC and other consumer and family representative organizations are rolling out the statewide implementation of the OQ® Measurement system.

Criteria 3: See Children's Section

Criteria 4: Homeless

Homelessness is a national problem affecting people from all walks of life; individuals with SPMI are no exception and are among the most vulnerable to the effects of being homeless. OAMHS recognizes the need for housing as well as the need for related supports and services as essential to recovery and successful community integration.

Independent housing vouchers represent a foundation of recovery and hope. To the greatest extent practicable, we empower consumers with tenant-based housing vouchers which enhance individual choice, independence, and control over where a person lives and what services (if any) such a person decides to receive. Systems of care are recognizing that access to safe, decent, and affordable housing is a medical necessity for many persons with disabilities. Independent housing vouchers: deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care. Such vouchers can be used in either the community or group settings—at the consumer's discretion. These vouchers are a logical extension of the concept, Money Follows the Person in which the consumer directs their own care and in this case, their housing as well.

Despite the challenges presented by economic recession, OAMHS continues to adhere

to a “housing first” philosophy and to maintain a recovery-oriented infrastructure that seeks to ensure successful community integration. The Bridging Rental Assistance Program (BRAP), Shelter-Plus Care (SPC) and the Project for Assistance in Transition from Homelessness (PATH) are examples of OAMHS successful housing programs. Although individuals with SPMI who are homeless or at risk of homelessness are given priority for assistance, OAMHS remains cognizant of the fact that the need for safe, adequate housing exceeds currently available funding. OAMHS continues to advocate strongly for additional funding for housing resources. We are pleased to announce that OAMHS has received a 30 % increase in its state funded Bridging Rental Assistance Program and more than $1,000,000 in new Shelter Plus Care grants from HUD for FY12.

The OAMHS reorganization has re-dedicated resources to Policy Development which includes persons dedicated to coordinating and developing housing resources, including the Bridging Rental Assistance Program ($4,000,000 state funded) and the Shelter Plus Care program ($11,000,000 HUD funded). Maine’s housing programs are becoming evidence based best practice models and have been presented at local, regional, and national conferences. Our administrative and management systems provide for clear lines of accountability, efficiency, and transparency. These systems and models have been duplicated in several other states. Our program manuals have been utilized by the U.S. Department of Housing and Urban Development in their creation of HUD’s Shelter Plus Care Resource Manual.

Intensive Case Management services are available for individuals with SPMI who are homeless or at risk of homelessness. ICM services include comprehensive outreach and service linkage and maintenance. Services include assistance in obtaining housing, often utilizing Shelter Plus Care (SPC), the Bridging Rental Assistance Program (BRAP) and/or the Project for Assistance in Transition from Homelessness (PATH). The immediate goal for any identified homeless consumer is housing and stability.

OAMHS is a recent recipient of a SOAR (SSI/SSDI Outreach, Access and Recovery) grant. We anticipate this will further enhance the effectiveness of engagement of homeless persons into mainstream benefit programs for which they are eligible. Our two pilot sites include the City of Bangor and our ICM program. We are also incorporating SOAR into our PATH program as well. There is a need for sustainability of the SOAR program and the Block Grant may serve this purpose.

Having a safe and decent place one can call home is a core element of recovery. However, housing in and of itself for individuals with SPMI, is often insufficient to successfully integrate into the community. Services and supports, as directed by the consumer, lead to stability and recovery. Combined housing and services are a essential to the recovery process. OAMHS has a long and very successful history of linking housing and services, as directed by the consumer. We have been using a ‘housing first’ model in our rental assistance programs (BRAP and Shelter Pus Care) before there was a best practice known as ‘housing first.”

Criteria 4: Rural
Maine is a predominately rural state with many of the issues and challenges inherent in the provision of mental health supports and services to persons with SPMI across a large geographic expanse. If expectations remain constant across service regions, service provision becomes problematic. Time, distance, smaller pools of service providers (particularly for individualized special needs) and fewer individuals needing specific services are problematic throughout rural Maine. Widespread and entrenched poverty, lack of reliable transportation in remote regions and regional/cultural attitudinal differences regarding acceptance of treatment, supports and services for individuals with SPMI all factor into the challenge of service and support provision in rural areas.

Many national issues also exist in Maine and can have a profound effect on rural mental health service delivery. These include:

- The national and global recession, which is exacerbating to the decline of Maine's rural economy;
- Increasing stress on communities, families and individuals resulting from the soaring costs of basic needs – food, gas, heating oil, etc.
- A growing rate of unemployment in rural areas;
- A lack of decent, affordable housing options which has been impacted by the recession and age of Maine's housing stock (the 5th oldest in the country)

With at least half of the State of Maine consisting of unincorporated territories, some mental health service areas are highly rural and isolated. In response, all mental health agencies operate branch offices in their regions. In addition, a variety of discrete programs and services are not readily available to rural areas, such as social clubs and supported employment. OAMHS is examining options for noncenter based peer services and uses for technology and cyberspace to link people. This includes telemedicine.

Through monthly statewide webinars hosted by the Office of Adult Mental Health, providers and consumers are able to form alliances to identify regionally specific problems and respond to challenges. Teleconferencing and tele-health are other strategies that continue to grow in serving rural areas. The QIC is actively seeking to expand its membership representing rural areas, tribal representation, and the Consumer Council System has worked diligently to develop and strengthen its local councils in all areas, including rural Maine.

Criteria 4: Elderly
The Department of Health and Human Services makes treatment and support services available to elder persons who have a mental illness or who experience cognitive and physical disabilities or substance addictions/abuse. However, circumstances associated with aging such as isolation, denial, and shame, impaired mobility, and diminished social supports present unique challenges to delivering effective services.

DHHS provides services to older adults with SPMI, utilizing a responsive, flexible approach that is specifically designed to meet individual needs, and with recognition that for many older consumers, traditional delivery models are neither appropriate nor efficacious. We have incorporated into contracts with several mental health agencies specific terms and expectations for effective outreach to elderly persons with SPMI. OAMHS and the Office of Elder Services continue to jointly pilot a project under the auspices of an AOA/CMS grant to develop Aging and Disability Resource Centers (ARDC). This project explores and develops creative methods of disseminating information about and providing access to long term supports and other resources of benefit to both consumers and providers. The project supports community coalitions to test methods to coordinate the connection of consumers with information about the full range of long-term supports available to adults of all ages and income levels. The information provided includes how best to leverage local resources to assist individuals who do not qualify for publically funded programs. The project also works to eliminate duplicative efforts and strives for efficient, high quality service availability and delivery. Each project site has an active local Community Coalition which provides project staff with a well rounded sense of the community's needs and available resources. Community specific knowledge further informs outreach efforts, allowing staff to initiate and maintain contact with stake holders and build collaborative relationships with area providers.

OAMHS utilization review nurses conduct regular reviews of the treatment, services and supports provided to individuals in specialized psychiatric nursing facilities, assuring the appropriate levels and quality of care.

OAMHS provides both general funds as well as Medicaid for home based services for outpatient therapy and medication management and is working with the Office of Elder Services to improve the integration of these services.

The Office of Elder Services offers comprehensive services and supports to meet the needs of older adults, their family members and their caregivers/providers. Other adult service programs in DHHS provide comprehensive supports to meet the needs of adults with mental illness, cognitive disabilities, brain injury and/or substance addictions/abuse. The services and supports within both these offices are individualized and person-directed. However, their services are not necessarily responsive to or effective in meeting the needs of older adults whose needs cross over both systems of service delivery. The older adult service system encounters difficulties addressing symptoms and challenging behaviors presented by those older adults who have mental illness, cognitive and physical disabilities, brain injury or substance addictions/abuse. Likewise, the integrated support service system is challenged in addressing issues encountered by older adults such as community isolation, living alone without supports, non-recognition or denial about diagnosis or service needs, shame about diagnosis, impaired physical or cognitive functioning, diminished social supports, and dual disorders. Older adults who may need the supports provided by the existing service systems include:

1. Individuals with chronic or long term conditions who are 60 and older and have aging issues that complicate symptoms of existing diagnosis. They may also have dementia in addition to existing diagnosis.
2. Caregivers who are older adults and who are caring for adult children with mental illness, developmental disabilities, brain injury, and/or substance addictions/abuse. They may now have mental health issues such as depression and anxiety disorders associated with their own aging and/or care-giving.
3. Older adults who have not accessed mental health, cognitive disability, brain injury and/or substance addictions/abuse services prior to 60 years old, but are now older adults seeking and needing to access services. They may have had chronic conditions that were undiagnosed throughout their lifetime or they may have newly emerging conditions resulting from medical conditions or issues as they age.

The Aging and Disability Resource Centers (ADRCs) implemented by area agencies on aging in three of the five regions of the state offer a point of information dissemination, resource identification, and service referral for adults, their caregivers, and community providers. OAMHS created two positions to address persons with complex needs and their service needs. Staff from Elder Services, Mental Health, Cognitive and Physical Disabilities, and Substance Abuse meet weekly to develop individual plans and pool resources.

Two members from Policy Management Division and Quality Management Division within OAMHS has been appointed the Maine Elder Death Analysis Review Team (MEDART). MEDART was established by the Maine Legislature under the auspices of the Maine Office of the Attorney General. 5 M.R.S.A. § 200-H. MEDART is charged with examining deaths and cases of serious bodily injury associated with suspected abuse or neglect of elderly or vulnerable adults. MEDART meets monthly to review selected cases. MEDART's membership includes representation from state, local, and county law enforcement, prosecutors, victim services, licensing and regulatory services, medical examiner services, adult protective services, long-term care ombudsman, mental health, emergency medical services, physicians, and healthcare crimes enforcement. The purpose of the review is to identify whether systems that have the purpose or responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. MEDART seeks to foster system change that will improve the response to victims and prevent similar outcomes in the future. MEDART was chosen early on as one of four "elder fatality review teams" in the United States to serve as a pilot program for a Department of Justice funded initiative managed by the Commission on Law and Aging of the American Bar Association. The goal of the pilot program was to expand the fatality review team concept, and to develop and disseminate a replication and best practices guide. In August 2008, the Maine Elder Death Analysis Review Team was recognized at the National Adult Protective Services Association annual conference. The Team's annual reports, procedures, recommendations, findings, enabling legislation, membership, and case reviews were discussed during a session that highlighted national promising practices and programs. Several communities across the country have contacted the Maine Team as they begin to develop new Elder Death Analysis Review Teams.

Criteria 5:
The Office of Adult Mental Health has reorganized to better align with changing state and federal priorities. This reorganization makes efficient use of existing staff and organizes work flow and arranges staff to align with areas of specialty and expertise. One essential element of this reorganization is enhanced communication by, between, and among our own workgroups. Leadership meets on a weekly basis as does program units which ensure bi-directional flow of information and direction. Attached is an organizational chart highlighting these significant elements, "Planning Steps_1 Org Chart_Adult MH".

Mental health service providers receive funding through a variety mechanisms, primarily state general funds and Medicaid. General funds are allocated through Maine's biennial budget process. The budget process is inclusive, in that OAMHS actively seeks provider, consumer, family and other public input in budget planning and development. The budget document presented to the Maine Legislature reflects the needs of consumers of mental health services based on the best data and information available. The legislative process is open and public comment is welcomed and listened to. OAMHS' budget is presented to the legislature within the context of the DHHS overall budget. In FY2012 the OAMHS budget received a $5.4 million dollar increase targeting Consent Decree Clients and the Bridging Rental Assistance Program mentioned earlier.

APS HealthCare, as the DHHS/OAMHS administrative service organization acts to ensure that funds are efficiently allocated and that supports and services provided are appropriate to the documented needs of consumers and of a consistently high quality. All contracted mental health service providers are enrolled with APS HealthCare. OAMHS provides, directly or through contract, training and technical assistance to mental health service providers statewide. Training initiatives are coordinated by OAMHS' Training and Best Practices Coordinator. The University of Southern Maine, Muskie School of Public Service provides data, research and technical assistance through a cooperative agreement. Tuition support is available for direct service staff for certification.

Examples of training provided include:
• Competency based certification training for Mental Health Rehabilitation Technicians including crisis certification
• Competency based certification training for Intentional Peer Support Specialists
• Competency based certification training for Mental Health Support Specialists
• Best Practice training for OAMHS medical staff, including utilization review nurses
• Specialized training in employment

OAMHS also sponsors statewide "summits" on domestic violence, criminal justice, forensic grand rounds and an annual consumer "Hope Conference." OAMHS provides technical assistance to providers and consumers on an as requested basis.

The correctional system has undergone a merger between the county and state systems and the Office is deeply involved in the design of the mental health and substance abuse delivery system. Protocols are being developed to ensure diversion whenever possible and quality services while incarcerated as well as a detailed re-entry plan.

Maintenance of Effort (MOE) Report:

It should be noted for FY12, The Department of Health and Human Services requested, and the legislature approved, an additional $5.6 million (representing nearly 20% of our allocation of general funds) to principally serve persons with Mental Illness who are currently not receiving services and/or who are uninsured.

Actual FY08	Actual FY09	Actual FY 10	Estimate FY11
$135,474,171.	$123,352,714.	$107,725,676.	TBD

The relevant factors that SAMHSA considers in making a recommendation
To the Secretary include: 1) whether the State maintained service levels,
2) The State's mental health expenditure history, and 3) the State's future
commitment to funding mental health services.

OAMHS will be conducting a thorough needs analysis of the MH Service system in the coming months. As mentioned previously our intent is to develop an RFP based on this assessment.

Currently we have a need regarding IT systems. Although we can collect client identifiable data from the Medicaid records we are having difficulty discreetly identifying individual clients served by particular grants funds including the Block Grant resources. The solution may be as simple as adding a modifier to existing data sets or as complex as examining entire IT systems.

Children's Behavioral Health Services

Application and Plan FY12/13

STEP 1: ASSESS THE STRENGHTS AND NEEDS OF THE SERVICES SYSTEM TO ADDRESS SPECIFIC POPULATIONS

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

Focal Point of Responsibility for Children's Mental Health: The State mental health authority is the Department of Health & Human Services. The focal point for children's mental health is the Division of Children's Behavioral Health Services within the Office of Child and Family Services, Department of Health and Human Services. The statutory authority for the Children's Mental Health Program is cited in PL1998, Chapter 790.

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

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 6204.1.A.) and to "(provide) in-home, community-based, family-oriented services." (34-B. section 6203.1.B.)

Target Population: The Children's Behavioral Health Services Division has three operational target populations:

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

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

c. Children, age birth through age 20, who have intellectual disability, autism spectrum disorders or pervasive developmental delay

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

Children's Behavioral Health Services Program - Current Operations

Number Served (FY'10) Source: Year End Contract Reports from Community Providers; MaineCare claims data from MECSM and clinical authorizations from Clinical Care Specialists: 51,136 total services provided to children and families; estimated unduplicated number of

children served 22,727; expenditures (FY11) $32,681,123 in State General Funds, including $15,543,097 state seed dollars for federal Medicaid (MaineCare) matching funds. Budget (FY12) $29,453,949 in State General Funds, including $15,546,457 state seed dollars for matching federal Medicaid (MaineCare) funds.

Children's Mental Health Services: CBHS Mental Health Program Coordinators and Resource Coordinators oversee regional program development; facilitate interagency collaboration provide information, referral and case advocacy and offer education and public awareness activities for children and families who are affected by neurobiological and other serious emotional disorders, and for their service providers. The Division of Children's Behavioral Health Services contracts with private community-based agencies to provide: case management; crisis services; individual planning fund administration, information and referral, clinical home and community based behavioral health treatment; rehabilitate community support services; infant mental health services; outpatient counseling and therapies; respite services, family support services, children's ACT services, medication management; early intervention services, therapeutic recreational services, homeless outreach, and short term, intensive residential treatment services.

Early Childhood, Intellectual Disability, and Autism Services: CBHS Regional Supervisors oversee staff that performs referral, prior authorization, utilization review, program oversight and overall quality improvement functions for community based contracted agencies. The contracted agencies provide home and community based identification and assessment; rehabilitative services; personal supports; case management; crisis services; medication management; early intervention services for infants/toddlers; preschool integrated support; short-term residential treatment ,individual planning funds, recreational programming and respite for children with developmental delay, autism spectrum disorders and intellectual disabilities.

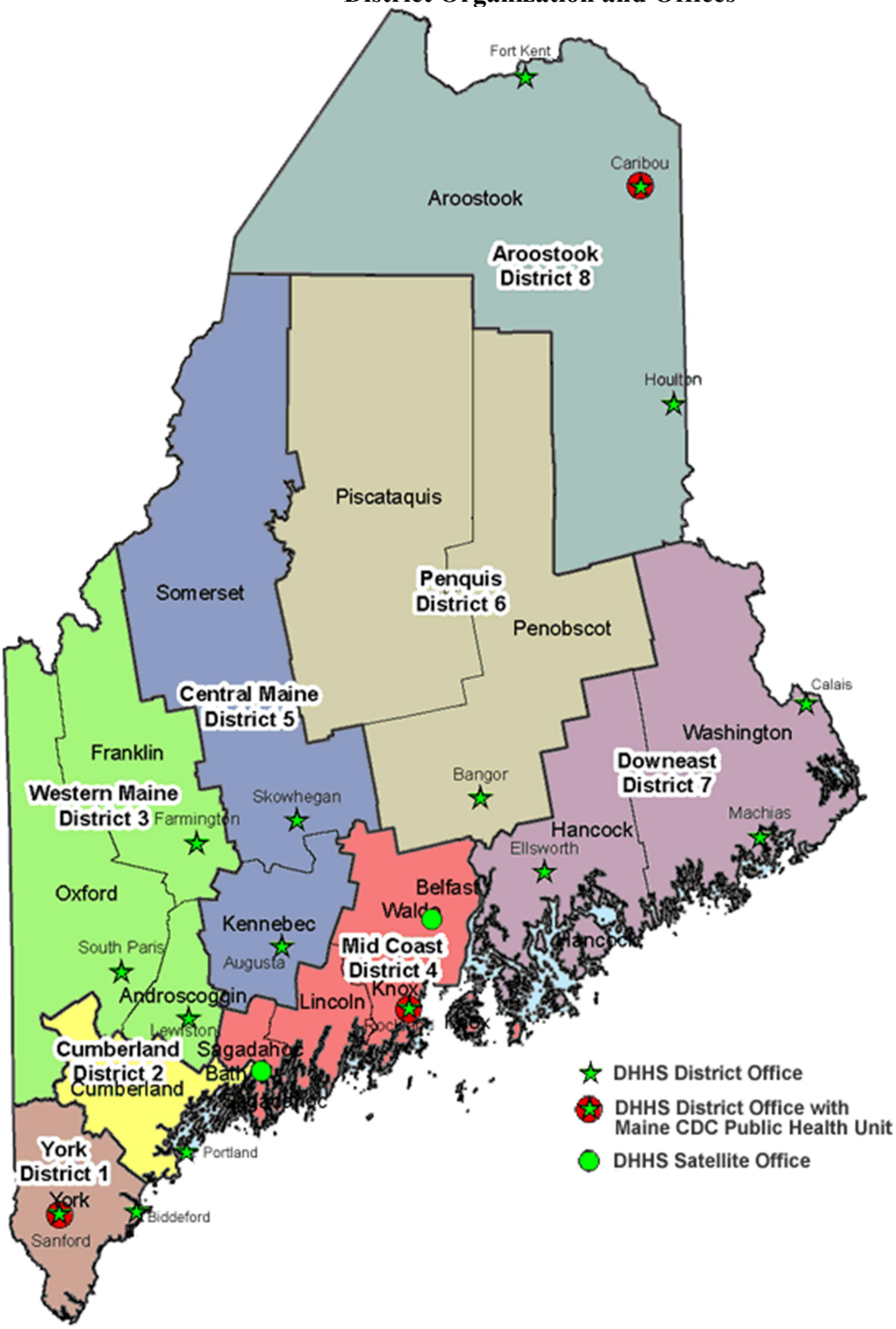
State/Local Administrative Structure: The integration of Children's Behavioral Health Services into the Office of Child & Family Services has fostered a common, integrated approach to the Department's local administrative structure. In FY08 CBHS began the transition from a regionally based construct to a district configuration that is compatible with other Offices within the Department of Health & Human Services. In 2007, the CBHS central office co-located with Early Childhood Services and Child Welfare Services in the main administrative office of the Office of Child & Family Services in Augusta. The operational integration of CBHS field personnel at the district level has been a CBHS Priority in FY10 and continues to be a key element of CBHS/ OCFS Integration.

CBHS Local Administrative Structure by DHHS District

District 1	York County	Formerly Region I
District 2	Cumberland County	Formerly Region I
District 3	Androscoggin, Franklin and Oxford Counties	Formerly Region II
District 4	Sagadahoc, Lincoln, Waldo and Knox Counties	Formerly Region II
District 5	Kennebec and Somerset Counties	Formerly Region II
District 6	Piscataquis and Penobscot Counties	Formerly Region III
District 7	Hancock and Washington Counties	Formerly Region III
District 8	Aroostook County	Formerly Region III

Maine Department of Health and Human Services
Office of Child & Family Services

District Organization and Offices



State Mental Health Agency and Other State Agencies

Structure of the System of Care.

Maine's mental health authority for children's mental health services is the Children's Behavioral Health Services (CBHS) program unit within the Department of Health & Human Services, Office of Child & Family Services (OCFS). Children's Behavioral Health Services central office provides leadership in systemic planning and policy development, budget oversight, interdepartmental collaboration, legislative initiatives and systems advocacy on behalf of children with emotional and behavioral needs and their families. CBHS is authorized 57.5 FTE positions which consist of the following personnel:

Children's Behavioral Health Services Central Operations

The Director of Children's Behavioral Health Services oversees all operations of Children's Behavioral Health Services from the central office level, and is responsible for financial oversight of the CBHS budget, develops and implements policies relevant to the mental health system of care for children, represents the Department on issues affecting Children's Behavioral Health Services to include strategic planning and work with the Maine legislature, oversee contract development, provides leadership within the CBHS program and directs staff within the central office operations and the regional Children's Team Leaders. These staff includes the following:

Children's Systems Manager, responsible for planning, policy development, and resource coordination of Department activities and program implementation for Children's Behavioral Health Services at the state and regional levels. Represents the Department on state level interagency/departmental committees to promote coordination and collaboration across child-serving state agencies and contracted local provider agencies.

Medical Director of Children's Behavioral Health Services is a full time child psychiatrist who provides clinical expertise, consultation on clinical issues and promotes evidence based and best practices in the field. The Medical Director consults with and supports field staff and provides clinical supervision to the Children's Behavioral Health Services Clinical Care Specialist unit. The Medical Director has responsibility for coordinating the management of children's behavioral health treatment services that require prior authorization and utilization review. The medical Director also provides technical assistance in the implementation and monitoring of fidelity of evidenced-based treatments.

Other personnel include a **Quality Manager**, who is the liaison to the DHHS Office of Quality Improvement and responsible for implementing the Children's Quality Improvement Plan, overseeing the staff training and certification process required for behavioral health services and rehabilitative services, and is the CBHS representative to the Lean Management Team. A **Program Specialist** responsible for preparation of reports required by federal, legislative or departmental personnel, analysis of non-clinical data and information, and preparation of the federal Children's Mental Health Block Grant application and the federal Thrive System of Care

Initiative, and the Healthy Transitions Initiative. **An Information Systems Manager** responsible for liaison and communication between CBHS 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 Behavioral Health Services. A **Behavioral Health Services Manager** responsible for the implementation of the delivery of mental health services to youth in the two Department of Corrections Youth Development facilities and Juvenile Services Regional 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 a federal Home and Community Based Waiver for children with intellectual disabilities and Autism Spectrum Disorder. A **Project Manager** responsible for the Healthy Transition federal grant initiative. A **Manager of Clinical Services** responsible for monitoring and coordination of the prior authorization of all children being considered for residential treatment and implementing any necessary changes. Other tasks include quality improvement monitoring, assisting in coordinating the integration of hospital and community services and assisting in coordinating the integration of residential treatment with community services. This position is also a liaison between the Division of CBHS and Child Welfare, as well as between OCFS and the managed care entity, APS Healthcare.

Children's Behavioral Health Services Field Operations

Mental health services for children are delivered at the local level through a regional/ district structure overseen by the Director of Children's Behavioral Health Services. **The Children's Behavioral Health Services Team Leader** manages all activities in the region pertaining to the development and delivery of behavioral health and rehabilitative services for children and their families, supervises all regional staff, and actively participates as a member of the Children's Systems 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. **Clinical Care Specialists** track utilization of services of children placed out of state and children placed in residential treatment settings within the state. They are involved in the prior authorization of children being considered for residential treatment as, well as clinical reviews and clinical consultations with mental health treatment providers, families, Child Welfare, Department of Corrections and others. The purpose of these reviews is to assure that children receive the most appropriate and effective treatment in the least restrictive, medically necessary level of care. Clinical Care Specialists routinely monitor the quality of treatment provided within residential treatment settings and respond to urgent situations when necessary. **Regional Supervisors** are involved in daily district operations, engage in issue/problem solving, participate in community meetings and select, orient and supervise the following front line staff**:** **Enrollment Specialists** are responsible for documenting individual access to community services, manage the collection of information from community agencies regarding children

receiving services and 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. Family Information Specialists are trained parent employees who are knowledgeable of the local service area and have a child with a disability.

Co-Location of Mental Health Staff in the Department of Corrections System

Mental health services are provided to youth served in the Department of Corrections, Juvenile Services Division. Three (3) **Mental Health Program Coordinators** are co-located in Juvenile Services field offices. The MHPCs screen all caseloads of the Juvenile Community Correctional Officers (JCCOs) to identify youth in need of mental health services. In addition a **Social Services Manager** and two (2)**Psychiatric Social Workers** are located the Long Creek Youth Development Center in South Portland and a **Mental Health Program Coordinator**, and a **Psychiatric Social Worker** are located at the Mountain View Youth Development Center in Charleston. These personnel provide treatment in the facilities and assist in the coordination and development of services for youth returning to the community.

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 (called individual planning 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 Early Intervention services for pre-school and very young children and includes identification of at-risk children, clinical consultation and information/education components. Services are designed to identify 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, and School Based Health and Mental Health Services.

Crisis Intervention and Stabilization Services are accessed through a single statewide, toll free 1-888-568-1112 Crisis Telephone line. Services include mobile crisis outreach services, crisis resolution, and short term crisis stabilization units. Crisis services provide support and stabilization services to children and youth in their 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, and development of a crisis stabilization plan, a crisis plan to follow in the event of re-occurrence, referral and follow up. Specific crisis interventions may involve a variety of in-home support services or short term out of home treatment in the community. In Maine, these services are funded by the General Fund, MaineCare - Crisis Services, MaineCare - Outpatient Services and the Community Mental Health Block Grant.

Individual Planning/Case Management Services consist of screening and assessment, individual service planning, homeless youth outreach and targeted case management. This core service is further described 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 Based Mental Health Services, and the PATH Grant (Homeless Outreach).

Family and Child Supports include respite care, parent and peer support services, information & referral services, flexible funds 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. 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, Community Mental Health Block 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, and children's home and community based treatment services that include several evidence-based practices. Clinical services represent a wide range of community based treatment, including specialized interventions for substance abuse, trauma, etc. Problem-oriented counseling, skills training and in-home behavioral treatment services to strengthen and stabilize the family living environment are designed to minimize the risk of out of home placement. School-linked mental health services provide a variety of educational/ psychological assessment and referral, individual & 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, School Based Health and Mental Health Services, Substance Abuse Block Grant and Part B-IDEA.

Residential Services include therapeutic (treatment) foster care and regular foster care for children in Child Welfare Services care, and short-term intensive residential treatment for children with behavioral health treatment needs. Out-of-home residential services include specialized therapeutic homes with foster parents recruited and trained to care for children with

serious emotional and behavioral challenges. Children's Behavioral Health Services provide short term, intensive temporary out of home treatment services (ITRTS) that are described in a following section. 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 10 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 : The Department has annually 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 11 years. This time frame coincided with planning efforts 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 FY10. The results are shown in the table below:

*

Children's Behavioral Health Services – Core Services – Numbers Served FY98 - FY10				
Service Area	**FY 98**	**FY 10**	**Increase**	**% Increase**
Crisis Intervention	2,144	5,546	3,402	158.7%
Outpatient Services*	6,949	19,088	12,139	174.7%
In-Home: Behavioral Health Treatment /Rehabilitative Community Services	90	4,323	4,233	4,703.3%
Case Management	1,532	9,696	8,164	532.9%
Respite Care	1,514	1,667	153	10.1%
Totals	**12,229**	**40,320**	**28,091**	**229.7%**

*Includes Medication Management

The expansion that has occurred over this twelve year period was driven in part by the demand for specific MaineCare services and by pre-Risinger litigation that emphasized the need for timely access to in-home behavioral health treatment services and rehabilitative community services and supports. 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 following the 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 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 FY11 the profile of the original Core Services had changed significantly. Children's Behavioral Health Services contracted with sixty-two (62) Targeted Case Management provider agencies; eighty-two (82) Outpatient Services providers, of which twenty (20) also provide Medication Management; fifty-one (51) Rehabilitation and Community Services providers that offer In-Home Supports; forty-four (44) Children's Home and Community Based Treatment Services providers of home-based behavioral health treatment services; nine (9) Crisis Services providers; nine (9) Homeless Outreach Services providers and eleven (11) Family Support Services providers that include Respite Care, Parent and Peer Support groups and Information and Referral Services. Many of these agencies serve more than one Region. A regional update of available services by CBHS Region for FY2011 appears in Criterion 4.

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 as well as screening instruments that profile the child's functional abilities. 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, as are persons whom the child and family prefer to be included as natural supports. Case management involves brokering services, advocacy, insuring that a quality treatment plan is developed and implemented, and reviewing the child's progress. Case management involves aggressive outreach on behalf of 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 MaineCare Targeted Case Management, Part B-IDEA, and PATH Grant (Homeless Outreach).

Children's Behavioral Health Services case management services are provided through contracts with local service providers. Case management services for children with behavioral health needs did undergo a major redesign that recognizes the need for uniform screening and assessment tools that are used to help determine the level of care or intensity of service that the child needs. These assessment instruments, the Child and Adolescent Functional Assessment Scale or the Children's Habilitation Assessment Tool are administered at the time of service entry, and re-administered every ninety days and at completion of services.

Nearly all Maine children receiving case management services are eligible for MaineCare, and are served through CBHS Targeted Case Management services under that funding mechanism. Eight years ago when CBHS staff assumed non-direct service responsibilities, case management services for children with intellectual disability and autism were transferred to community provider agencies. This change, coupled with a high demand for case management services from families who had not previously been served, resulted in a dramatic expansion of both provider agencies and numbers of children served in the MaineCare funded program.

The utilization of Targeted Case Management services has been under review in the past year with important adjustments and MaineCare policy changes under way. These proposed changes were part of the Department's Strategic Plan to implement a single case management system in FY10. Under a key Budget Initiative for FY10-11, the Department established measurable criteria to assist in the case management process by determining whether case management continues to be medically necessary on a case by case assessment for individual children and youth.

Inpatient Services and Hospital Capacity As of July 2011 the number of beds for children and adolescents at Maine in inpatient psychiatric hospitals totaled 99 and were allocated as follows:

Provider	Location	Service Type + amount	Total
Spring Harbor	Westbrook	Child=14, Adolescent=14 MR/DD/Autism Unit = 12	Total= 40
St. Mary's	Lewiston	Child/ Adolescent = 20	Total= 20
Northern Maine Medical Center	Fort Kent	Serves age range from 4-17	Total= 7
Acadia (Bangor)	Bangor	Child=16, Adolescent=16	Total = 32
Maine Inpatient Psychiatric Beds			Total =99

Maine has two free standing psychiatric facilities, one in Bangor with a child and adolescent unit with 32 beds, and one in Portland with two child and adolescent units of 14 each and a unit for individuals with MR/DD/ASD. There are two general hospitals with child psychiatric units: a 7 bed unit in northern Maine (Fort Kent), and a 20 bed unit in central Maine (Lewiston).

Children in Out of State Placement For a number of years Maine, like many other states, placed children and adolescents with behavioral health or habilitation needs in out-of-state residential programs or hospitals for behavioral health treatment services. This practice reflected a lack of appropriate in-state treatment programs and inpatient psychiatric capacity to meet the needs of these children. Both families and their children do far better when they are able to stay connected with each other during hospitalization or while in a temporary out-of-home treatment setting. Out-of-state placements typically mean that parents are separated from their children for extensive periods of time. This causes additional emotional stress on siblings and financial hardship that impacts the entire family.
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 Memorandum of Agreement between the former BDS and the Department of Human Services. This document establishes a priority 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.

CBHS authorizes and tracks out of state admissions of all children with behavioral health needs whose care is paid for by MaineCare funds.

- The census of children served out of state in July, 2010 was 26 and the census of children receiving treatment out of state in July, 2011 was 20, resulting in a net change of (-6) children during the 12 month period.

- The census in out of state program in July, 2011, was 4 for Child Welfare Services, which has responsibility for children in state custody, and 16 youth for Children's Behavioral Health Services, which has responsibility for children in parental custody or are their own guardian.

- The census over the past seven years represents a steady reduction in the utilization of out of state treatment programs and inpatient psychiatric care , decreasing from 68 in 2003 to 20 in 2011. Shortly after the passage of Chapter 790 in April, 1998, the census out of state was 260 children. Over the past 13 years the census has been reduced by 92% percent of that total, or by 239 children.

- The current census by facility type is Residential Treatment, 18 children or 86% and Hospital setting, 2 children or 14%.

- Of the 21 youth currently in out of state facilities, all reside in New England programs, either in Massachusetts or New Hampshire.

- Of the 18 youth currently in out of state residential programs, 6 (29%) are 18-21 years old, and are awaiting openings in Adult Waiver Services for individuals with Cognitive & Physical Disabilities.

Over the last several years there has been greater availability of in-state resources such as intensive home and community behavioral treatment services, intensive temporary out-of-home residential treatment programs, and other specialized treatment options developed in Maine where none existed in earlier years. These factors have had a positive effect on decreasing out of state placements over time.

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 Children's Behavioral Health Services and Child Welfare Services.

The Department established a Children's Services Utilization Review Program 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 Behavioral Health Services Clinical Care Specialist staff 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.

Residential Treatment Services: Intensive Temporary Residential Treatment Services (ITRTS) Policy

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

In FY10, MaineCare eligibility criteria was amended for residential treatment which established a two level system of need. (Mental Health I & II and Intellectual Disability/Pervasive Developmental Disorders I & II). The determination of a Level I (moderate behavior) or Level II (severe behavior) is dependent upon the child's presenting unsafe behaviors and the clinical intervention necessary to meet the needs of the presenting behaviors. The use of this two level system has continued throughout FY11.

Intensive behavioral treatment is provided in order to address the specific unsafe behaviors that necessitated the child needing to leave the home. Once the behaviors that were unsafe have decreased, the child will return to his/her own home and continue treatment as necessary with community based treatment services. 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 back into his/her home and community. The focal treatment approach of ITRTS should minimize the time that the child is physically out of the home. A basic premise of this program is the requirement of active caregiver involvement in the child's treatment, so that new skills acquired by both the child and the caregiver can be practiced together leading to better success in generalizing these skills in the home upon discharge.

Formal prior authorization and continued stay processes for residential treatment is required for all children regardless of custody status. This single integrated system is to ensure that all children across the state receive the most effective treatment services, in the least restrictive environment, for the right duration of time. The prior authorization process includes submission of an application and clinical documentation that is then reviewed by a Clinical Review Team.

In FY11, the Clinical Review Team composition was changed from a team made up of multiple staff from both CBHS and Child Welfare (CW) to a team of two that includes the CBHS Mental Health Program Coordinator and CBHS Clinical Care Specialist. The CBHS Medical Director is involved as necessary. This change was in relation to efficiency of the Prior Authorization process and the direction of the State in regard to managed care. The Clinical Review Team receives and reviews documentation for each request for residential treatment, determines if the child meets the level of care for this service, determines Level I or II if the child meets the level of care for residential treatment, reviews the initial treatment plan submitted from a prospective provider, and authorizes admission to a residential treatment program.

Once a child is admitted into a residential treatment program, any requests for continued stay are submitted by the residential provider to the state's Administrative Service Organization, APS Healthcare. APS Healthcare utilizes the same eligibility of care criteria used during the prior authorization to determine if the child continues to need this level of care. Training continues for Child Welfare staff, community case managers, Guardian Ad Litems, AAG's and other service providers about residential treatment and the prior authorization/utilization review process.

ITRTS residential data reflects all children who have received residential treatment regardless of custody status. In FY11, a total of 650 children received residential treatment services. Of this number, 167 were in state's custody (Child Welfare Services). In FY11, CBHS served 483 children and youth in residential treatment services. CBHS continues to monitor these numbers and implement Continuous Quality Improvement measures in an effort to ensure that children in Maine receive the most effective treatment services in the least restrictive environment possible.

Overall 58 fewer children received out of state treatment services decreased by 8.2%
Number of CWS children who received out of state treatment services decreased by 39.5%
Number of CBHS children who received out of state treatment services increased by 11.8 %

Office of Substance Abuse: Co-Occurring/Dual Diagnosis Services

Services to children and adolescents with co-occurring mental health/substance abuse needs are provided by the Department of Health & Human Services through the Office of Substance Abuse.

OSA reports in FY 11 that a total of 1,115(unduplicated) admissions for services were provided to children and adolescents, up to age 20 years. Of those admissions 530 (o 47.5%) were identified as children with dual diagnoses, specifically with substance abuse and mental health needs. Specific unduplicated services provided to this population were; Outpatient (357); Intensive Outpatient (63); Evaluation (18); Detoxification (10); Residential (64); Methadone (13) and Shelter (5).

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

The Co-occurring State Integration Initiative is a grant- funded project designed to help DHHS develop infrastructure as well as clinical capacity to provide integrated care to those with co-occurring mental health and substance use disorders. The Co-occurring State Incentive Grant (COSIG) was awarded to Maine by SAMHSA in 2005 and will be extended through 2011. The grant addresses the needs of both adults and children.

Since 2005, the project has overseen the development of a Department-wide policy on integration of care applicable to all providers, has helped to write and implement new licensing regulations related to co-occurring care, has written contract language requiring co-occurring capability for all providers, and has implemented a standardized state-wide screening tool that has a specific child version. A set of clinical standards and guidelines for co-occurring practice has been published and will be made available to all providers. A new code for integrated services has been added to the outpatient mental health MaineCare regulations. Finally, at least four of 30 pilot sites engaged with the project are specifically child-serving agencies. Data was collected from these sites, along with date from both juvenile detention facilities, providing a small sampling of outcomes and demographic characteristics for these children. Maine has been able to make small inroads into new clinical approaches for children who have mental health as well as substance abuse disorders and will work over the coming year to sustain and advance these achievements.

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 Health and Human Services (DHHS), Center for Disease Control. Children's Behavioral Health 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, which is now part of the State Children's Health Insurance Plan (SCHIP).

State Children's Health Insurance Program

MaineCare is the umbrella term in use in the State of Maine to collectively refer to all benefits provided under previously separate program names such as Medicaid, SCHIP, CubCare, etc. The name change (a Legislative mandate) is administrative in nature and represents no change in benefits or rights of beneficiaries. MaineCare is administered by the Department of Health and Human Services, Office of MaineCare Services.

MaineCare, with Title XIX funding, provides coverage to children from birth to 12 months of age in families with income through 185% of the federal poverty level (FPL), children ages 1 through 5 in families with income through 133% FPL, and children ages 6 through 18 in families with income through 125% FPL. With Title XXI funding, (under MaineCare expansion), MaineCare provides coverage to children ages 1 through 18 in families with income from 133%/125% through 150% of the FPL; and under a separate child health program (formerly "CubCare") provides coverage to children from birth to 12 months of age in families with

income from 186% through 200% of the FPL, and to children ages 1 through 18 in families with income from 151% through 200% of FPL

Covered MaineCare services, both Title XIX (Medicaid) and Title XXI (CHIP) funded, includes but is not limited to: hospital, physician, therapies (OT, PT, and Speech), medication, lab and x-ray, durable medical equipment, vision and hearing, ambulance, transportation, behavioral health, family planning and case management. Over the course of FY11, the CHIP caseload averaged 10,291 children per month.

Rehabilitation and Employment Services

Children's Behavioral Health 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 the Office of Adult Cognitive and Physical Disabilities (OACPD) 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 who is age 18 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 Behavioral Health Services contracted case managers. Training included such topics as vocational rehabilitation, guardianship issues and consumer perspective. In FY09 CBHS collaborated with the Office of Adult Mental Health Services and produced a formal Memorandum of Understanding around transition of youth from children's service to adult services, described in Criterion 3, Children's Services.

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

Department of Education

The Maine Department of Education publishes a Child Count, of the total number of students in Maine. The Child Count data is a snapshot of students ages 3-21 receiving special education and related services on December 1st. The Child Count is completed by school administrative units and the 9 regional Child Development Services 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. The December, 2010 census for this selected group of students shows a decrease of 742 children or 0.5% from 2009. These categories, with child count data are listed as follows:

Department of Education - Special Education - Child Count Data
December, 2010

Disability/Exceptionality	Age 3-5 CDS	Age 6-21 School Age	Total	% of All Child Count
Intellectual disability	12	710	722	2.24
Emotional Disability	748	2,512	2,560	7.94
Specific Learning Disability	*	**	9,311	28.93
Multiple Disabilities	78	2,088	2,878	8.92
Developmentally Delayed	745	49	794	2.46
Autism	405	2,241	2,646	8.20
TOTALS	**1,288**	**7,600**	**18,911**	**58.69**

* DOE suppresses numbers for confidentiality purposes when number is less than 10.
** Suppressed to avoid mathematical exposure

Child Development Services (CDS)

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

Maine's CDS system at the end of FY11 showed a census of about 5.353 children. In the IDEA Part C program for children ages 0-2, the total count of active children was 1,253. Children remain in Childfind status after they have been referred to CDS until they have been evaluated and determined eligible for services. Childfind accounted for 379 of Part C children. The rest, 874 children, had qualified and had an Individual Family Service Plan (IFSP).

Part B –619 the program for children ages 3-5, accounted for 4,100 of the children in the system, 641 had been referred and were being evaluated to determine if they qualified for services. 3,459 children in this age group had been found to be qualified and had a plan of service in place. The total served under both parts was 5.353 children. The services that each child receives are determined by either an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP) which has been developed by the child's early childhood services team.

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.

Managed Care Initiative

Administrative Services Organization/ APS Healthcare : In September, 2007, the state entered a two-year contract with APS Healthcare (since, extended to four years) to act as an Administrative Services Organization and provide managed care services for adult and child mental health and substance abuse services. APS provides prior authorization and/or utilization review for children's mental health services, including Targeted Case Management, Outpatient Services, Home and Community-Based Treatment, Children's Assertive Community Treatment, Crisis Services, Residential and Inpatient Psychiatric Services. Children's Behavioral Health Services and APS work on collaborative models of utilization management, care management, provider relations and quality improvement that emphasize community partnership, training and technical assistance

Maine continues in to work on developing a managed care system. The particular model of managed care has not been selected as of this date. The decision as to the model and the RFP and start-up of the managed care entity is anticipated to occur by July 2012.

The Managed Care Design Management Committee (DMC) met for the first time in mid-August 2010. The DMC is responsible for overseeing the Managed Care initiative; interfacing with the Stakeholder Advisory Committee; developing overall design of the program; articulating goals and objectives; directing assignments to, and coordinating various subcommittees. CBHS staff will actively participate on these subcommittees, which will cover issues such as quality care, operations, financial and special topics/populations.

Children's Behavioral Health successfully advocated for active youth and family involvement within the formal Stakeholders Advisory Committee (SAC). There is a representative from Youth MOVE Maine, a youth representative from the Child Welfare Services' Youth Leadership Advisory Team, a family representative from the GEAR Parent Network, which is the Maine chapter of the Federation of Families for Children's Mental Health, from the Autism Society of Maine and NAMI Maine. As directed by the legislature, this committee will provide guidance to the Director of MaineCare Services during both the initial design and then the implementation phase for the Managed MaineCare program.

In preparation for this effort in FY11, CBHS developed a document related to the Outcomes and Processes to be Specified in the Managed Care Contract, which will be a helpful guide to assure that we continue to keep child, youth and family related issues in the forefront of this work as the services/benefit options are developed in the coming year. This work is a major systemic change in the oversight and management of services and supports for all Medicaid populations. This direction will have a major impact on the roles & responsibilities of Children's Behavioral Health Services staff at both the local and central office levels.

The CBHS Director is a member of the Managed Care Design Management Committee (DMC), which reports directly to the Commissioner's Office.

This year the Department of Health and Human Services (DHHS) has developed a four-pronged value-based purchasing strategy to achieve target savings and improve health outcomes. Value-based purchasing means holding providers accountable for both the quality and cost of care, through:

- increased transparency of cost and quality outcomes,
- rewards for performance, and
- payment reform.

Below are the proved health outcomes:

1. **Emergency Department Collaborative Care Management Initiative**

   Over the past year, MaineCare conducted a collaborative care management pilot with Maine General to reduce non-urgent use of their Emergency Department (ED) by MaineCare members. The pilot saved an estimated $100,000 in reduced ED costs just from working with approximately 35 members. MaineCare has decided to expand the pilot statewide in the face of increasing ED costs and an expressed interest from hospitals in increased care management capacity. This summer, MaineCare has met with all of Maine's hospitals to discuss the initiative and to assess the care management capacity of their respective hospital systems, the members' primary care provider offices or patient centered medical home, and community care teams, where available. MaineCare will utilize the identified care management resources as the first line and, where care management services are not available; MaineCare will provide the care management resources.

2. **Transition toward risk-based contracting with qualified providers; exploration of global and/or bundled payments.**

   MaineCare will build off its work with hospital EDs to enter into risk-based agreements with capable providers for the care management of their members. In exchange for a per member per month administrative fee, providers will collaborate with hospitals and EDs, primary care providers, specialists and other entities to achieve quality outcomes and cost savings. MaineCare will explore the possibility of phasing in alternative payment modes such as shared savings, bundled episode of care payments, or global payments

3. Leveraging and/or expansion of current initiatives and federal opportunities

Pay for Performance: MaineCare is conducting an analysis of its Primary Care Case Management (PCCM) and Primary Care Provider Incentive Payment (PCPIP) to identify opportunities to better incent providers to deliver quality, cost efficient care. Reforms under consideration include a more stringent baseline for providers to qualify for incentive payments, and increased payments for providers who do qualify. We are also looking at shifting the emphasis on payment criteria on which the payments are made from access, where significant progress has already been made, to reduced ED utilization, attainment of clinical quality benchmarks, and the provision of cost efficient care

Transparency & Reporting: MaineCare will continue to provide quality and utilization reports to its PCCM providers. In addition, MaineCare plans to learn from the efforts of the State Employee Health Commission, the Maine Health Management Coalition and Quality Counts! to develop provider rankings to share with MaineCare members and the public.

4. Targeting Individuals with Dual Medicaid and Medicare Eligibility, Chronic or Complex conditions:

MaineCare currently has 26 multi-payer Patient Centered Medical Homes (PCMH), initiatives which have gained national recognition for the "promising trends" they show on cost and quality, as well as "greatly improved access to care."[i] Medicare is joining the PCMH Pilot in October 2011 under the Medicare Multi-Payer Advanced Primary care practice (MAPCP) demonstration, at which point Community Health Teams (CHT) will be introduced as a strategy to improve care and reduce avoidable costs for PCMH patients, especially those with complex or chronic conditions. MaineCare plans to leverage the PCMH and CHT partnership to take advantage of the Affordable Care Act's (ACA) Health Homes option for enrollees with chronic conditions. Implementation of the State Health Homes Option will enable Maine to receive an enhanced 90/10 federal match for the first eight quarters of the initiative. This enhanced match could in turn fund the expansion of PCMH beyond the current 26 practices.

In addition, the Centers for Medicare and Medicaid (CMS) Innovation Center is testing new payment and service delivery models to achieve cost reductions and quality care for Medicare-Medicaid enrollees. MaineCare plans to pursue a model under which they could receive retrospective performance payments for achieving target Medicare savings through improved care coordination for Medicare-Medicaid enrollees under Health Homes or other primary care delivery models.

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 through 20 years of age who needs care for one of the following reasons:

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

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

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

Maine continues to define children with Serious Emotional Disturbance (SED) in accordance with the accepted federal definition for this segment of the target population covered under the Children's Mental Health Block Grant State Plan.

Maine Estimates of SED Population

In this year's Block Grant Application estimates of the number of children with SED are allocated within the Office of Child & Family Services local District Office structure that is comprised of one or more of Maine's 16 counties. County population information is from the Bureau of the Census (2010) for all children ages 0-17. The estimated State SED population (URS Table 2) was used to estimate the District SED population.

CMHS Data Infrastructure Plan Maine Population Estimate for Children Under Age 18 with SED		
Office of Child & Family Services - Districts	**All Children Ages 0-17 Years 2010 Estimated**	**Estimate of SED Population (yr.2010)**
Aroostook – District 8	14,384	1,030
Downeast – District 7	16,541	1,184
Penquis- District 6	33,720	2,414
Central Maine – District 5	36,484	2,612
Mid-Coast Coast District 4	29,747	2,130
Western Maine – District 3	42,672	3,055
Cumberland District 2	58,894	4,217
York District 1	42,091	3,014
STATE TOTAL (7.16%)	**274,533**	**19,664**

Sources of Data and Information in this Application

Because the FY12 Block Grant Application and Plan rely on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plan, it is useful to state at the beginning of Criterion 2 the specific data sources that Maine employs for these purposes in the current application.

Year End Contract Reports Children's Behavioral Health Services (CBHS) 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 (yearend) reports are a major source of data used by the Department, and are referenced in this Application. Yearend reports are not always available in August of the previous full fiscal year; which is the case for State Fiscal Year 2011. Because Year End Contract Reports for FY10 are complete for all services covered, this is the base year available for inclusion in the current Plan. Contract reports show unduplicated counts of children served for the particular service component under contract. However, when different types of services are added together, the total number is a duplicated client count.

Maine Integrated Health Management Solution (MIHMS)

This is the current MaineCare claims management system that replaced the MECMS system. This system came on-line in September, 2009. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.

Enterprise Information System (EIS) This is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children's Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children's Home and Community Based Treatment and Children's Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08 . An updated version of this system became operational on July 1,2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY10 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health & Human Services for children, through the Division of Children's Behavioral Health Services and for adults, through the Office of Adult Mental Health Services. These expenditures are the source for reporting the State's general fund contributions to the Maintenance of Effort data that is required by CMHS and reported in Part B, Section 3. of the Mental Health Block Grant Application and Plan.

Children Receiving Publicly Funded Services

Children's Behavioral Health Services accounts for the number of children served using Departmental funds by three primary sources: (1) Year End Contract reports submitted to the Office of Quality Improvement by provider agencies that include both general funded and MaineCare funded children; (2) Information from internal accounting systems capturing services provided on a per diem basis for children served in residential treatment programs - known as Intensive Temporary Out of Home Treatment Services; (3) MaineCare only funded programs such as Children's Home and Community-Based Treatment (HCT), Assertive Community Treatment (ACT) and Rehabilitative Community Services (RCS) and supports for children who have emotional/ behavioral needs. Contract Services are listed below for FY10, using information reported to CBHS field personnel, Purchased Services Agreement Administrators and/or the Office of Quality Improvement for MaineCare services. The Intensive Temporary Out of Home Treatment Services count is derived from residential placements for youth in the care of CBHS, paid through the CBHS budgeted Room & Board account and reported by CBHS Clinical Care Specialists.

Children's Behavioral Health Services
Children Served, by Program Type
Under Community Provider Contract FY10*

Type of Service	#Served	Type of Service	#Served
Case Management	9,696	Outpatient Services	14,664
Crisis Services	5,546	Medication Management	4,444
Early Intervention (0-5)	3,814	Parent Self-Help/Support	4,359
Assertive Community Treatment	505	Sibling/Peer Support	474
Homeless Services	2,506	Residential Treatment	650
Respite Services	1,667	Rehabilitative Community Support	1,492
Flexible Funded Services	2,179	Home&Community Based Treatmt	2,774
Functional Family Therapy (FFT)*	310	MultiSystemic Therapy (MST)*	415

*** Evidence Based Practice**

TOTAL SERVICES PROVIDED to CHILDREN 51,136 (FY10)

Estimation of Unduplicated Count of Children Served

Individual service categories reported above provide an unduplicated count of all children who received that service during FY10. 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 Behavioral Health Services has employed a planning assumption that children and families in Maine receive an average of 2.25 different types of service over a year. Based on that assumption, then **it is estimated that the unduplicated count of children served was 22,727 in FY10**.

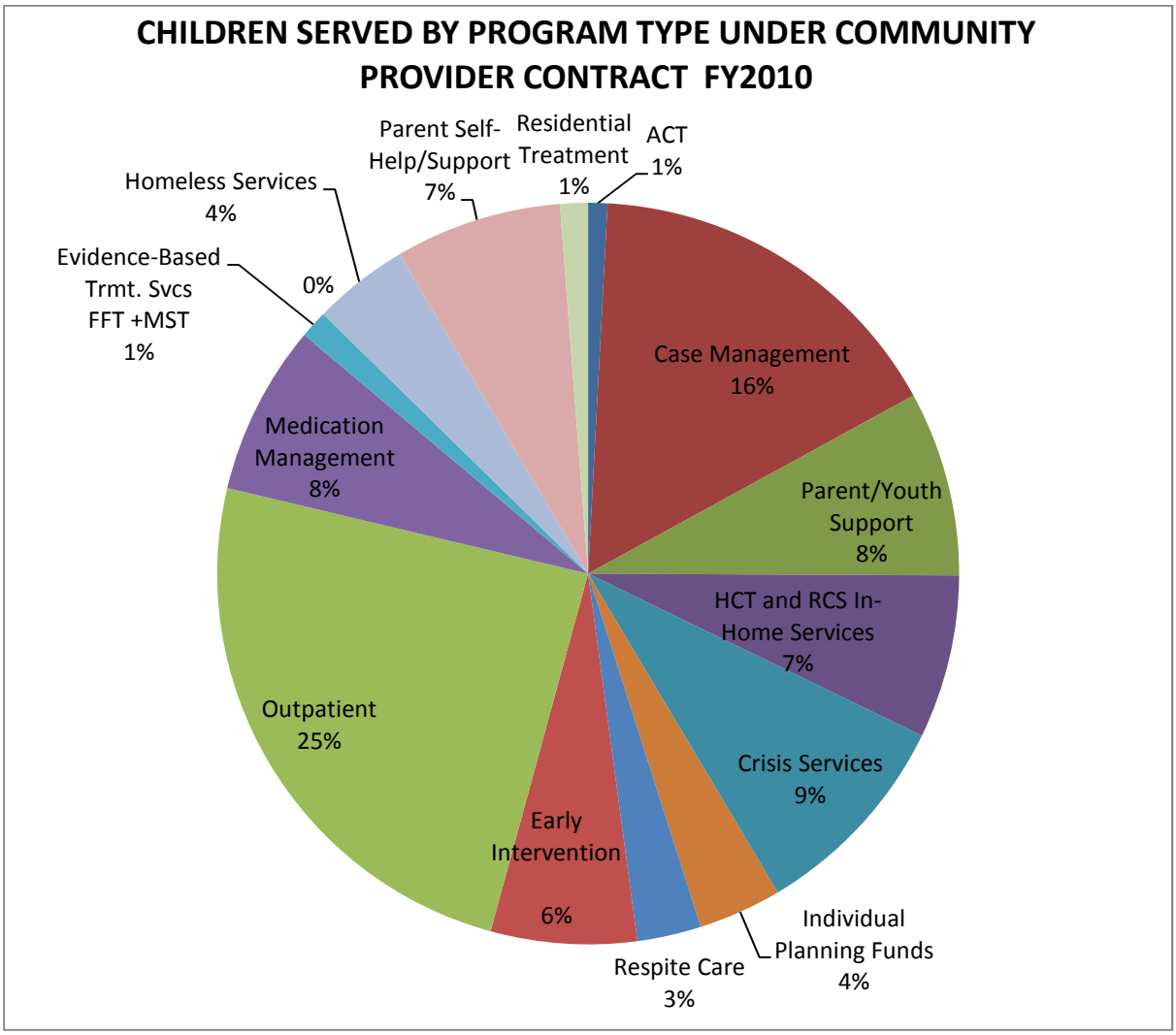
Target for Criterion 2 In addition to the National Outcome Measure (NOM), URS Basic Table 2A which measures increased access to services for children and youth who receive MaineCare behavioral health services, the Department and CBHS also monitor estimates of the total number of children that are served in the fiscal year.

The total unduplicated estimate for FY10 above includes children and their families who are receiving both MaineCare and non-MaineCare covered services such as respite, flexible funded services and/or other family support services. This population also includes children whose service needs are not specifically behavioral health, such as children with intellectual disability who are receiving Rehabilitative and Community Support services, young children with developmental needs who are receiving Early Intervention Services or children whose needs require Therapeutic Recreation/ Socialization activities in the community, provided through Flexible Funds.

The estimated unduplicated count for all children being served in FY10 was 22,727 and the MaineCare behavioral health count (NOM URS Basic Table 2A) was 18,664 (82.2%), leaving

an estimated 4,063 (17.8%) children whose primary diagnoses are likely to include intellectual disability, autism or early childhood developmental delay.

While CBHS does not set a state performance indicator similar to the federal NOM for all services delivered in a fiscal year, the total number served in any fiscal year is critical to track because it is one of the most frequently asked questions directed to the Department. Total children served, by program, are meaningful statistics to program administrators, Departmental officials, the Executive Department and Governor, the public at large and members of the Maine Legislature's Joint Standing Committee on Health & Human Services and the Joint Standing Committee on Appropriations and Financial Affairs.



CRITERION 3: INTEGRATION OF CHILDREN'S SERVICES

Children's Behavioral Health Services has developed strong and viable relationships with other child-serving state agencies, notably the Department of Corrections, Juvenile Services; the Department of Education, the DHHS Office of Substance Abuse and within the Office of Child & Family Services, the Divisions of Child Welfare Services and Early Childhood Services.

These relationships are nurtured and strengthened through active collaboration within the system of care. Collaboration and partnerships are developed at the regional and district levels where services are delivered to children and their families, at the policy level where strategies are formulated and values are supported, and at the practice level where behavioral health services are shaped, evaluated and promoted, based on outcomes beneficial to children and their families. CBHS promotes the interests of families through relationships with other state agencies and their divisions, and affiliates such as the Department of Education through the Maine Association of Special Education Directors.

The Division of Children's Behavioral Health Services is also connected with other state agencies and entities that are not directly involved with services for children and their families, but are important potential future way stations for some youth as they begin to age out of the children's service system. These agencies include the Office of Adult Mental Health Services which may be a provider for young adults with Serious Mental Illness (SMI) and the Office of Adults with Cognitive and Physical Disabilities Services that could be a destination for high need youth whose emotional, physical and behavioral needs require intensive and long term attention and support that would be available under the Home and Community Based Waiver offered through that Office.

Children's Behavioral Health Services enjoys a close and productive working relationship with the DHHS Office of MaineCare Services (OMS), the Maine Center for Disease Control and Prevention (MCDC), and the Office of Quality Improvement (OQI). These units of the Department provide essential subject matter expertise to CBHS and they have been long standing partners in key areas within the children's behavioral health services program.

OMS continues to be a valued partner by collaborating with CBHS in writing Medicaid (MaineCare) rules for high quality and essential behavioral health services that incorporate promising, proven and evidence based practices. The MCDC has been supportive in promoting the integration of mental health services with physical health policy as well as other important work with CBHS on the Maine Youth Suicide Prevention Committee's Steering and Action Committees. The OQI has been instrumental in collecting and evaluating data on client outcomes related to specific behavioral health services, and reporting performance indicators for contracted programs that are an important element of the data included in the Mental Health Block Grant Application.

System of Integrated Services

This section of the FY12/13 application focuses on the development of relationships between Children's Behavioral Health Services and the other child-serving agencies that are essential partners in Maine's comprehensive system of care. This section documents the identification of CBHS as the mental health authority in the State of Maine via legislative act, Chapter 790, Public Law 1997.

Historically, many positive steps have been taken leading toward increased integration of behavioral health services within and throughout public and private entities providing behavioral health services to children and youth in Maine. These steps include legislative activity with resulting mandates, memoranda of agreement amongst several state agencies, and between

services divisions within state Departments, and emergence of operational processes that, over time, have strengthened integration as the model of service delivery replacing the more compartmentalized system existing prior to the passage of Chapter 790.

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 Behavioral Health Services statute under Title 34-B, which includes children who have developmental disabilities, intellectual disability, 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 intellectual disability

Section 15002: Children's Mental Health Program

This program represents the structure that will coordinate the children's mental health care provided by all child serving departments. The program is now under the supervision of the Commissioner of DHHS. The Director of Children's Behavioral Health Services 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. 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 recognize 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 Behavioral Health Services is responsible for developing policies and rules regarding access to care, eligibility standards, uniform intake and assessment tools, and access to information among departments. This includes responsibility to coordinate with the other Departments on developing community resources and support services and for monitoring care and services. The Departments must also determine existing service capacity, unmet needs and the need for increased service capacity. The law instructs DHHS to adopt rules for mental health care for children under the Medicaid (MaineCare) program.

Chapter 790 requires that the Departments implement fiscal information systems that can track all appropriations, expenditures and transfers of funds that are used for children's mental health services. CBHS has this capacity within the Office of Child and Family Services through the integration of CBHS, Early Childhood Services and Child Welfare Services fiscal data managed by the OCFS Program Fiscal Coordinator. Chapter 790 requires that federal block grant monies are to be used for children who are not eligible for Medicaid. General funds will be used to maximize the use of federal funds, including Title IV-E and other federal funds for the 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 (Chapter 790) placed considerable emphasis on regular reporting to newly created oversight committee and to the legislature's Joint Standing Committee on Health and Human Services. Over the first 6 years of the legislation the Departments generated reports on a regular basis at the direction of the committee. These reports included specific topics of interest concerning Juvenile Services, Education, Child Welfare and Children's Behavioral Health Services. All child-serving Departments continue to provide information to their legislative committees of jurisdiction, such as the Joint Standing Committee on Health & Human Services

that oversees DHHS Office of Child & Family Services' Child Welfare Services, Early Childhood Services and Children's Behavioral Health Services. Other committees of jurisdiction include the Joint Standing Committees on Education & Cultural Affairs and Criminal Justice and Public Safety.

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

CBHS, in consultation and cooperation with the other child serving departments, was charged to develop a comprehensive system of services for children with autism, developmental disabilities and intellectual disability. In designing the service system, the department utilized the framework of the Children's Mental Health Program. Children's Behavioral Health Services has fully integrated children with intellectual disability and autism spectrum disorders into the system of services developed for children with mental health needs. Examples of this integration include Targeted Case Management services and community based mobile crisis services.

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 since that time. 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.
These collaborative efforts are summarized as follows:

Children's Behavioral Health Services/ Office of MaineCare Services

In pre-merger years, both Departments have worked closely on a number of initiatives. Now that the unification of the former DHS and BDS has occurred, Children's Behavioral Health Services and the Office of MaineCare Services, in accordance with their previous 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 OMS, the state Medicaid authority. Public informational 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 reflective of the excellent working relationships between the state agencies.

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 MaineCare policies. One of the very important changes occurred over the last two years with the development of MaineCare rules establishing the Children's Home and Community Based Treatment Services, including evidence-based practices such as MultiSystemic Therapy and Functional Family Therapy.

Other Medicaid policy areas underwent revision and resulted in the consolidation of many individual treatment services that are now incorporated in a single section of policy under

Children's Mental Health Services (MaineCare Section 65). Currently there are major policy changes focused on Targeted Case Management services and Residential Treatment services.

Interdepartmental MOU for Assisting Children At Risk

The goal of this protocol was 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. Children's Behavioral Health Services and Child Welfare Services expected 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.

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 clearly identified 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 DHHS/ Child Welfare Services Adoption Program and Children's Behavioral Health Services, regarding children receiving adoption assistance who also access CBHS grant funds for residential treatment. Both CWS and CBHS facilitate coordination of resources to maximize utilization of appropriate funding and prevent duplication.

Adoptive parents applying for residential services (Intensive Temporary Residential Treatment Services) are informed of CWS and CBHS coordination regarding children receiving Adoption Assistance through Child Welfare Services. Families receiving post-adoption assistance, who have children with special needs, are encouraged by CBHS and its contracted providers to access appropriate services available through the CWS Post-Adoption Support Program. Families receiving post-adoption assistance, who have children with special needs, will be encouraged by the CWS Post-Adoption Support program to access assistance available through Children's Behavioral Health Services and its contracted providers. Both CBHS and CWS 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.

CBHS Partnership with Maine Center for Disease Control

Project LAUNCH: Linking Actions for Unmet Needs in Children's Health is the most recent illustration of close and successful intra-departmental relationships that CBHS has established with its peers in Maine's Department of Health & Human Services. The Maine Center for Disease Control, Division of Maternal and Child Health, in collaboration with the Office of Child and Family Services, including CBHS, was awarded one of six SAMHSA grants funded

for five years at $916,000 per year to promote wellness for children birth to 8 years of age. Wellness is defined as a state of positive physical, emotional, social and behavioral health. The goal is to create a shared vision for the wellness of young children that drives the development of Federal, State, Territorial, tribal and locally based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed. Project LAUNCH is grounded in the public health approach, working towards coordinated programs that take a comprehensive view of health, addressing the physical, emotional, social and behavioral aspects of wellness

The Community Caring Collaborative (CCC) in Washington County implemented Project LAUNCH. CBHS has had a continuing relationship with this collaborative prior to this current initiative, providing Children's Mental Health Block Grant support for an infant mental health specialist position to develop a curriculum for working with new parents with substance abuse issues. The CCC is comprised of community members, child-serving agencies and tribal entities. The CCC has developed three groups to advance its collaborative efforts. A work group of front-line workers and family members define areas of concern and needs. The Executive Council includes heads of agencies or tribal organizations and family members develops policies and procedures for the collaborative. The State Agency Advisory group explores policy and program issues that require state action and inclusion. The children to be served under Project LAUNCH include those born affected with substances or are at risk due to a variety of other issues and their families and older siblings through age eight. Currently, approximately 100 infants are born a year within this at risk population. Including siblings and parents or caregivers the total population to be served is 300.

CBHS Collaboration with Early Childhood Care and Education

The National Early Childhood Technical Assistance Center (NECTAC) in collaboration with the Office of Special Education Programs (OSEP) is supporting 11 states that are establishing a statewide framework to strengthen families and support a continuum of inclusive community-based early care and education opportunities. Children's Behavioral Health Services is a member of the expanded cross-systems team known as Maine's Expanding Inclusive Opportunities Initiative that is ensuring that children birth through 5 and their families have increased access to high quality community based inclusive early care and education. The team works collaboratively and transparently across sectors and systems both locally and statewide to promote interagency understanding and support of this inclusive initiative.

Assistance to CMS Long Term Services and Supports

Maine is participating in a two-year grant sponsored by the Center for Medicare & Medicaid Services (CMS). Phase I requires the development of a state profile tool that identifies the current long term services and supports system, describes the administration of these services and supports and includes demographic and utilization data. In Phase 2 Maine will work with a National Balancing Indicator Consultant (NBIC) to develop common measures across states for measuring the balance between home and community based services and institutional services. The Office of Child and Family Services is contributing to this project by providing vital

information on children with long term service and supports needs. Central office personnel supporting this work include the CBHS Quality Assurance and Training Manager and the CBHS Information Systems Manager.

Department of Corrections - Juvenile Services/Children's Behavioral Health

CBHS/DOC Summary for FY11

The following narrative summarizes the work of Children's Behavioral Health Services staff assigned to support the Department of Corrections (DOC), Juvenile Services, in all 4 DOC regional offices and in the 2 Youth Development Centers in Fiscal Year 2011.

The collaborative integration of behavioral health services within the juvenile justice system is managed by a CBHS Social Services Manager who oversees the behavioral health services provided within juvenile facilities and by CBHS Team Leaders who supervise Mental Health Program Coordinators attached to the community-based system in DOC regional offices.

The original Memorandum of Agreement beginning this collaboration and the placement of children's mental health staff in Juvenile Youth Development Centers and co-location DOC field offices was signed in 2002 between CBHS and Juvenile Services and was updated in 2007. In the early days of this collaboration, most of the CBHS staffs' efforts were on educating their counterparts within juvenile services that some of the youth on their caseloads were in need of behavioral health treatment. These efforts centered on helping staff have a basic understanding of mental illness and then on removing barriers in order that youth and their families would get the treatment and support that they needed. Over several years this relationship has matured to the point where today the work of staff involved with this program fall into two broad categories: individual consultation, assessment, treatment and advocacy, and system integration and improvement. Those efforts are described below.

Individual Consultation, Assessment, Treatment, Advocacy

Initial Mental Health Assessment- Long Creek and Mountain View Youth Development Centers have worked hard to implement a system to assure that each youth entering the facility has a mental health assessment. Both facilities administer the Massachusetts Youth Screening Inventory-2 (MAYSI-2) to each youth upon admission. The results are given to nursing personnel who further assesses the youth. If a youth scores in the critical area of suicide they are immediately put on a "watch" and further assessed by the Suicide Prevention Protocol. Results of the MAYSI are then given to the CBHS clinical social worker who then completes an additional mental health assessment. These results inform staff about the level of support that youth may need while in the facility, and help inform their teams on mental health symptoms that may need to be treated once they leave the facility. Prior to this system, CBHS clinicians relied on client's self referring, staff observation or on reports from outside providers to signal that a youth may need mental health support. The MAYSI assessment tool and process now provides an objective and systematic way to screen for mental health needs and has been especially helpful in detecting youth with internalizing behaviors.

Aggression Replacement Therapy "ART" This is a multimodal therapy designed to help reduce aggressive behavior in chronically aggressive youth. CBHS staff at Mt. View have co-lead this group therapy with DOC staff.

Trauma Affect Regulation: Guide for Education and Therapy--"Target"- This is a psycho-educational program which teaches youth to manage the symptoms of complex trauma. While some clinicians at Long Creek and Mt. View are trained in the TF-CBT model of trauma treatment, DOC chose to implement Target as it has been designated a promising practice by National Child Traumatic Stress Network, for use with youth in the juvenile justice system. It is basic enough that non-clinical staff are able to help implement it and because it does not require exposure therapy, it is anticipated that this model will be better suited to the sometimes re-traumatizing correctional setting. CBHS staff from Long Creek attended an intensive training and co-facilitated Target groups for girls in the facility. CBHS Mental Health Coordinators will also be attending this training to better understand which youth can benefit from this model.
Team meetings- Mental Health Coordinators spend the bulk of their time in team meetings on individual youth. This provides the opportunity to educate teams on how the youth's mental illness may be interfering with their functioning and on treatment that is matched to their needs. Many of the youth are connected with community mental health case managers, but even in this situation, having a person who understands the complexities between correctional and mental health needs is valuable. It offers someone who is not deeply involved in the day to day challenges of the case to be able to ask questions, and can most often help the team reframe some of their thinking and give hope to parents that their child and family's functioning can improve.

Systems Collaboration/Integration

Youth with Complex Needs- This meeting of Child Welfare, DOC and CBHS Central Office staff and DOC facility staff was initiated because of concern over a number of youth with serious emotional disorders and developmental disabilities who had been detained. These youth did pose a high risk to the community because of aggressive behaviors, but treatment within a correctional system could have the unwanted effect of increasing their criminal risk. This collaborative problem-solving group has been instrumental in developing a systematic approach in considering youth under these circumstances, to include:

Interagency Protocol for Detained Youth - This approach calls for a multidisciplinary team meeting on all detained youth with a joint recommendation to the court in order that the youth can be detained. It outlines steps to move the case to higher administrative levels when a joint agreement cannot be reached. Even with this improvement in the process, monitoring and enforcing a multi-departmental protocol has proved difficult, highlighting the differences in management styles and expectations between the agencies.

Interagency Case Review – Problematic cases are presented, dissected and reviewed with recommendation given for future changes in process.

Jurisdictional Team Planning- JTP involves regional groups of multidisciplinary providers including attorneys, judges, mental health providers and correctional providers who meet on a regular basis to develop ways to avoid the use of secure detention and to increase evidence based practices. Efforts have been extremely fruitful, resulting in a significant decrease in the number

of youth being detained and the length of time they are detained. Other tangible outcomes from this working model have included:

- Resource Guide for parents who have youth in the Juvenile Justice System
- Formal training protocol given to law enforcement officers at the Police Academy to educate them on responding to a crisis
- Formal protocol for police responding to juvenile crisis to document and refer cases to crisis services for follow-up
- Developing a multi-system case review system for families with complex needs and who are involved with multiple providers and services.
- Developing a case review system to address family/ youth situations where multiple police responses have occurred. This is an off shoot of the juvenile reporting form and training that a local police officer spearheaded this past summer.
- Participating in workshop for families who have youth heading toward the JJ system—designed to help them understand modalities that are available to help and designed to get families to be more involved in the development of resources in their communities.
- Redesigning the initial juvenile intake form to identify natural supports and assets early in a youth's involvement with Corrections as a way to begin effective case planning, crisis planning and diversion.

Juvenile Justice Task Force- In April 2009, Chief Justice Saufley, First Lady Karen Baldacci, and Dean Pitegoff of the Maine School of Law convened this task force of state agencies, branches of government and sectors of the non-profit agencies to reform the Juvenile Justice system. Goals included, "increasing educational attainment, access to community-based services, correctional practices, resource allocation and organizational structure and development." While similar to other initiatives such as JTP, Regional Children's Cabinets, the Juvenile Justice Advisory Group and Regional Wraparound Maine Advisory Board, the Juvenile Justice Task force has the advantage of coming from the Governor's office and has been able to actively bring the Departments of Education and Labor to the table.

On April 7th, 2010, Governor Baldacci signed LD 1703 into law – Resolve, To Implement the Recommendations of the Juvenile Justice Task Force – Reinforces the Juvenile Justice Task Force report from March 2010 that called on the state to make major changes to how it treats at-risk or troubled teenagers, proposing a list of goals aimed at keeping youth in school and out of correctional facilities. Since that time, the state has been divided into 8 geographical districts with each district inviting professional providers along with community members to develop a strategic plan for their district on how they will achieve the goals outlined.

Intensive Temporary Residential Treatment "ITRT"- CBHS staff present and review youth to determine level of care, when this is a treatment option that is being considered

Sexual Behavior Treatment- CBHS staff, along with DOC staff present cases to consultant Dr. Sue Righthand to insure youth get appropriate levels of treatment

Girls Case Management- CBHS staff are working with DOC staff to develop and implement gender specific case management guidelines for girls in the correctional system. Currently there are two Juvenile Community Corrections Officers (JCCO's) who have all girls caseloads and are slowly implementing these practices. The group is also working on how to screen girls early in the process to identify mental health needs.

Substance Abuse Collaborative—Mental Health Coordinators are members of this collaborative, aimed at improving system delivery to youth with substance abuse problems. The focus statewide of substance abuse treatment has been to have all providers capable in treating substance abuse in a co-occurring model

Aggressive Youth in Residential Treatment-CBHS and DOC staff work together to ensure that residential treatment facilities respond appropriately when youth with dual mental health and correctional involvement become violent.

Mt. View Facility and Community Collaborative - Monthly meeting where mental health staff from DOC and CBHS who work in the facility are joined by their counterparts in the community to help identify and plan for youth who are transitioning out of the Mt. View facility.

Education on Evidence Based Treatment/Promising Practices-Mental Health Coordinators in each region meet with providers and corrections frequently to disseminate information about evidence based treatment and connect people with the agencies providing these treatment modalities. MST, FFT, Multidimensional Treatment Foster Care, TF-CBT, and Wraparound Maine have all been promoted in this population. Due to needs identified, in part by the Mental Health Coordinators, Kennebec Behavioral Health expanded their MST services several years ago to include a Sexual Behavior Specialty.

Enterprise Information System (EIS)- Mental Health Coordinators are beginning to use this electronic record system to better document, track and share information on the youth they work with.

Continuous Quality Improvement (CQI)- Mental Health Coordinators are working alongside the other Clinical Staff and families, youth and providers to develop an effective tool to measure the quality of services that CBHS contracted providers deliver.

Goals for Fiscal Year 2012

Each year, a substantial amount of the staff's time is spent maintaining the basic foundation of the collaborative work—educating, sustaining relationships, continuing practices that have been put into place. In FY12 these and the above efforts will continue, along with some new initiatives which include:

Crisis Planning- Insuring that all youth have a crisis plan that is easily utilized and that includes natural supports. York County JTP is gathering data on the effectiveness of the crisis protocol they developed in conjunction with local and state police.

Restorative Justice- At least two areas of the state have a Restorative Justice Program. Both York and Cumberland County JTP's are looking to expand this to their regions. The Restorative Justice Project of Midcoast serves juvenile offenders in Knox and Waldo Counties and in four additional counties (Washington, Sagadahoc, Lincoln and Hancock).
Parents who have youth in the system are interested in assisting with this project. In the current legal system youth are frequently not encouraged to take responsibility for their actions, any consequence for their action may be months away from the actual offense they committed. From a developmental perspective, this is not effective. The current legal system frequently minimizes the victim's experience and pushes the youth further away from their community and from the people they may have caused harm to. Restorative Justice is a model that better matches adolescent development and helps the youth become a productive citizen of their community.

Transition- With a good foundation of treatment both in the community and in the correctional facilities, the next step is to refine the transition process for those youth going from one setting to the other. CBHS staff will continue to work with youth and families to assist in individual transition plans and to better operationalize the transition process.

Summary of Direct Services Provided and Utilization of Individual Planning Funds

In addition to systemic work, CBHS mental health personnel provided direct service to youth and families involved in DOC Juvenile Services and authorized funding for services and items that were not able to be paid by existing funding sources.

Mental Health Consultation- Consultation by community and facility based staff was provided by Mental Health Coordinators for approximately 475 individual youth. These consultations ranged from brief contact with a parent or provider while other consultations required extensive involvement, such as when youth with high risk behaviors and complex mental health needs transitions to another part of the continuum (community to facility or facility to community) or transitions to adulthood.

Clinical Counseling at Long Creek- Both clinical social workers at Long Creek left for other employment and these positions have not been filled. The workload of individual clinical counseling, suicide assessments, initial assessments, team meetings and behavior stabilization are being covered by the Program Manager and other DOC staff.

Mental Health Coordinator and Psychiatric Social Work Services at Mt. View

80 mental health appraisals for detained youth
10 initial assessments for committed youth
11 youth were served with ongoing case management
29 youth were provided cognitive skills training
16 youth were provided Aggression Replacement Therapy

Individual Planning Funds - In FY11 $105,985 was spent on youth who had entered the DOC system. The highest percentage was spent on specialized assessments and on specialized treatment. Expenditures were as follows:

	Region 1	Region 2	Region 3	Mt. View	Long Creek
Case Management		766			
Clothing			281		
Clinical Treatment		11,762			1,200
Crisis Support		1,333			
Evaluation	51,920	20,149	3,480	900	3,800
Family Support	783	445	610		
Housing					
Medication/medical equipment			329		
Recreation	1,115	422	597		
Respite					
Safety Equipment		503			
Supported Employment					
Transportation		681	2,319		
Emergency Funds to Keep Youth in Their Home (fuel/utilities)		668	1,925		
Totals	53,818	36,726	9,541	900	5,000

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 Health & Human Services custody. Because all departments recognize that there are consequences to removing children from their parents' custody, emphasis is placed on making all reasonable efforts to secure alternative options before consideration of state custody.

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 Youth 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 until June 30, 2010.

In FY11, OSA provided the following substance abuse services to adolescents (under the age of 19 at admission) in Maine: Evaluations (53) Outpatient (650); Intensive Outpatient (47); Detoxification (9); Residential (80); Shelter (1); and Methadone (10). The unduplicated clients served totals 851.

Data available from a survey of selected public schools conducted last year by the Office of Substance Abuse suggest that Maine has made progress in decreasing alcohol, marijuana, and other drug use among its youth. Detailed reports can be found in the right hand navigation bar at the following link: http://www.maine.gov/dhhs/osa/data/cesn/index.htm . During state fiscal year 2009, among the 985 youth who needed substance abuse treatment, most (49%) entered treatment for marijuana abuse. Thirty percent entered treatment for alcohol abuse, 12.5 percent entered treatment for opiate abuse, and ten percent entered treatment to address issues with other substances. OSA will continue to work with treatment providers and others to determine what barriers exist for adolescents and families trying to access treatment services.

Department of Education/CBHS

Children's Behavioral Health 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 is the Interdepartmental Resource Review Committee which identifies priority needs for all children, and reviews new or enhanced program models. Presently, this committee is active in assisting providers in the redesign of their residential programs from long-term residential to shorter-term, family focused treatment programs with the goal of lessening length of out-of-home placement and maintaining connections to a child's natural community and extended family.

The Department of Education is a frequent collaborator with the other child serving state agencies, either as a participant or advisor to new initiatives which involve multiple agencies. CBHS has been an active partner with DOE regarding specific behavioral health MaineCare services provided through DOE. CBHS staff have assisted in re-writing policy related to children in the educational system that included Day Treatment Services (Section 41) and Early Intervention Services (Section 27).

Child Development Services (DOE)/ Children's Behavioral Health Services

In FY12/13 Children's Behavioral Health Services will continue close collaboration with Child Development Services within the Department of Education. A major objective will be to identify common connections with families that receive services from both CDS and CBHS. These connections can be identified through CBHS contracted case management agencies.

Other objectives include training initiatives that provide a consistent and comprehensive overview of the CDS and CBHS missions and operations for pre-school/ early intervention services and to identify the assessment tools used by CDS and CBHS.

The Department supports a strengthened and enhanced relationship with CDS at the community level that will improve the coordination of care and service delivery to this population through vehicles such as team meetings and individual plan development.

MADSEC/BDS Liaison Committee

In an effort to support and implement the Memorandum of Agreement with DOE, 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. CBHS central office and regional staff are active members of this committee.

For the past several years, this committee provided several statewide trainings called "Building Mutual Respect for Working Relationships" for participants and audiences which include parents, youth, community case managers and school personnel, and state child-serving department staff. This initiative grew out of the need to improve working relationships between community case managers and educators. Its mission has been "to foster statewide cooperation, collaboration, commitment and utilization of resources, services and personnel to provide timely and appropriate services for children/youth with disabilities."

Areas reviewed and discussed include the departments/agencies/school's respective missions, legal mandates and statutes, and includes information on the type, range, and access of services available from each sector. The trainings have been a welcome and helpful avenue for stakeholders to learn about others' roles and responsibilities and to build effective working relationships so that everyone may better serve children and families. Trainings were provided by various members of MADSEC, DHHS, DOE, local school personnel, parents and youth. Evaluations of the training have universally been very positive. In January 2009 the committee completed its work, concluding that its mission had been accomplished.

School-Based Health Centers

Twenty-seven (27) Maine schools have established a School-Based Health Center (SBHC). A School-Based Health Center is a health center located on or near school grounds and staffed by qualified health professionals. Each center operates under the guidance of a local advisory board, broadly representing the community, including parents and students. The Health Center Advisory Board decides what services to offer at each center.

Services are provided by physicians, physician's assistants, nurse practitioners, mental health providers, and dental hygienists, in cooperation with school nurses. A medical director oversees

clinical services. Health Center staff work closely with school staff and student's primary care providers.

Most schools value the importance of the integration of physical and mental health services. Counseling, mental health and substance abuse services can include:

- Individual and group counseling
- Referrals to community providers
- Preventive health guidance/education
- Nutritional education and counseling
- Support groups for eating disorders, chronic diseases, smoking cessation, grieving, substance abuse, etc.
- Sexual health counseling
- Pregnancy counseling
- Job counseling
- Family counseling

School-Based Health Centers are funded from a variety of sources that may include the Fund for Healthy Maine, State general funds, federal funds, local school funds, and cash or in-kind services from schools, service providers and other community entities. Most SBHCs receive reimbursement for eligible services from public and private insurers.

Day Treatment/Local Education

Day treatment services are available to participating schools through Maine Care Day Treatment Services, Section 65. DHHS Maine Care has initiated several major policy changes related to school based behavioral health day treatment, programs for children with cognitive impairments, and various related special education services such as Speech and Language Services, Physical Therapy and Occupational Therapy. The Department of Education is working very closely with Maine Care staff to provide training and certification for Behavioral Health Professionals who will provide direct services to students in day treatment programs.

Day treatment services are designed to improve a child's functioning in daily living and community living. Programs commonly include a mixture of individual, group and activities therapy, and may also include therapeutic treatment oriented toward developing a child's emotional and physical capability in areas of daily living, community integration and interpersonal functioning. Services will be provided as prescribed in the Individual Education Plan and Individual Service Plan.

Transitional Services for Adolescents and Young Adults

In October 2002 an interdepartmental protocol for the coordination and transition of children served by the former DHS and BDS was completed. This protocol covers youth with identified diagnoses of mental illness, youth with intellectual disability 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 Child Welfare and Children's Behavioral Health services systems.

Currently, both the Office of Elder Services (OES) and Office of Adults with Cognitive and Physical Disabilities (OACPD) within DHHS are committed to providing a close collaborative working environment in order to plan and work together and share common expertise to support youth and young adults who are consumers of State services. Elder Services provides adult protective services to youth who transition and OACPD provides services for adults with intellectual disability. In setting forth this Protocol, the DHHS reaffirms its commitment to providing the best services and supports possible by building on the strengths of their mutual work. An interactive training module around guardianship was produced through the Muskie Institute in collaboration with Elder Services and OACPD at: http://www.maine.gov/dhhs/guardianship/guide.shtml.

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.

MOU between CBHS and OAMHS Regarding Transition Age Individuals

An important product of the *Moving Forward* Initiative (discussed later in this Criterion) has been the concurrent development of an updated Memorandum of Understanding between the Division of Children's Behavioral Health Services and the Office of Adult Mental Health Services (OAMHS). This MOU, effective May 14, 2009 formally addresses the roles, responsibilities and commitments of Maine's Mental Health Authorities to enhance and sustain a high quality mental health system of care for transition age individuals. Both offices recognize the need to enhance and coordinate policies, procedures, services and supports for individuals from ages 16-25.

OAMHS and CBHS are committed to collaborative systems approaches to ensure timely access to needed services and continuity of care to ensure a seamless transition to adulthood. The mental health system of care will be family-driven, youth guided, culturally competent, strengths based, trauma informed and apply the principles of effective interventions for transition age individuals.

The MOU details the responsibilities of both parties and contracted provider agencies regarding joint tracking of individuals from the age of 16 who are expected to require mental health services and supports into adulthood and to engage consumers, families, providers and advocates in the development of state regulations to ensure that services are available and consistent across child and adult services and barriers to accessibility are eliminated. Staff from both state agencies will be cross-trained in the Transition to Independence (TIP) curriculum, as will community providers.

Provider contract obligations will ensure that relevant information for transition planning is exchanged with individuals, other treatment providers, family members and others involved in the planning process. Both offices agree to monitor provider outcomes in a coordinated fashion

at the regional level, and coordinate on any corrective action plans with providers, and jointly monitor progress on plans.

CBHS and OAMHS will develop and implement training and support for case managers and clinicians in implementing effective transition planning, using TIP as the foundational approach to transition planning. Both parties agree to maximize existing and available resources to support individual needs, and to identify available funding and possible methods for integrating or enhancing funds related to individuals transitioning within the public mental health systems.

The policies and procedures developed under the MOU will be reviewed on a semi-annual basis by central office staff responsible for policy development and implementation, including the Directors of each Office. This review covers policies and procedures that in any way impact the system of care for transition age individuals. Data collected by each Office will be used to jointly evaluate the utility and benefit of the agreement by establishing performance measures to monitor the progress towards attainment of goals and to measure the level of progress.

Youth Transitioning from Foster Care

Children's Behavioral Health Services is one of several collaborators actively involved with Child Welfare Services to improve outcomes for youth leaving foster care, and to enhance opportunities to help these youth make a successful transition to adulthood.

Child Welfare Services has worked in collaboration with the University of Southern Maine, through the Jim Casey Youth Opportunities Initiative (JCYOI), and public and private partners on improving outcomes of youth transitioning from publicly funded foster care for the past 5 years.

This Collaborative, known as the Maine Youth Transition Collaborative (MYTC), with the help of JCYOI and The Finance Project, are identifying potential funding streams that could be used to assist youth in foster care to transition to adult life. This information will be used to prioritize youth transition services within the context of the following key goals: 1) Establishing permanent connections to family and other lifelong resources; 2) Ensuring economic stability-including education, employment, and housing; 3) Ensuring health and well-being.

With the knowledge and expertise of the working group, a broad range of resources are being categorized that will assist youth in accessing services and making informed choices as they prepare to leave the foster care system and improve their outcomes as adults. The entities helping to map out the options in a path to adulthood include staff from the Departments of Health and Human Services, Corrections, Labor, and Education. They are joined by other committed parties such as the Maine Youth Transition Collaborative, Common Sense Ventures, and Jobs for Maine Graduates.

As this initiative progresses the next steps will be to find local people, organizations or foundations that are "door openers" for these youth to find opportunities for independent living in Maine communities.

Additionally, as part of the Maine Youth Transition Collaborative, this public/private partnership, is also working on community engagement in York County. Implementing the network strategies of the Interactive Institute for Social Change, and in following the model of youth and adult partnership, Maine is focused on improving outcomes for youth transitioning from foster care in the areas of permanency, housing, education, and employment. Maine is looking this year to assist in similar network and community engagement efforts in Penobscot County as well.

Children's Behavioral Health Services and Child Welfare Services are also working in collaboration with the Office of Adult with Cognitive and Physical Disabilities (OACPD) to develop a protocol to assist in the smooth transition of young adults from the children's behavioral health system to the system serving adults with intellectual and cognitive disabilities. Under this newly developed protocol, Child Welfare Services will continue to provide placement and other funding for youth on a Voluntary Extended Care Agreement, while they receive all case management services from OACPD.

Notably, Child Welfare Services and Children's Behavioral Health Services worked in collaboration with youth in care and formerly in care to revise the Child Welfare Youth Transition Assessment as well as the Child Welfare Youth Transition Policy, which includes an enhanced Voluntary Extended Support Agreement that will more fully address on-going transition planning with youth.

Intellectual Disability Services Transition

Strategies that were initiated prior to the merger of the two Departments included work with Children's Services and the former Adult Intellectual disability Services. These discussions resulted in agreement on a number of points. Youth should have 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. A website is available for the public, case managers and service providers to be informed on eligibility at: http://www.maine.gov/dhhs/OACPDS/DS/CommCaseManagement/CM_Manual/Eligibility.html

There will be a collaborative financial planning process when development of resources for children will impact the adult services system. Training in the adult intellectual disability services has been delivered for all CBHS contracted case managers in all regions. Regional staff is meeting regularly to discuss planning efforts and ongoing collaboration. Finally, protocols for information sharing and resource development have been developed and agreed upon.

Wraparound Maine

Wraparound Maine is an initiative jointly funded through Child Welfare Services and Children's Behavioral Health Services that is operational in nine (9) sites in Maine. This state initiative focuses on school aged children and youth with severe emotional disturbance who are involved with multiple child-serving agencies and are in residential treatment or at risk for residential

placement. Sites are overseen by a statewide governing council and local collaborative boards consisting of child-serving agency representatives including personnel from the Office of Child & Family Services, Child Welfare Services, Children's Behavioral Health Services, the Department of Corrections, Juvenile Services, and Department of Education as well as local school systems and service providers. Parents and youth who have experience with the wraparound process are valuable members of the governing council and they share equal status with the other membership.

These sites are funded through a $4 million annual appropriation which is the equivalent in savings generated from a reduction in Child Welfare Services costs of residential foster care services over recent years. Wraparound or flexible funds are employed to address individual needs of families and youth when there is no other dedicated or categorical funding available to meet the individual's identified needs. CBHS pays the MaineCare seed costs for Targeted Case Management services for individuals served through Wraparound Maine. This initiative currently serves an average of 200 youth at any point in time.

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, Health and Human 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 was previously chaired by the First Lady Baldacci. In 2007 the Children's Cabinet selected 3 priorities that were: Early Childhood Initiative; Adverse Children's Experiences (ACES) and Transition of children to other systems. In 2008 these priorities were expanded with greater definition and they work towards systems change. Initiatives include Early Childhood Systems and Supports, to sustain and enhance accomplishments in the juvenile justice system, to sustain and enhance permanency in Child Welfare, focus on children living in poverty or who are hungry, and a systemic approach to "Creating Safe, Fair, Healthy and Responsive Schools" training and supports.

The Children's Cabinet's approach includes a Shared Youth Vision Council for 18-24 year olds providing ongoing, cross-systems and stakeholder issues relating to youth in transition with a plan to replicate Trauma-Informed Systems of Care as an approach to Adverse Childhood Experiences.

In addition, the Children's Cabinet's Task Force on Early Childhood, now a legislated standing committee called the Children's Growth Council, inspired and informed the 2007 Governor's Summit on Economic Investment in Early Childhood from which the Educare Center project emerged. Educare Central Maine will open in August 2010 and be the demonstration program for the highest quality systems change to include public/private investments, childcare and

developmental supports, child and family/parent mental and physical health needs, home visiting and prenatal care, economic security, data-collection and tracking in Maine and New England.

The enthusiasm surrounding Educare's emergence in Maine spans across private and public sectors, early childhood provider groups, K-12 and higher education leaders and staff, and across state agencies serving families with young children. The recent focus on the need for quality early childhood expansion is grounded in a very tangible goal, as the national, state and local planning teams responsible for the first Educare Center in New England look at the short and long-term implications for policy and its related early childhood systems change.

Like all Educare centers across America, Educare Central Maine will provide center-based, birth to five early care and education focused on narrowing the student achievement gap between young children growing up in low-income families and their more advantaged peers. Educare center programs are a public-private partnership model that set high expectations for both quality and results for the infants, toddlers, pre-school-aged children, and their families.

Regional Cabinets, Communities for Children and Youth Coordinating Councils

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 and Youth (C4CY) is a statewide prevention and positive youth development initiative of the Governor's Children's Cabinet connecting 65 local communities throughout the State. This network also has strong ties with several local initiatives.

For example, the C4CY office is managing two federal grants from the Department of Justice (Office of Juvenile Justice and Delinquency Prevention) that serve its constituency. The "Diversion to Assets" project is a pilot in five local communities that diverts youth who have their first encounter with law enforcement to strength building opportunities in the community. The local coordinator in Lewiston is from Thrive, the trauma-informed system of care initiative. The C4CY College Community Mentoring project is a primary prevention program funded by OJJDP which pairs college students in 7 community colleges in Maine with elementary or middle school students identified by their guidance counselors and teachers as in need of extra social and academic support. Both of these projects support the mental health needs of many Maine children.

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. 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.

In FY10, Local Case Review Committees in Regions 1 and 3 sustained their collaborative efforts and helped to form the newly legislated eight District Youth Coordinating Councils. These councils are under the Children's Cabinet's Shared Youth Vision Council, which also emerged in FY09 and FY10, as the statewide stakeholder group to implement the Dropout Prevention and Juvenile Justice Task Force recommendations that seek to identify barriers and recommendations for systems change, in support of Maine's highest-need children and youth in transition. For the first time in Maine, there will be a comprehensive, statewide strategic plan emerging for specific school dropout plans as well as plans to reduce detention and incarceration of Maine youth.

Healthy Transitions Initiative: *Moving Forward*

Early in 2007 Children's Behavioral Health Services, the Thrive Trauma-Informed System of Care Initiative, Tri-County Mental Health Services and many other community agencies joined with the Maine Children's Cabinet to seize an opportunity to "marry" the Cabinet's Transition Priority with the Shared Youth Vision Council's interests in Trauma-Informed Services by writing a federal grant that would focus on the common goals of all parties involved in this collaboration.

In May, 2009 Children's Behavioral Health Services responded to the federal Center for Mental Health Services Request for Applications, Cooperative Agreements for State/Community Partnerships to Integrate Services and Supports for Youth and Young Adults 16-25 with Serious Mental Health Conditions and Their Families (short title: Healthy Transition Initiative). State applicants are expected to select a locality in which to implement a comprehensive service delivery program that includes a strategic plan for promoting the successful transition to adulthood for youth and young adults with serious mental health conditions. In September, 2009 CBHS was notified by SAMHSA that it was one of only seven national applicants to be awarded a Healthy Transitions Initiative grant.

Maine is well positioned to address the purpose of this Initiative through its response titled **"*Moving Forward*: Achieving Independence for Transition-Aged Youth"**. The Maine Department of Health and Human Services, representing both children's and adult mental health, has joined with Tri-County Mental Health Services, the Thrive system of care Initiative which through its experience has developed solid relationships with local youth and has established credibility and trust with them, and with many other providers to implement the Transition to Independence (TIP) model in one of the neediest counties in the state, Androscoggin County.

Transition to Independence is an evidence-based practice which emphasizes youth-directed planning and development of practical skills which lead to independence. Maine intends to enhance TIP in two key ways. One is to train Peer Youth Specialists to support youth through the process of setting their goals and achieving their dreams. Among these will be members of Youth M.O.V.E.Maine, a local and national advocacy organization for youth, and the Somali Bantu Youth Association. The second is to assemble three community mental health agencies who will implement TIP, Tri-County Mental Health, Common Ties and New Beginnings, into a Learning Collaborative. The Learning Collaborative serves to support the case managers who implement TIP and reinforce the initial training provided by the TIP developers.

In addition, through the program's links to the Maine Children's Cabinet and Shared Youth Vision Council, *Moving Forward* will address identified systemic issues bridging the children and adult mental health systems including the different policies, structures and eligibility criteria that exist in each system**.**

Moving Forward aims to increase high school graduation or GED attainment, and increase access to higher education for these youth who complete high school. Other targets include reduction of involvement with juvenile justice, and increases in employment, satisfactory living arrangements, use of the community and informal supports, and increasing the perception of personal well-being by young people whose functioning has been impaired by substance abuse or mental illness.

Maine's Healthy Transitions Initiative is known as *Moving Forward*: Achieving Independence for Transition-Aged Youth. Moving Forward is in its second year with progress on numerous levels.

First, training in the Transition to Independence (TIP) model of case management was completed for staff at three local agencies collaborating with CBHS. The mission of the initiative is to provide youth and young adults with a seamless transition from the child serving system to adulthood and opportunities for meaningful participation in a system of care that empowers through leadership and advocacy. This is being accomplished by working diligently with Youth Move Maine, TriCounty Mental Health, New Beginnings and Common Ties which are all agencies located in the Initiative's targeted geographic area.

A second round of training in TIP is scheduled for August and invitations will be sent numerous to mental health professionals in an effort to perpetrate the use of the model across a multitude of venues and agencies. This model is evidence-based and youth driven and has been proven successful within the targeted population of the Initiative. As part of this round of training, Maine is well on the way to having a nationally certified TIP trainer based in Lewiston. This certification will allow Maine to continue to train others and is in line with our goal of sustainability.

A state advisory council has been established with the goal of crafting policy aimed at improving the seamless delivery of transition services in Androscoggin County and, eventually across Maine. Evaluation is ongoing with Hornby Zeller Associates conducting interviews with youth, gathering program information and participating in a nationwide evaluation among the states originally awarded the Healthy Transitions grants.

Staffs at three service delivery agencies identified as partners in Moving Forward continue to serve youth in Androscoggin County. Monthly case-based review meetings are on-going and provide support and education to case managers.

The evaluation component of Moving Forward is ongoing. Hornby Zeller Associates continues to work on a database for information sharing and federal reporting. Cross site evaluation between the seven states receiving the Healthy Transitions Initiative funding is in progress and Maine is actively involved in that process. SAMSHA is promulgating national evaluation

standards and Maine is working with that group to include information about Moving Forward is that study.

Moving Forward will continue to serve 30 to 50 youth per year experiencing serious mental health conditions that are disconnected from their homes and risk homelessness. Many will have experienced trauma from domestic violence, child welfare and juvenile justice involvement, and homelessness and some will have been displaced from their native countries such as Somalia.

Moving Forward continues to seek ways to involve state agencies providing services to adults in the application of the model. The common goal remains the transition of youth to successful adulthood in any of its myriad manifestations.

Keeping Maine's Children Connected

Keeping Maine's Children Connected (KMCC) is a program sponsored by the Maine Children's Cabinet in response to the rising incidence of school disruption. School disruption has reached alarming proportions not only in the State of Maine but also nationally, and is one of the major predictors of academic failure and school withdrawal. This program is an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement in-patient psychiatric care, and/or high mobility or combinations of the above.

The intent of the Keeping Maine's Children Connected is to simplify the process of transition to-and-from educational programs so that these students can stay connected or can re-connect to their education programs as soon as possible. Liaisons have been assigned statewide in regional state agency offices, juvenile corrections facilities, in-patient psychiatric facilities, residential treatment facility agencies and school districts. Children's Behavioral Health Services has been an active supporter of several "pilot" programs and members of a community training team with those programs. A very successful example is the Hospital to School Initiative model that has proven its value to children with serious emotional or behavioral needs and their families, and thus has since "graduated" from pilot status to become replicated in other areas of the state today.

KMCC received a planning grant from US Dept of Education to increase community capacity and coordination between school districts and mental health services. KMCC worked closely with CBHS on the implementation of the grant activities. For the first time in Maine, mobile crisis programs and the psychiatric hospital in Southern Maine are now tracking contacts with school districts. The initial data from the crisis programs showed a documented increase in the number of times crisis workers spoke with parents/guardians about coordinating with schools, and a marked increase in the number of contacts with schools. In regards to contact between schools and hospitals, data showed that hospital staff initially contacted schools 68% of the time, and data now shows that the number of contacts has risen to 81.5% of the time. As a result of the success of the pilot initiative, the tracking program will be expanded to mental health crisis programs statewide so school staff can more effectively support the mental health needs of their students.

Geographic Areas within Children's Integrated System of Care

The Department of Health & Human Services, Office of Child & Family Services (OCFS), is organized and administered through 8 District Offices. The District office structure is defined geographically by counties and the boundaries of each District are coterminous for the Divisions of Child Welfare Services, Children's Behavioral Health Services and Early Childhood Services. A visual map of the Districts appears in Section I of this Plan.

The Department of Corrections, Division of Juvenile Services is organized according to 4 Districts, in addition to Mountain View Youth Development Center in Charleston and Long Creek Youth Development Center in South Portland. Regionally based Juvenile Community Corrections Officers (JCCO's) serve as the correctional case managers for juveniles who are under the supervision of the Division, regardless of their status within the legal system. The main offices are located in South Portland for Region 1; Lewiston for Region 2; Augusta for Region 3; and Bangor for Region 4. The long standing boundaries for each region are also defined by county lines and do not conform to those of OCFS. CBHS personnel are assigned to and co-located within these offices and facilities. The behavioral health and juvenile corrections systems are fully integrated and have established exceptional working relationships as evidenced in the materials included earlier in this section of the Application.

The Department of Education conducts administrative and program operations from its central office in Augusta. The Department serves a diversified public school constituency at the local level. DOE's Special Education unit relates primarily to Special Education Directors within the public schools.

Last year Maine had 164 school administrative units comprised of 490 municipalities. These school administrative units were served by 132 Superintendents of schools in 143 administrative offices. Over the course of FY11, the Department of Education continued to create new districts that conform to legislatively mandated guidelines that are intended to create cost savings through greater efficiencies of size, administration and operations. In July, 2011 this consolidation process had successfully reduced the number of districts approved by the Department to 249. Presently 56 school administrative units do not fully conform to the mandated guidelines.

Likewise, Child Development Services has undergone a reorganization of their system as a means to achieve parity in the size of sites and as a cost savings measure of 3 million dollars for FY 2011 beginning July 2010. These savings are to be achieved through efficiencies that include elimination of administrative positions. The original 16 sites have been consolidated and reduced to 9, and reconfigured to coordinate with School Administrative Units (SAU's) rather than county lines that cross SAU lines.

With the consolidation of sites the hope is to achieve more intra-state consistency while conforming to expanding national requirements and still maintaining the highest level of family/child commitment. In FY11 considerable work was done to organize and plan any resulting staff relocation, case management catchment area changes, program continuation for families and children, and site assignment changes for direct service providers. The focus of the

work has been to lessen the impact of the change on all involved with the system and to ensure that families and children are served with minimal interruption.

CRITERION 4: TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

Outreach to Homeless Youth

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 Behavioral Health Services and the Office of Adult Mental Health which contract these services to community service providers.

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 FY10

Region	Area Served	Agency	#Served	Funding
Region I	York County	Sweetser Children's Services * 30 day agreement	2	$3,042
Region II	Waldo/Knox Counties Lewiston/Auburn Areas	Home Counselors New Beginnings	1,96 35	$73,958 $36,500
Region III	Bangor area	Shaw House/Streetlight	394	$ 36,500
PATH Homeless Youth Totals				**$150,000**

State Funded Services to Homeless Youth: An expansion of funding for homeless services in 1998 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 this new funding also meant that agencies were able to support more than a single staff person.

PROGRAMS SERVING HOMELESS YOUTH FY10			
Agency	**Service Area Focus**	**Number of Youth Served**	**FY10 Funding**
Day One	Cumberland County	55	$134,500
Preble Street Resource Center *	Cumberland County	1302	$310,000
Total Region I		**1357**	**$444,500**
Children's Center	All 8 Counties in Region 2	278	$25,000
Home Counselors includes: New Beginnings: Youth & Family Services :Rumford Group Home:	Knox, Waldo and Lincoln County Androscoggin and Franklin County Somerset and Kennebec County Oxford County	196 total youth Consortium	$335,875
New Beginnings	Androscoggin and Franklin County	35	$36,500
Total Region II		**509**	**$397,375**
Acadia	Bangor area	176	$6,500
Shaw House*	Bangor area	394	$223,000
Penquis Community Action Program	Penobscot, Piscataquis, Hancock and Washington County	70	$47,000
Total Region III		**640**	**$276,500**
*Includes Child Welfare Svcs. Funds			
STATEWIDE TOTALS, HOMELESS YOUTH SERVICES		**2,506**	**$1,118,375**

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 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.

Using these new appropriations for homeless services, 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 Learn to Earn program provides formalized job placement and training services for homeless youth. The Teen Center offers a drop-in option for homeless and street-involved youth. The Teen Center operates 7 days/week, 365 days/year. In FY10 Preble Street programs served 1,302 youth.

Day One of Portland provides mental health community support services through case management and supportive counseling. Day One staff work closely with the Preble Street Teen Center staff to do outreach to youth who come into the Center to access food and safety. In FY10 Day One served 55 youth in Cumberland County.

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. Outreach workers provide comprehensive community support services to youth consisting of some combination of community support, prevocational/ vocational and supported employment services for homeless youth with serious emotional or behavioral problems. The consortium which includes Home Counselors, New Beginnings, Rumford Group Homes and Youth & Family Services served 196 youth in FY10. Flexible funds to meet the needs of homeless youth throughout Region II in central Maine were provided to 278 youth through The Children's Center in Augusta.

The Shaw House Streetlight Outreach Program in Greater Bangor works to identify and assist homeless and at-risk youth through street outreach efforts. Shaw House funding also 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 with Acadia Hospital, which provides evaluation and diagnostic services by a substance abuse counselor for homeless youth identified through the Shaw House outreach services. In FY10 Shaw House programs served 394 homeless youth and Acadia served 176 youth.

The Penquis Community Action Program provides outreach activities to teens to work with them on life skills. Staff provides resources and referrals for teens and parents seeking assistance. Penquis CAP serves youth ages 12-18 in Penobscot, Piscataquis, Hancock and Washington County who are at risk of leaving home or who are homeless, due to conflict and works toward reunification with the family when youth are homeless. The agency provided services to 70 youth and their families in FY10.

Services in Rural Areas

The State of Maine is essentially a rural state when considered in light of its land area, 30,862 square miles, and the total population of 1,328,301 according to the most current estimate of the

United States Census (2010), and the distribution pattern of the population within the geographic area, including Maine's island communities. Given these conditions, for purposes of planning the term "rural" means any area of Maine not identified by the United States Census Bureau to be a Core Based Statistical Areas (CBSAs).

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

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

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.

Health Technology/ Tele-Health Given today's technological possibilities in the area of communication, Maine is beginning to move forward to provide professional behavioral health consultation services using telecommunications as a medium. A first step was the addition of formal rules that recognize tele-medicine as a legitimate medium to provide consultation through broadcast sites that connect the behavioral health professional with another professional (or with a client in a direct service encounter) which is capable of reaching people in remote and or rural areas.

With the involvement of the Medical Director, CBHS has collaborated with and received support from the Office of MaineCare Services in developing a MaineCare policy that now includes tele-psychiatry as a reimbursable Medicaid service. This policy has expanded access to and allows for financial support of psychiatric services for children and their families who are in rural or remote sites, and who would otherwise not benefit from these services. There are, however, barriers to using this technology for direct services, including service providers apprehension about using the telemedicine in Emergency Departments and crisis programs due to concerns about confidentiality on the part of individuals in crisis using tele-medicine.

In FY11, the Department continued work to create and pilot a centralized system for making tele-medicine psychiatric consultation available to primary care physicians statewide in order to determine its feasibility. The planning for this initiative has been directed through a working group co-convened by the Governor's Office of Health Care Policy and the Maine Health Access Foundation (MeHaf), which is currently surveying stakeholders regarding barriers to implementation of this process.

The Maine Medical Center (Portland) applied for and received a grant from Maine Health Access Foundation to pilot the Massachusetts Child Psychiatry Access Project in the Mid Coast Region of Maine. The purpose of this program is to make available: 1) immediate phone consultation to primary care physicians regarding behavioral problems in children; and if necessary 1-4 hours of face to face evaluation and consultation to the primary care physicians. In addition the psychiatrist involved provides a monthly seminar on the basics of child and adolescent psychiatric assessment and provides supports to enhance the skills of the primary care physicians. The goal of this approach is to enhance the behavioral health skills of primary care physicians and their staff, providing knowledge and personal support. The program is extremely well received and appreciated by primary care physicians. In addition to providing a direct service, the program is collecting data to document changes in behavioral health care.

Increasing Services Statewide

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

In 2011, fifty-four (54) 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 un-served 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-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 2011, forty four (44) agencies were providing Children's Home and Community Based Treatment services from 68 community based locations, delivering these services in the family's home and communities. Additional children are served under a separate in-home support program, Rehabilitative Community Support Services (RCS). In FY11 fifty-one (51) agencies were providing RCS in the family's home from 68 community based locations. In FY10 these programs combined served 4,323 children. Clinically based treatment and in-home supports represent the essence of addressing the rural challenge, since the service comes to the child and family, in their own home and own community.

Over the last 5 years new, clinically focused MaineCare Children's Home and Community Based Treatment (HCT) services became available to serve many children who transitioned from several previously available MaineCare services that were discontinued in FY08. Children's Home and Community Based Treatment services are treatment based intervention services provided by a clinician and a community based services professional. In 2010 the former Habilitation Services were replaced by Rehabilitative and Community Support Services (RCS) with much improved qualitative elements for persons with cognitive and physical disabilities.

Regional Programs and Resources

Children's Behavioral Health Services does not provide direct behavioral health services to children with serious emotional disturbances, intellectual disability or autism. However, CBHS does provide funding for a wide array of behavioral health services, habilitation services and family supports in every region of the State of Maine through contracts with private non-profit agencies and a small number of for-profit organizations. There are no for-profit agencies that provide community services paid under CBHS contract that receive federal Children's Mental Health Block Grant funds.

Maine's Block Grant Application contains descriptive and statistical information about services that are available to children and families in several other sections of this plan. The table below illustrates the availability of core behavioral health services and supports within the three service regions of the DHHS. This section contains a Maine map illustrating where the 3 Regions are located. Region I forms the two southernmost counties and includes the city of Portland; Region II consists of nine counties stretching across central Maine and includes the cities of Augusta, Lewiston and Auburn; Region III is the northernmost section encompassing five counties including the cities of Bangor and Presque Isle.

The table below focuses on the geographic distribution of services available within each CBHS region in the State of Maine. The count of services available within each region is based on the number of provider agencies that deliver each type of direct service in that region. A number of these agencies offer services in more than one region; therefore there is duplication of providers reflected in the regional and statewide Total columns. The data that is the basis for this table is obtained from CBHS Resource Development field staff and from the DHHS Division of Purchased Services which works directly with the contracted agencies that are funded by Children's Behavioral Health Services. This data covers all contracted agencies that provided children's services in Fiscal Year 2011.

NUMBER of PROVIDERS LOCATED IN REGION (FY11)

SERVICE PROVIDED (and Unduplicated # Providers)	Region I	Region II	Region III	Total
Targeted Case Management (62)	28	47	24	99
Outpatient Services (62)	27	28	25	80
Medication Management (20)	5	12	8	25
Rehabilitative and Community Support Services (RCS) (51)	22	30	23	75
Children's Home and Community-Based Treatment (HCT) (44)	17	24	27	68
Crisis Services (9)	2	6	2	10
Respite Care Services (3)	1	1	1	3
Peer/Family Support (8)	6	5	5	16
Early Intervention Services (12)	5	5	3	12
Homeless Outreach (8)	3	3	3	8
Assertive Community Treatment (3)	2	1	0	3
Number of Provider Locations Regional and Statewide (138)	**118**	**162**	**121**	**399**

CRITERION 5 MANAGEMENT SYSTEMS

Fiscal Resources to Implement CBHS Goals, Targets and Action Plans

The FY12/13 budget (Allocation Plan) for Children's Behavioral Health Services shown in the Table below represents state general funds and seed to match MaineCare, and other federal funds (MH Block Grant, PATH/Homeless, and SAMHSA System of Care funds for Thrive and the Healthy Transitions Initiative) that are available and allocated for contracts with community service providers to support the behavioral health system of community services.

Department of Health & Human Services Office of Child & Family Services FY12 Children's Behavioral Health Services Funding - Community Services					
Services	General Fund 013607	MaineCare Seed*FY11 073117	MH Block Grant 015 Federal	Other 013 Federal/ HTI Thrive/PATH	Total
ACT		337,111			337,111
Crisis	1,859,693	1,306,307			3,166,000
Case Management		1,033,678			1,033,678
Rehabilitative Community Services and Supports (RCS)		2,848,526			2,848,526
Deaf Support (TCM)	120,000				120,000
Family/ Youth support – self help	102,448		641,378		743,826
Home and Community Based Treatment Services (HCT)		3,202,626			3,202,626
Outpatient Services		4,326,264			4,326,264
Medication Management		1,081,566			1,081,566
Homeless/ PATH	628,500			150,000	778,500
Early Intervention	883,789				883,789
Mediation	5,000				5,000
Flexible Funds	1,119,535				1,119,535
Respite	2,278,000				2,278,000
Information & Referral			110,500		110,500
Residential Treatment		1,966,483			1,966,483
Room & Board	4,282,932				4,282,932
Child Steps Initiative	277,994				277,994
Thrive Initiative	369,226			139,875	789,101**
Healthy Transition Initiative				480,000	480,000
Other /Place Holder	69,773		209,321		279,094
Total	11,996,890	16,102,561	961,199	769,875	30,110,525

* Estimates based on a proportion of FY11MaineCare expenditures **Total includes non-federal in-kind match

Note - The budget for the Division of Children's Behavioral Health Services was established in the FY12 state budget law enacted by the 125th Maine Legislature. Allocation of MaineCare seed by program type was estimated based on available expenditure information and trends from FY11.

In addition to these resources, the FY12 budget includes $4,990,660 in state funds for Personal Services which support 57.5 CBHS central office and regional staff who perform administrative, oversight, quality improvement and other functions that contribute directly to the achievement of the Priorities outlined in this Application and the Goals, Targets and Action Plans that appear in this Plan.

Training for Providers of Behavioral Health Services

Children's Behavioral Health Services is actively engaged in training for contract providers of children's services. This training is conducted by Children's Behavioral Health Services staff with the assistance of the Office of Quality Improvement (Assessment Training), and by consultants where there is an identified need (Wraparound Training for Case Managers, Training for Children's Home and Community Based Treatment Services and Services for Children with Intellectual disability or Autism Spectrum Disorders). Service providers also offer training for their staff that is supported by CBHS as a cost in determining their service rate. Specific examples of training that has been initiated over the past 6 years and continues on a regular basis include:

Ongoing training and staff certification for direct service providers of Children's Home and Community Based Treatment Services (HCT).

Training is developed through the Behavioral Health Sciences Institute and delivered to community agency personnel in a train the trainer model. A non-licensed individual who works under the supervision of a licensed clinician, and works one on one with the child in the home and community is required under MaineCare rule to complete 55 hours of training in addition to First Aid, CPR and blood borne pathogen training. Successful completion of this training and demonstrated competency of the individual trainee results in certification as a Behavioral Health Professional. Over the past eight years 1,822 individuals have successfully completed this training. In FY11 there were 883 Behavioral Health Professionals trained, with an additional 487 BHP's receiving certification in the previous 3 years.

MaineCare enacted several policy changes during 2010 that impacted the provider training system including the creation of Rehabilitative and Community Support Services for Children with Cognitive Impairments and Physical Limitations (RCS), and expanding Home and Community Based Treatment Services (HCT) to qualified children in a classroom setting. Both policies require the direct service provider achieve certification as a Behavioral Health Professional (BHP). CBHS has responded to the policy changes by adapting the BHP curriculum to reflect the policy changes, increasing the tracking capability of the certification process and diversifying the training method.

An on-line curriculum is now available which provide an additional training option. A demonstration of knowledge and skills is required before certification is complete. The on-line curriculum provides direct service staff flexibility in choosing the time and place to acquire the foundation for delivering children's behavioral health services.

Training for Providers who use the CAFAS

The Child and Adolescent Functional Assessment Scale (CAFAS) is used by several MaineCare services to assist in determining the appropriateness of treatment. The CAFAS is legislatively mandated to be administered to each child requesting or receiving Targeted Case Management. The CAFAS is also used to determine the appropriate level of care for children receiving Treatment Foster Care, and it continues to be used in Home and Community Based Treatment Services while providers transition to the Youth Outcome Questionnaire (Y-OQ).

CBHS worked with the company that produces the CAFAS, Functional Assessment Systems (FAS), to develop a cadre of certified CAFAS trainers and to bring the electronic version of the CAFAS to providers. FAS delivered a three day training to 21 staff at the master's or higher level from CBHS and provider agencies to create a pool of certified trainers. Sustaining a high quality training program that assures tool fidelity is achieved through regular communication via an electronic list serve and a monthly conference call meeting, training notification and registration using an on-line calendar and providing training in teams.

Functional Assessment Systems has developed an electronic version of the CAFAS that enables the agency to track and analyze the CAFAS results and to produce reports for personnel who administer the tool, the supervisor and the family. In addition to the increased capabilities of the CAFAS, the electronic version is "green", greatly reducing the provider's dependency on paper.

Other trainings available to CBHS service provides include:

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

- Use of the Children's Habilitation Assessment Tool (CHAT) for school age children and youth, delivered to all case management providers. Children with intellectual disability or autism spectrum diagnoses are assessed by the CHAT.

- 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, Juvenile Services staff on mental health and related issues for youth who are involved with the juvenile justice system in the community and for youth who are detained in the Youth Development Centers. Specific examples of these current issues and on-going dialogue and training delivered by mental health that are co-located in the juvenile services system and correctional staff are discussed in Criterion 3, Children's Services.

- Training on Evidence-Based Practices through the University of Southern Maine, Muskie School of Public Service with members of the CBHS Evidence Based Practice Committee and CBS staff.

- Training on a single case management system with Child Welfare Services and the University of Southern Maine, Muskie School of Public Service.

- Training children's case management service providers regarding transition to adult intellectual disability 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.

Training for Clinicians on Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood (DC: 03R)

This tool is available to clinicians who work with very young children (age's birth through 5 years). The Self-Study Guide assists the clinician in making observations, drawing conclusions and applying the DC-03R to make appropriate diagnoses. The Maine 0-3 Committee developed a DVD that is case-based. The DVD is promoted through the Maine Infant Mental Health Association and is now used as a centerpiece in the Association's menu of trainings.

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 be certified as a Mental Health Rehabilitation Technician/ Crisis Services Provider (MHRT/CSP) prior to providing services.

The requirements for certification as MHRT/CSP were revised in February 2007 and became applicable for all existing crisis staff as of April, 2008. These requirements include:

- A minimum of an Associates Degree
- Successful completion of the Crisis Training Curriculum
- Non-didactic training such as job shadowing, skill practice, role-play and case discussions

All crisis services staff are required to demonstrate competency in crisis practice by successfully completing the Crisis Training Curriculum module tests. The curriculum was developed by The Maine Crisis Network, a collaboration of Maine crisis providers and professionals with extensive experience in the field. The following modules are included in the Crisis Training Curriculum:

- Values and Attitude – Crisis professionals are obligated professionally to react and intervene objectively and on purely clinical grounds; close and careful examination of personal attitudes, strengths and vulnerabilities can assist in providing services consistent with professional obligations.

- Theories of Human Development – The focus of this training is to present selected development theories that will aid crisis workers in developing and implementing intervention and stabilization plans with clients and client's systems.

- Psychosocial Rehabilitation – Understanding effective psychosocial rehabilitation models and interventions that include the importance of recovery orientation, goal setting, skill assessment and training, and linkage with community supports.

- Crisis Theory and Principles of Crisis Management - The framework presented in this module will support a thorough understanding of current best practice in the crisis field.

- Safety – The mobile, community-based, 24 hour design of crisis services provides unique safety concerns for crisis workers, consumers and administrators. This module provides an overview and understanding of various risk factors, how to recognize risky situations and how to manage them.

- Crisis Assessment – This module provides crisis workers with an investigation of the skills and knowledge needed to conduct a comprehensive accurate evaluation of clients in a behavioral crisis.

- Crisis and Trauma – Traumatic events shape the people that experience them. Having a basic understanding of the ways that these experiences may affect a person's emotional, behavioral and relational reality is key to providing effective crisis services.

- Crisis & Co-occurring Disorders – This module provides an overview of the principles of crisis management within the context of co-occurring disorders. The training highlights the need and importance of assessing accurately for the presence of co-morbid substance abuse, and how substance abuse can, at times, mimic the symptoms of a psychiatric disorder.

- Crisis Intervention – This module provides a general framework for implementation of a solid clinical intervention. This 6 step Crisis Intervention Model has been designed and researched by Gilliand and James, 2003, taking into consideration the complexity of crisis situations associated with mental health and substance abuse crisis intervention strategies and methods.

- Consultation and Collaboration – The crisis worker is frequently functioning alone in the field but is ultimately only a part of a consultative team. The nuances of how and why crisis work is structured in this way comprise the content of this module.

- Legal and Ethical Issues in Crisis Work – This module will assist the crisis worker with the development of a working knowledge of client rights, professional conduct as a crisis worker, confidentiality and its exceptions, protective custody and mandated reporting, plus the potential risks of ethical mistakes.

- Hospitalization – Admission to psychiatric inpatient hospitalization is a lengthy and detailed process. This module will familiarize crisis workers with the specifics of this process, offering instructional detail, procedural rationale and opportunity for review of other ethical and clinical considerations.

- Documentation – Accurate and appropriate documentation is almost as important as accurate and appropriate clinical work. This module offers crisis workers step-by-step guidance to the appropriate documentation of crisis assessment.

DHHS Disaster Response Plan

In FY07 the Department of Health & Human Services, through a newly created position of Program Director of Disaster Behavioral Health Services, funded through the Maine Center for Disease Control, produced an initial Pandemic Disaster Response Plan. In the event of a disaster within the state of Maine, the emergency management system would be activated and if the event is large enough, the governor may declare a state of emergency. DHHS resources would be allocated to respond to the disaster.

One possible resource available would be mental health and substance abuse providers to respond to the emotional needs of citizens. In order to provide these types of emergency services a training curriculum has been developed and is offered to personnel who may provide this type of service. The training curriculum was researched and chosen by a statewide Disaster Behavioral Health committee. The state of the art curriculum chosen was developed in New York following the September 11th 2001 disaster. It has been adapted to be specific to Maine and has recently been updated to reflect scenarios relevant to recent experiences, e.g., H1N1 response. The purpose of the curriculum is to provide behavioral health providers with the knowledge and skills to be able to respond to the needs of citizens in the event of a disaster. As a result of attending the training, participants will learn:

- Key phases of disaster preparedness, response and recovery and the role of emergency management personnel
- Range of psychological and psychosocial reactions that individuals experience in the aftermath of disasters
- Key interventions and activities utilized by behavioral health professionals in the aftermath of disasters
- Self-care tips for behavioral health professionals

This training is 16 hours in length and has been offered in 14 of 16 counties throughout the state of Maine. The trainings are conducted by the Director of Disaster Behavioral Health and other individuals specifically experienced in the area of disaster preparedness and response. The

Office of Public Health Emergency Preparedness within the Maine Center for Disease Control and Prevention oversees this program. Two additional areas of complimentary training are offered annually in conjunction with the curriculum. The national Incident Command System (IS-100) and the National Incident Management System (IS-700a), which is required for team membership, are offered as well as independent training in Psychological First Aid.

The Director of Children's Behavioral Health Services is an active member of the State's Emergency Operations Center located within the facility of Maine's Emergency Management Agency (MEMA).

The Emergency Operations Center members have been activated three times this past year, during a winter storm, flooding in the spring and Hurricane Irene. There is a much greater appreciation for the value of having the mental health / behavioral expertise at the table.

Disaster Behavioral Health: A Critical Response Maine's training curriculum for Behavioral Health, Spiritual Care and Substance Abuse Professionals and Natural Community Helpers has developed a skilled response team across the state

The volunteer teams of disaster behavioral health responders are available to provide mental health and substance abuse support in the event of a disaster or local emergency. The teams are managed at the state level by the Program Director of Disaster Behavioral Health Services through clinical team leaders at the local level. Each local team consists of those who have been trained in the curriculum, have completed the requisite FEMA courses (ICS, NIMS) and have undergone a background check. These teams are deployed through the state emergency management system. Teams are trained to respond to the emotional needs of disaster victims, responders, or community members in local, state, or nationally declared disasters as well as other traumatic incidents requiring a behavioral health response.

The training program is two full days in length. Team members must attend the full two-day training to become registered as a Disaster Behavioral Health volunteer.

Day One: Participants will learn about the behavioral health impact of disasters on individuals and communities. They will also learn about normal and adverse stress reactions. They will also be given information about how the state and national disaster preparedness and response systems work. Day Two: Participants will learn disaster behavioral health interventions used to identify and address these reactions (such as psychological first aid). They will go through an exercise to learn how to set up a family assistance center and respond to the needs of the victims and families. Finally, they will have the opportunity to learn about and join the formal state team in Maine tasked with responding to the behavioral health needs of the community after a disaster.

This training is intended for mental health and substance abuse providers, psychiatrists, nurses, psychologists, social workers, spiritual care providers, first responders, and other individuals who wish to learn more about the behavioral health response to disasters or are interested in joining the Maine Disaster Behavioral Health Response Team.

The Director of Disaster Behavioral Health Services (DBH) coordinates responses from the state Emergency Operations Center through team leaders at the county level. A quarterly newsletter and annual drills keep volunteers in touch and updates skills.

Disaster Behavioral Health provided three trainings last year, participated in a full scale county drill, offered two Psychological First Aid courses and an IS-100 & IS-700a qualifying course. Three trainings were completed last year in Franklin, Somerset and York Counties. In the coming year, trainings are planned for Sagadahoc, Hancock and a return to Penobscot counties.

Intended Use of CMHS Block Grant Fund

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 behavioral health services, with special emphasis on alternatives to inpatient hospitalization. Funding requested for support to community-based programs is compatible with the direction established by A Plan for Children's Mental Health Services, as directed and accepted by the 118th Maine Legislature.

Distribution of federal funds under the CMHS Block Grant is implemented through decisions made by the Department through the Director of Children's Behavioral Health Services, in consultation with the Statewide QIC Children's Committee. The Department contracts for services which are funded entirely or in part through the Block Grant. The Children's Behavioral Health 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. DHHS Purchased Services Administrators monitor contracts through quarterly and year end fiscal and narrative reports from service providers. Regionally based CBHS Team Leaders and Resource Coordinators monitor services by regularly scheduled meetings with providers. The Children's Committee also will receive these reports in FY11.

Maintenance of State Effort (MOE)

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 behavioral 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 means state general funds expended by the Division of Children's Behavioral Health Services within the DHHS Office of Child & Family Services and those expended by the DHHS Office of Adult Mental Health Services. Actual expenditures are compiled by the Department's Financial Service Center through the Advantage ME financial information system.

Maintenance of Effort
State General Fund Expenditures Children's Behavioral Health
State Fiscal Years 2009-2011

	SFY09	SFY10	Ave SFY09+10	SFY11
Children's Services	$54,540,651	$47,990,876	$51,265,764	$43,741,734

The average of state fund expenditures for Children's Behavioral Health Services in FY09+10 was $51,265,764. Expenditures for FY11 are $ 43,741,734 which is less than the two year average by (-$7,524,030). Children's Behavioral Health Services expenditures therefore do not meet the CMHS federal Block Grant program Maintenance of Effort criterion for State Fiscal Year 2012.

Maine dedicates more than three quarters (75%) of its Center for Mental Health Services Block Grant funds to address the needs of children who have serious emotional disturbance and their families. The allocation of FY11 Children's Behavioral Health Services Block Grant funds, including unallocated funds follows:

CHILDREN'S MENTAL HEALTH BLOCK GRANT FY12
Distribution by Region/Service Type

Agency	Service Funded	Amount	Estimated # Total Served
REGION I			
Community Counseling Center	Peer Support for Youth	33,000	75
S. Maine Parent Awareness	Family Support/I&R	44,000	500
Region I Total		**$77,000**	**575**
REGION II			
Community Concepts	Family Support	11,000	20
Region II Total		**$11,000**	**80**
REGION III			
Helping Hands	Family Support/I&R	50,000	500
Region III Total		**$50,000**	**500**
STATEWIDE			
Crisis & Counseling – GEAR	Family Support	212,000	962
Crisis & Counseling - GEAR	**Parent Advocacy FACES**	**60,000**	**750**
Maine Parent Federation	Information & Referral	32,000	NA*
Maine Parent Federation	**Starting POINTS Media**	**60,000**	**3,500**

Maine Parent Federation	QIC Support	5,000	N/A*
NAMI Maine	Information & Referral	18,500	**230**
NAMI Maine	**Primary Care**	**60,000**	
TCMHS – Youth MOVE	**Youth Transformation**	106,378	80
	Youth Transformation	**60,000**	**60**
Statewide Total		**613,878**	
Total Allocated 7/1/11		**751,878**	**7,850**
BG FY11Award Available	To expend by 9/30/11	136,678	
BG FY12 Award Available	To expend by 9/30/12	824,521	
Total Available		**961,199**	
Unallocated to Expend FY11		**209,321**	

* Information & Referral data contain substantial duplication and therefore are not added to the regional subtotals or the state total for number served. **BOLD = Transformation Activities funded by the Block Grant in FY12.**

Block Grant distribution among specific contracts are made at the central office level, using rationale that identify programs that serve children that are not covered by MaineCare and those which provide services to children who are not eligible for MaineCare funding. More recently, a third consideration is to use mental health block grant funds for initiatives that are transformational in nature and directly benefit children with serious emotional and behavioral issues, and their families.

Limitations for Expenditure of Block Grant Funds

Distribution of FY12 CMHS Mental Health Block Grant funds is 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.

Maine law M.R.S.A. Title 34-B 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 (State Children's Health Insurance Program)."

Background to 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 or for services that are not Medicaid reimbursable, such as respite care and family support.

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.

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 prior years the committee recommended family support and children's transition services to adult 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.

In recent years, 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 DE appropriation of grant dollars. The Department utilized unobligated block grant funds to restore level funding for all family support programs affected by these reductions. For the last six years the Department has continued its support of family organizations and family support services through federal funds in order to preserve these services, which are highly valued but vulnerable to state general fund budget reductions.

QIC Children's Committee Commitment to Transformation

In June, 2007 the Director, Children's Behavioral Health Services, and members of the Children's Committee of the Quality Improvement Council discussed possible investments in focused activities using Block Grant funds in the FY08 fiscal year. There was a mutual interest in doing significant work with family organizations in 2007, in addition to the family support work of various types and focus that these organizations have typically done in the course of carrying out their unique missions. Accordingly, each organization was asked to submit a proposal to the Director that would capture the spirit, intent and focus of transformation that would benefit and support families with children and youth with serious emotional disturbance. These proposals, each in the amount of $60,000, were reviewed by Children's Behavioral Health Services and subsequently recommended for consideration by the Children's Committee of the QIC for one year funding.

Children's Committee Recommendations for 2012/2013 Plan

This year the Children's Committee worked on standardizing the content of the Transformation Award proposals.

The Children's Committee discussed in detail recommendations for the award of block grant funds for new initiatives and for continuing support of funding for programs. The committee expressed a strong commitment to transformation in considering funding with block grant dollars, accountability for programs that have received block grant funds, and certainty that funding would be used for children with high emotional/ behavioral needs. The committee discussed some examples of transformational priorities such as new and innovative approaches to reaching these children and youth, family driven care, youth development and evidence-based practices.

On several occasion in July 2011 the Children's Committee met to review the four transformation initiatives seeking continuation of support or for a new initiative using FY12 Block Grant funding. As in the previous year, each applicant presented its accomplishments, progress and goals and measurable objectives for the coming year. The Children's Committee reviewed and voted to approve or disapprove the proposal. If a proposal was disapproved and opportunity was given to the applicant to meet with the committee and discuss the reasons why the proposal was rejected. An opportunity to revise and resubmit the proposal was given. Two proposals were rejected and revised to meet the requirements that the services be transformational in nature.

After committee discussion with each presenter, and specific suggestions for change, emphasis or addition, all three proposals were recommended for funding.

The committee approved the proposals outlined below:

Allocation of Children's FY12 Block Grant Funds for Transformation Activities

Provider	Transformation Initiative	NFC Goal	Block Grant $
Maine Parent Federation (MPF)	*Starting POINTS for Maine Families* delivers online access to information, support and networking that will make knowledge of children's mental health more available to families statewide. Web page connects families to a variety of short presentations and allow for easy, personal feedback that will be used to tailor topics of interest as the initiative is implemented over time. Focus this year will be on building the content, usability, evaluation and outreach for Starting POINTS, Facebook and Twitter. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Military Families, Recovery and Resiliency and Public Awareness and Support.	2	60,000

NAMI Maine	Transform access to mental health and substance abuse services for youth across the state of Maine by helping schools to identify and refer students in need and who have challenging behaviors. NAMI Maine will work with designated schools to assure they are implementing practices that build resilience in students and engaging students in activities that build resilience, and (2) transform the delivery of primary care health services to children and youth by assisting Primary Care Physicians and pediatricians to better identify and treat their patients with behavioral health issues. This is year 2 of the initiative. Relevant SAMHSA strategic initiatives: Primary Prevention, Public Awareness, Strategic Partnerships	3 1	60,000
GEAR Parent Network	Development of 5 community Family Advisory Councils in areas where there are trained parents and alumni of the Family Empowerment Institute who are available to serve in an advisory capacity to local and state decision-makers. Involve other family organizations in the outreach to identify council members and broader family membership. FY12 will focus on training/ education/ awareness of trauma on families and caregivers, and advocacy for trauma-informed services for children and youth in the Council's geographic areas. Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Supports; Trauma and Justice	2 5	60,000
Youth MOVE Maine	Continued investment in support for developing a visible and active youth voice of the State in FY12. Maine's Youth MOVE Chapter will guide the implementation of an infrastructure of three staffed regional offices each having a strategic plan developed for achieving organizational and Youth and Family program goals. Each plan will include target audiences, a youth committee regional goals, a list of local resource partners, a continuous quality improvement plan and social marketing and outreach plan. Outcomes include community based trainings, peer-to-peer partnerships, anti-stigma campaign and youth training and provider technical assistance Relevant SAMHSA strategic initiatives: Public Awareness and Support, Recovery Support, Trauma and Justice	2 5	60,000
	FY12 Mental Health Block Grant Transformation Funding		**$240,000**

Management Systems
Children's Mental Health Transformation Efforts and Activities in Maine

Note to Readers: Each activity identified as Transformational is associated with one or more of the six Goals outlined in the New Freedom Commission on Mental Health (NFC), Achieving the Promise: Transforming Mental Health Care in America, DHHS Publication, Rockville MD, 2003.

NFC Goal 1. Americans Understand that Mental Health is Essential to Overall Health

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

- The Mental Health Recognition Day in 2011 featured expanded geographical visibility and fresh ideas to promote the positive aspects of mental health treatment, resiliency and recovery for children and youth and reduce the stigma associated with mental health issues for children and their families. This sixth annual celebration "Building resilience in young children dealing with trauma" gave us the opportunity to hear Maine youth and family members share stories of resiliency and the natural supports and skills so important in their lives. We heard how they have built and nurtured resiliency and gained empowerment through empathy and understanding, knowledge sharing, skills and love. We heard how resiliency and self-advocacy can be intergenerational with lessons learned passed from one generation to the next. The most visible setting to deliver this year's message was at the State House, Hall of Flags, where many service providers, youth and families were in attendance to hear the Governor's official Proclamation of Children's Mental Health Day and to speak out that it's okay to ask for help. Other local activities included a welcome breakfast cookout for OCFS staff, and, at a variety of local venues across the State, youth shared their experiences before public audiences in person and through "Digital Stories" visual media.

- The Maine Youth Suicide Prevention Program has been a long standing program in Maine and it receives support through the Director of Children's Behavioral Health Services and the CBHS' Medical Director's active participation in the MYSSP Clinical and Professional Committee. CBHS partners with MYSSP to promote effective clinical and professional practices and to improve access to mental health, substance abuse and crisis services.

NFC Goal 1.2: Address mental health with the same urgency as physical health

- Integrating Mental Health with Physical Health has been an ongoing effort for several years with CBHS playing an active role with other interested state agencies and public and private health care organizations. This effort has focused on collaborating with primary care physicians about signs of mental illnesses during early childhood, decreasing stigma for children and youth

receiving mental health services, and improving access to mental health services. Families strongly prefer that early childhood diagnosis, evaluation and referral to treatment lodged at the primary care professional practice level and not in a hospital or a community mental health outpatient clinic.

Child Psychiatry Access Program (CPAP): The Maine Medical Center (Portland) applied for and received a grant from Maine Health Access Foundation to pilot the Massachusetts Child Access Program, in another effort to provide psychiatric expertise in areas lacking these services. These services are delivered through consultation to pediatricians in the Mid Coast Region of Maine. The purpose of this program is to: 1) inform primary care practice about available community resources; 2) provide immediate (within 45 minutes) phone consultation to the primary care physician regarding behavioral health challenges; 3) quarterly office based educational sessions on common child psychiatric disorders; and 4) when indicated 1-4 hours of face to face psychiatric assessment. The goal of this approach is to enhance the behavioral health skills of primary care physicians and their staff, providing knowledge and personal support.

Criterion 3: Integration of Children's Services
NFC Goal 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

- Thrive's family representatives (now transitioned for sustainability to G.E.A.R. Parent Network's Family Advisory Councils for Empowerment Statewide-F.A.C.E.S.) received the silver award in the Professional Outreach category for Together we can build a bridge ("Bridge") July 21 at the 2011 Excellence in Community Communications and Outreach recognition ceremony sponsored by the Substance and Mental Health Services Administration's Caring for Every Child's Mental Health Campaign. As of August 1, 2011, Bridge has been viewed 1000 times on You Tube, and been broadcast by 40 Community Access TV stations to over 3.5 million homes in 70 Maine communities; 13 other states, South Africa and New Zealand. It has been presented by members of F.A.C.E.S. to hundreds of providers and service agencies at the state and local level throughout Maine.

NFC Goal 1.2: Address mental health with the same urgency as physical health

- Project LAUNCH is 6-year project that represents a strong partnership between Maine's public health and mental health domains that jointly commit to promote the overall wellness of young children.

Criterion 5: Management Systems
NFC Goal 1.2: Address mental health with the same urgency as physical health

- Work with Primary Care Physicians to educate on the importance of identifying and treating young children and school age children for signs of early mental health issues, and

with schools to educate professionals around the mental health and substance abuse resources in the local community to improve access to these services. – NAMI Maine

NFC Goal 2. Mental Health Care is Consumer and Family Driven

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- Family Organizations continue to respond to and support the Department's invitations to participate in critical areas of policy development by adding their voices to the discussions and in the process inform and educate others about what is important to families and their children. Representatives from these organizations have a long history in Maine of meaningful involvement, advocacy on behalf of families, contributing their values and perspectives to the system of care, informing parents on issues of the day through family friendly literature and information, and supporting and training their family members to more confidently navigate the system of care.

- In Youth MOVE Maine's second year they have been able to build off of the foundational work of 2009 to develop a strong, sound program through leadership of the Advisory Council, partnership with community members and supportive organizations, energy and inspiration of a broader network of youth members, and dedication of staff who identify as peers and interact with youth and young adults with reverence for the unique expertise they offer through the life experiences they have had.

  Youth MOVE Maine has developed as an organization to have a majority youth and young adult board, by-laws, standardized staff training, policies, procedures, a logic model and strategic plan and quality assurance measures, to ensure the program is youth-led, trauma-informed and achieving specified objectives.

NFC Goal 2.4: Create a comprehensive State Mental Health Plan

- **Criterion 1** addresses the development of a comprehensive, community based mental health system. CBHS notes that over the past decade, children's mental health services have expanded significantly. A retrospective look at service data 1998 to 2008 shows this transformation in the context of the original Children's Services 10 year plan.

- Restructuring of crisis programs. Integrating child and adult crisis services at the district level with assurance, those children's crisis personnel are appropriately trained to deal with issues presented by youth and their families. Restructuring achieves greater efficiency throughout the statewide system and established fiscal allocation criteria to enhance resource equity among crisis providers.

- Reduction in Out of State Placements. Criterion 1 presents data that clearly shows the transformation from Maine's previous practice of sending children out of state for treatment. Over the past 12 years the population out of state for treatment decreased from 260 in 1998 to 20 in 2011, certain evidence that a transformation has occurred.

However, this transformation was made possible by service expansion in Maine that was tailored to and met the needs of these children and youth, by increased public financing of the children's mental health system, and through the extraordinary diligence over the past few years by CBHS Utilization Review Specialists and Child Welfare Services to determine real need for placement and finding and developing the right services to bring children back home and keep them home.

- Improve coordination of care among multiple systems through collaboration with Child Welfare Services and Early Childhood Services in order to avoid parallel and duplicative behavioral service systems and transform them into a single behavioral health system of care.

Criterion 3: Integration of Children's Services
NFC Goal 2.1: Develop an individualized plan of care for every adult with serious mental illness and child with a serious emotional disturbance.

- The Office of Child & Family Services awarded four competitive grants to community providers in 2007 to receive training in the High Fidelity Wraparound process by national expert John VanDenBerg. The centerpiece of the wraparound process is the development of quality Individual Service Plans that emphasize the use of existing community resources, families, extended families, friends and other natural supports. Funding would be employed not as the first step in the process, but only to augment the people and systems that are committed to child and family's interests, and therefore are likely to be sustainable over time. These projects total $4 million in state general funds and became available through cost savings achieved from reduced expenditures in residential treatment services funded by Child Welfare Services.

- CBHS Child Psychiatrist provided training for CWS supervisors and caseworkers to ensure that the children they served received effective psychotherapy services. Training included development of a Fact Sheet used to guide the worker's interaction with the therapist, specifically regarding questions to ask when therapy is being considered as a treatment option.

NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- In the past year, the Thrive System of Care Initiative has established the value of youth participation in all aspects of Thrive is planning, organizing, and governing council business. Youth are especially visible in the community and their actions demonstrate a singular commitment to informing the public about the essential elements of trauma informed services. The youth voice is expanding to other areas of the state using a statewide youth conference as the initial vehicle to promote increased involvement at the local level.
- Youth and young adults have had numerous opportunities to address policy, including

- Co-chairing the Continuous Quality Improvement Workgroup for CBHS, where youth and families have co-led the development of Six Key Quality Areas to define quality services for children, youth and families, which will guide all CQI efforts.
- Development of a Youth And Family Workgroup advising CBHS from a collaborative youth and family perspective on key issues such as residential standards, implementation of the Youth Outcomes Questionnaire, CQI efforts, and more
- State and regional participation on the Shared Youth Vision Council, dedicated to reducing recidivism in Juvenile Justice and increasing successful school completion
- Developing a guide with another youth empowerment program, YLAT, to informed consent to Anti-psychotic medication for youth, which is being used as a foundation for similar national work with the FDA and SAMHSA
- Advising on peer support with the Moving Forward Healthy Transitions Initiative and Wraparound Maine

NFC Goal 2.4: Create a comprehensive State Mental Health Plan

- Criterion 3 of the Application discusses a number of formal Memoranda of Agreement or Understanding and describes collaboration between CBHS and other state child serving Departments that are both historical and recent. These agreements and working relationships continue to the present, and they are evidence that integrating children's services is a transformational process that takes time, effort and hard work. Each new component to inter-agency relationships is valuable no matter how small. Many examples of these steps are noted above. All of these steps add to the transformation from "silos" to collaborative working partners that are building a single system of children's behavioral health care.

- The 2009 Memorandum of Understanding between CBHS and Office of Adult Mental Health Services on transition of youth from the children's service system to adult mental health services goes beyond the traditional "public service system to another public service system," and instead it focuses on independent living, youth choice and needed skills to survive in an adult world. This MOU is framed in the larger picture of life and is more realistic as to the roles CBHS and OAMHS can play in preparing youth for adult living.

- Preparation for more independent living is also enhanced by the Jim Casey Youth Opportunities Initiative which has been an evolving project that now has focused on the Finance Project as a means to identify resources available for youth in foster care to transition out of the Child Welfare Services system. This work clearly involves the right partners in planning and is not limited to state child-serving agencies alone, but has reached down to the local and community level where the reality of independent living is.

- Of all the examples and successes described under Criterion 3 – Integration of Children's Services, perhaps the most exemplary example of transformation and sustainability at the state agency level has been the extraordinary working relationship between Children's Behavioral Health staff assigned to work within the Juvenile Justice system and Department of Corrections field and facilities personnel.

Criterion 5: Management Systems
NFC Goal 2.2: Involve consumers and families fully in orienting the mental health system toward recovery

- Web-based electronic information resources for parents, including interactive mode for users of the *Starting POINTS* system that also offers connections to other mental health information sites in a user –friendly design – **Maine Parent Federation FY12 Block grant activity**

- New Behavioral Health Informational Materials and Training Collaboration – **Maine Parent Federation FY12 Block grant activity**

- Parent Advisory Councils and Advocacy (F.A.C.E.S) with a FY12 focus on trauma – informed services - **GEAR Parent Network FY12 Block grant activity**

- Youth MOVE Maine provides an infrastructure for youth with emotional and behavioral challenges and those who have overcome them to participate fully in their communities and give their voice in advocacy and decision making while showing their strengths and abilities as a means to reduce metal health stigma by personal example – **Youth MOVE Maine FY12 Block grant activity**

NFC Goal 3 Disparities in Mental Health Services are Eliminated

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 3.1. Improve access to quality care that is culturally competent

- Project LAUNCH is a 6-year project is a partnership between Maine public health and mental health domains that jointly commit to promote the wellness of young children by selecting Washington County as the project site, an area that is severely economically deprived, has a diverse cultural background and heritage and will serve both addicted mothers and their infants.

- CBHS has established a collaborative partnership with APS Healthcare, which is providing valuable services to CBHS and the Office of Adult Mental Health Services as the Administrative Service Organization (ASO). This next step in the process of developing managed care system comes at an opportune time. CBHS now has additional utilization review capacity to monitor behavioral health treatment services for many children and youth in the system of care. The ASO represents another step forward toward in the transformation process that will ensure quality, effectiveness and appropriate duration of service that will benefit the child and family.

- Maine's first Multi-Cultural Conference was sponsored by Thrive, the Department of Health & Human Services and CBHS in 2007. The conference focused on youth with behavioral health needs and the importance of outreach and service delivery tailored to the needs of cultural and diverse societies within cities and towns in Maine. The most recent Multi-Cultural Conference, held in Kennebunk, Maine October 2008 was a stunning success on several fronts. The theme for "Healing Invisible Wounds" centered on a multi-generational perspective of trauma as told from an ethnic viewpoint that included recent refugees, immigrant adults and children as well as Native Americans living in Maine. This conference attracted a wide audience including attendees coming from many of the northeast States. As well received as this conference was locally, it also received national recognition by winning the SAMHSA System of Care Golden ECCO Award – first place for national Excellence in Community Communication and Outreach presentations at the Annual System of Care Conference in Anaheim, California in July 2009.

NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- Maintain full compliance with Revised Risinger Settlement Agreement which has been an 8 year effort to transform access to Maine's core case management and in-home behavioral supports from lengthy waiting periods for children in need of treatment to a responsive community based system of providers, available in all geographic areas of the state.

- Integration of all home-based treatment services in a single MaineCare section, Children's Home and Community Based Treatment, that has clinical and treatment integrity, provided by a team directly in the home and community, with the full participation of the family and an active utilization review component that assesses client progress measured by treatment outcomes. This is a transformational process that has taken 3 years of collaboration and dialogue with providers and families to achieve.

Criterion 2: Mental Health System Data Epidemiology
NFC Goal 3.1. Improve access to quality care that is culturally competent
NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- **The National Outcome Measure (NOM) Increased Access to Services (Number),** URS Basic Table 2, applies to Criterion 2 and is reported under the Goals, Targets and Action Plans (Performance Indicators) section of this Application.

- CBHS monitors program activity (total numbers served, State General Fund and MaineCare) expenditures to date) during a fiscal year when this information is needed by the Director, CBHS, the Office of Child & Family Services, the Department of Health and Human Services, the Executive Department, and Legislative Committees of

Jurisdiction. Yearend totals, such as contained in the Criterion *2 Children Receiving Publicly Funded Services*, provide a common foundation against which yearly changes in service activity and finances are analyzed and reported. One such reporting venue is SAMHSA, Division of Grants Management, Block Grant Office, which requires that comparative total fiscal data be compiled for purposes of determining the State of Maine's Maintenance of Effort (MOE) and Children's Set-Aside expenditures.

Criterion 3: Integration of Children's Services
NFC Goal 3.1. Improve access to quality care that is culturally competent

- CBHS Quality Improvement staff is trained to provide focused consultation services to assist contracted service providers. This training expands their ability to engage in a broader array of quality improvement functions, including consultation with families and providers as well as developing specialty roles for QIS staff as program consultant and auditor.

Criterion 4: Targeted services to homeless and rural areas.
NFC Goal 3.2: Improve access to quality care in rural and geographically remote areas.

- Expansion of service providers in all areas of the State of Maine, especially in Regions II and III that are heavily rural in composition (compared with Region I in Southern Maine). Provider availability allows for family choice, as well as increased timely access within rural communities.

Criterion 5: Management Systems
NFC Goal 3.1. Improve access to quality care that is culturally competent

- Work with Primary Care Physicians to educate on the importance of identifying and treating young children and school age children for signs of early mental health issues, and with schools to educate professionals around the mental health and substance abuse resources in the local community to improve access to these services. – NAMI Maine

NFC Goal 4 Early Mental Health Screening, Assessment and Referral to Services are Common Practice

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 4.1: Promote the mental health of young children

- CBHS District Staff continue to work on quality improvement and service expansion for the early intervention services providers. Significant revision occurred to multiple agreements. One long term provider agreement was revised to provide a new evidence-based early intervention services. In another district, staff assisted in the merging of two agencies into one organization in order for them to better manage resulting in cost savings; while also providing seamless services to these children and families. Technical assistance was provided to another agency which guided them in streamlining their budget, while also reflecting a program with specific goals aimed at establishing better

performance measures. One of the highlight form a northern district was assisting a provider in the redesign their early intervention supports to enhance and expand the services they were providing to a greater geographic area and support a larger number of children.

- The District Staff regularly monitors all of these agencies regarding their delivery of early intervention services. As unexpected adjustments are revealed due to unforeseen situations by any agency, the district staff is prepared to negotiate in order to offer a proper conclusion and reach a decision in accordance to the contract requirements that is extended to the provider on an annual basis.

NFC Goal 4.3 – Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies.

- Project LAUNCH is 6 year project is a partnership between Maine public health and mental health domains that jointly commit to promote the wellness of young children. By selecting Washington County as the project site, an area that is severely economically deprived, has a diverse cultural background and heritage and will serve both addicted mothers and their infants. LAUNCH is also improving access to quality care that is culturally competent.

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 4.1: Promote the mental health of young children

- A 2009 Quality Improvement initiative utilized CBHS regional Quality Improvement Specialists and other staff in statewide review of all Early Intervention contracts to assure consistency with and adherence to the program model and adjusting contract service strategy or content when necessary. This effort demonstrated the capacity of CBHS field personnel to successfully perform contract management, monitoring and quality improvement functions and integrate those responsibilities within OCFS operations at the District level.
- Children's Behavioral Health Services has engaged with Child Welfare Services on several trainings to improve assessment and screening of children with behavioral health issues, to improve knowledge of certain types of medications and improve caseworker interaction with behavioral therapists.

- Screening all children coming into CWS care for mental health needs. After study and consultation with CBHS, the Pediatric Screening Checklist was chosen based on its extensive reliability and validity data, and is being used for screening children ages 5-18 in primary care settings.

- CBHS is actively collaborating with the Office of MaineCare Services to identify infants and younger children with Developmental Disabilities in the child's home. This work is part of the ABCD Academy (Assure Better Child Health and Development). The screening would be done during well child screening visits.

NFC Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC Goal 5.2: Advance evidence –based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation

- CBHS is moving ahead with proven evidence based practices and conducting inquiry, research, and consideration of other promising practices on the horizon. CBHS, Juvenile Justice and Child Welfare Services are all engaged in supporting the 3 required Children's EBP'S for the FY12 Plan (Therapeutic Foster Care, Multi Systemic Therapy and Functional Family Therapy). Other practices are under consideration by the DHHS Evidence-Based Practice Committee. Other practices have already been implemented such as Children's Assertive Treatment Teams. In 2008 the System of Care site (Thrive) chose Trauma-Focused Cognitive Behavioral Treatment and Child and Family Psychotherapy in a process that included youth and parents. One year later extensive training opportunities have been realized by agency clinicians and independently licensed professionals through supervision and professional growth in a learning collaborative setting through Thrive.

NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- Infusing Trauma Informed Care within CBHS Systems and Practice. All contracted provider agencies will implement Quality Improvement Plans addressing needs identified in system of care self-assessment for federal system of care principles. The principles are family driven, youth guided, culturally and linguistically competent and Maine has added trauma informed. Thrive and CBHS will continue work to develop training and technical assistance for agencies in the form of webinars, written training materials, learning collaborative and agency trainings.

- Developing Co-Occurring Competency within CBHS Systems and Practice. All contracted provider agencies will implement Quality Improvement Plans addressing needs identified in Co-Occurring self-assessments. Trainings and technical assistance are available through the Maine Co-Occurring Collaborative Serving Maine and CBHS.

Criterion 3: Integration of Children's Services

NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- The Thrive Initiative can be credited for many successes during its first 4 years of operation. Among its many areas of strength is the planning work done with child-serving state agencies in local and district offices. This year continues an expansion of direct trauma informed services to the regional juvenile justice community based service

system, following the lead of involvement in the child welfare system last year. Thrive stands alone as the only Children's System of Care site that is committed to public and private inter-agency collaboration that recognizes and focuses on childhood trauma, and improving the quality of behavioral health services by implementing a trauma informed approach to services through education and training through local partnerships.

- Training on psychotropic medication prepared by a CBHS Child Psychiatrist centered on Fact Sheets developed for Child Welfare staff on the major classes of types of medication such as: stimulants, non-stimulant ADHD medications, antidepressants, atypical antipsychotics and typical mood stabilizers.

- A screening tool designed to identify and treat children in the Child Welfare system who have experienced trauma or may have other mental health disorders is being studied by the CBHS Director of Clinical Policies and Practices. Final selection of this instrument will greatly aid child welfare staff, and will be applied to cases where there is a substantiated finding of child abuse or neglect, which is highly suggestive of trauma.

Criterion 5: Management Systems
NFC Goal 5.4: Develop the knowledge base in four understudied areas; mental health disparities, long-term effects of medications, trauma, and acute care

- Parent Advisory Councils and Advocacy (F.A.C.E.S) with a FY12 focus on trauma – informed services - **GEAR Parent Network FY12 Block grant activity.**

- Youth MOVE Maine FY12 provides an infrastructure for youth with emotional and behavioral challenges and those who have overcome them to participate fully in their communities and give their voice in advocacy and decision making while showing their strengths and abilities as a means to reduce metal health stigma by personal example –

NFC Goal 6 Technology is Used to Access Mental Health Care and Information

Criterion 1: Comprehensive Community-Based Mental Health Services Systems
NFC 6.2: Develop and implement electronic health records and personal health information systems

- Networks of Care became fully operational in 2009. This is an internationally recognized web-based system for personal health record portability and resource access. Families and youth can place their personal health records with this secure site and grant access to others they choose so that they do not have to repeat their history multiple times, and feel safe about the privacy of their information.

Criterion 4:

- Initiation of tele-medicine as a psychiatric consultation option, with planning to implement a statewide tele-medicine pilot to determine feasibility for use at the primary care level of medical care delivery.

[i] Mary Takach, Reinventing Medicaid: State Innovations to Qualify And Pay For Patient-Centered Medical Homes Show Promising Results, *Health Affairs*, 30, no.7 (2011):1325-1334