

## IV: Narrative Plan

### N. Support of State Partners

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#### Narrative Question:

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The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

## N. Support of State Partners

### **Children's Behavioral Health Services (CBHS) 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**

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 affect 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 is major policy changes focused on 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. A family 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. 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 will implement 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 develop 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.

### **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**

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. Current work of staff involved with this program fall into two broad categories:

### **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 is 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 offshoot 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 boards, 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 7<sup>th</sup>, 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, and Child Welfare 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 is 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 girl 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.

### **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.

### **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 as 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 has 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, its primary focus is to enhance the communication, and coordination among schools, CBHS 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.

### **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 mental retardation and youth who are in need of adult protective services who will transition from youth services to adult services. This protocol also covers youth served by both 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 mental retardation. 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 affect 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. Other committed parties such as the Maine Youth Transition Collaborative, Common Sense Ventures, and Jobs join them 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 Disabilities Services Transition**

Strategies that were initiated prior to the merger of the two Departments included work with Children's Services and the former Adult Mental Retardation 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](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 affect the adult services system. Training in the adult mental retardation 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. 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 oversee sites. 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.

### **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 is chaired by the First Lady. 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.

### **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.

### **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.

## **Office of Adult Mental Health Services**

OAMSH has long and successful history creating and managing a myriad of partnerships in pursuing recovery for persons with mental illness. These diverse partners enrich and inform the system of care by promoting an environment where ideas and best practices can be shared. These partners included sister state divisions and agencies, networks of consumers and family members, and provider agencies which include Community based mental health centers as well as primary and hospital care centers.

Examples of these collaborative partnerships include:

Through legislation, The Department of Health and Human Services consolidated Behavioral Health with the State Medicaid Agency. Combining these resources has enhanced both the sharing of information and ideas by and between Behavioral Health Program and Medicaid Policy.

A component of the OAMHS reorganization includes staffing for integrated services coordinator. An Adult Services Consortium was developed and memorandum of understanding executed for the sharing of information between Office of Adult Mental Health Services (OAMHS), Substance Abuse (OSA), Adult with Cognitive and Physical Disabilities (OACPDS) Office of Elder Services (OES) to address the needs of consumers that are complex and cut across multiply offices and services; and to provide a collaborative departmental wide approach to addresses these cases.

The Office of Adult Mental Health, Division of Community Forensic and Outreach Services is developing a memorandum of understanding with Department of Corrections, Adult Services, which, together, provide a continuum of services for those people who are qualified to receive services from both state agencies. DCFOS and DOC are committed to collaborative system approaches in an effort to individualize treatment/service plans for all adults, specifically joint assessment, planning, and implementation to target both mental health needs and criminogenic risk factors. See DRAFT Document in Attachment Section titled: N. Support of State Partners\_Adult MH MOU Dept. of Corrections and DHHS OAMHS.

Another long standing partnership exists between Maine State Housing Authority (MSHA) and OAMHS. We have formal data sharing agreements and meet regularly at both the program and executive level. OMAHS has influenced MSHA's Section 8 Administrative Plan by prioritizing persons on our Bridging Rental Assistance Program for Section 8 vouchers.