



Maine Department of Health and Human Services

Office of Child and Family Services

Children's Behavioral Health Services Assessment Final Report

December 15, 2018

ACKNOWLEDGEMENTS

We would like to thank the leadership and staff at the Maine Department of Health and Human Services and the Office for Child and Family Services for their time, attention, and assistance with this assessment; Disability Rights Maine for their input and advocacy on behalf of children and families; and the many stakeholders who provided input for this assessment, including providers, schools, juvenile justice and law enforcement, and families and youth.

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EXECUTIVE SUMMARY

This report is the culmination of a five-month assessment of children's behavioral health services (CBHS) in Maine conducted by Public Consulting Group (PCG) on behalf of the Maine Department of Health and Human Services (DHHS).

Throughout this assessment, PCG interviewed stakeholders on the system's strengths and challenges from across the CBHS system of care, including staff throughout DHHS, behavioral health providers in community and institutional settings, families, advocates, and other system of care partners. PCG also analyzed data and information provided by DHHS, surveyed over 900 individuals, and conducted 13 Town Hall Meetings.

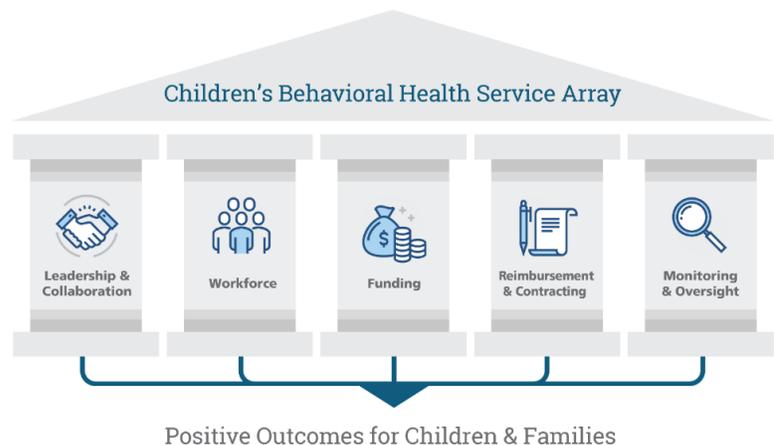
Project Goal: Obtain an independent assessment of the CBHS system of care, including its strengths and weaknesses, quality of outcomes, service array, capacity, funding structure, and program operations.

The assessment process revealed many strengths across the children's behavioral health system of care, including dedicated and highly skilled state staff and behavioral health service providers, deeply committed families and advocates for children, and numerous system innovations and best practices, including evidence-based practices and value-based purchasing models.

The last major assessment of CBHS was over 20 years ago, and while much has changed, Maine, like many states, still struggles with some barriers to high-quality services. This report presents five major system findings that impact the experience of children and families seeking and receiving services and ultimately the outcomes for individual children and the system of care as a whole. The findings are as follows:

- 1) **Access:** *Children's behavioral health services are not available immediately (or at all).*
- 2) **Proximity:** *Behavioral health services are not always available close to the community where children live.*
- 3) **Appropriateness:** *When children do get services, it's not always the right service.*
- 4) **Quality:** *The quality of behavioral health services is not consistent.*
- 5) **Coordination:** *Coordination with other child-serving agencies and transition to adult services is inadequate.*

To address these findings, this report proposes 24 recommendations. These recommendations are guided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) thirteen *System of Care Guiding Principles* as well as the "pillars" or foundation of a robust, high quality children's behavioral health service array – *Leadership & Collaboration, Workforce, Funding, Reimbursement & Contracting, and Monitoring & Oversight* (see Figure to the right).



The final 24 recommendations are summarized in the table below where the party with primary responsibility for implementation, the timeframe (short-term is less than six months, long-term is greater than six months), and the recommendation name are indicated. Full details on these recommendations, including sub-recommendations, are provided in the full report.

While Maine faces many unique challenges among its peers – a declining and aging state population and vast rural areas of the state – it is also experiencing the same workforce shortages facing behavioral health nationwide. Furthermore, many of the issues that were highlighted in this assessment – access, quality, and oversight – have been a focus of major reform efforts in other states. Maine can learn a great deal from its peers about how to support families, raise quality, contain costs, and work collaboratively across the children’s system of care. This report provides an outline of where the state may choose to focus efforts to improve children’s behavioral health services. The next step for Maine will be to develop a strategic plan for CBHS and commit to the necessary changes and prioritization to implement these recommendations in a manner that will create meaningful, sustainable change.

Final Recommendations Index			
	Responsibility	Timeframe	Recommendation Name
1	DHHS	Short-Term	Develop a strategic plan and vision for CBHS that engages all system of care stakeholders and builds off this CBHS assessment and recommendations.
2	DHHS	Short-Term	Establish advisory committee(s) that includes child-serving agencies and stakeholders to improve outcomes for children.
3	DHHS	Short-Term	Hire a full-time on-site OCFS Medical Director.
4	DHHS	Short-Term	Amend current service definition for Section 28 (Rehabilitative and Community Services) to focus on effective, targeted interventions for I/DD and Autism.
5	DHHS	Short-Term	Revise the waitlist procedure for home- and community-based services to ensure optimal client/provider assignment.
6	DHHS	Short-Term	Expand access to respite care services for families.
7	DHHS	Short-Term	Improve coordination for youth transitioning from child to adult behavioral health services.
8	DHHS	Long-Term	Develop regional Care Management Organizations (CMOs) to provide intensive care coordination for children with moderate to high behavioral health needs.
9	DHHS	Long-Term	Review and align residential services to best practices and new federal quality standards.
10	DHHS	Short- and Long-Term	Improve the quality, responsiveness, and role of children’s behavioral health crisis services.
11	DHHS	Long-Term	Develop a CBHS Data Task Force to use collect, analyze, and report on data that drives decision-making in CBHS.

Final Recommendations Index			
	Responsibility	Timeframe	Recommendation Name
12	DHHS	Long-Term	Facilitate access to services that can help families support children with behavioral health needs.
13	DHHS	Long-Term	Develop MaineCare funded out of home placement for children with behavioral health issues (aka Treatment or Therapeutic Foster Care).
14	DHHS	Long-Term	Continue to review how Accountable Communities can support the behavioral health needs of children in Maine.
15	DHHS	Long-Term	Conduct further analysis on the coordination between behavioral health services and substance use disorder treatment for youth.
16	System of Care	Long-Term	Develop a statewide strategy to address shortages in the health care workforce.
17	System of Care	Long-Term	Clarify roles, responsibilities, and mechanisms to ensure that children's behavioral health services are safe, effective, and high quality.
18	System of Care	Long-Term	Establish local Care Review process to support team decision making and best practices.
19	System of Care	Long-Term	Expand access to high-quality children's behavioral health expertise across the state.
20	System of Care	Long-Term	Develop behavioral health urgent care clinics.
21	System of Care	Long-Term	Explore the use of Pay for Success to leverage philanthropic investments in evidence-based practices.
22	System of Care	Long-Term	Strengthen the relationship between juvenile justice and CBHS.
23	System of Care	Long-Term	Conduct further analysis on the coordination between behavioral health services and the educational system.
24	System of Care	Long-Term	Support initiatives to enhance skills of early childhood and home-based workers to address challenging behaviors in young children.

I. PROJECT OVERVIEW

The Maine Department of Health and Human Services (DHHS) contracted with Public Consulting Group (PCG) to conduct an assessment of children's behavioral health services (CBHS) in Maine, which are overseen by the Office of Child and Family Services (OCFS).

The goal of this project is to obtain an independent assessment of the CBHS system of care, including its strengths and weaknesses, quality of outcomes, service array, capacity, funding structure, and program operations. Throughout the engagement, PCG regularly met with OCFS and Disability Rights Maine (DRM) to review the project plan, share project status updates, identify key stakeholders, and troubleshoot any challenges.

The assessment culminated in a series of short- and long-term recommendations regarding the CBHS system of care. These recommendations may be used to inform the strategic planning process at OCFS. This report summarizes our methodology and findings for OCFS and DRM and our recommendations for Maine.

Methodology

PCG utilized a variety of qualitative and quantitative methodologies to conduct this assessment. We conducted interviews with relevant stakeholders from key agencies, including DHHS, OCFS, Office of MaineCare Services, and DRM to identify strengths, weaknesses, and gaps within the system of care. Throughout the assessment, we interviewed 150 stakeholders, including families, behavioral health service providers, OCFS staff, juvenile justice staff, advocates, attorneys, and school staff.

At the outset of this project, we submitted a data and information to request to OCFS to understand previous and current policies, procedures, reports, data dashboards, and other materials. The below list summarizes some of the information obtained from over 300 documents:

- Policies, procedures, training information, forms, reports etc. related to:
 - Child Health Assessments for Foster Care
 - Client Rights & Grievances
 - First Episode Psychosis Programs
 - Flex Funds
 - Medication Management
 - Provider Management
 - Quality Assurance
 - Residential Treatment Services
 - Respite
 - Specialized Evaluation
 - Transition Services
 - Waitlist Management
- CBHS Budget Data
- CBHS Job Descriptions
- CBHS Program Descriptions
- Child Welfare Data
- Community Listening Session Notes
- Maine Statutes and Rules related to CBHS
- MaineCare Expenditure and Service Data
- Provider Contracts

We also reviewed national and state reports on children’s behavioral health services, conducted research on national best practices and programs in other states, and drew upon PCG subject matter expertise.

The graphic below (Figure 1) summarizes the key stakeholder engagement and data collection activities undertaken during this assessment, including interviews, data analysis, and an online survey. Additional information was provided by stakeholders at the Town Hall Meetings in October and November 2018, as well as feedback from OCFS and DRM on the content of this report. The online survey was completed by 942 respondents. Detailed information about survey respondents is included below in Figure 2.



Figure 1. Stakeholder engagement and data



Figure 2. Survey respondents

Assumptions and Limitations

While we refer to recipients of children’s behavioral health services as “children” throughout this report, for consistency, we acknowledge that many individuals accessing services could be better described as “youth” up to the age of 21.

Children’s behavioral health services in Maine exist within a vast, interconnected system of care, including important stakeholders, such as early childhood providers, the school system, medical providers, juvenile justice, and substance use disorder providers. While all of these partners were mentioned as important in the system of care, due to the limitations of the scope of this project and the time allotted, we were unable to explicitly or deeply explore how these systems collaborate and influence the types of experiences for children and families served by the behavioral health system. Several experts have already conducted reviews on some of Maine’s parallel systems, including early childhood¹ and juvenile justice,² and we

¹ Smith, S. and Granja, M.R. (2017) The Voices of Maine’s Early Care and Education Teachers: Children with Challenging Behavior in Classrooms and Home-based Child Care. New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

² Center for Children’s Law and Policy and Maine Juvenile Justice Advisory Group. (2017). Long Creek Youth Development Center Conditions Assessment Narrative Report. Corrections Documents. 34. Retrieved from http://digitalmaine.com/doc_docs/34

encourage OCFS to review these recommendations and collaborate with system partners on implementation.

In addition, despite strong efforts by OCFS and DRM and the cooperation of families and providers, the youth voice in this report is underrepresented. Ongoing and regular opportunities for youth to be engaged going forward is encouraged, as the recommendations that ultimately result from this report will impact them directly.

This assessment relies heavily on information about publicly funded services and programs through MaineCare, state general funds, and other federal sources. Information and data on children with private insurance or who self-pay for services could not be obtained, and while some of these children may access services through the Katie Beckett Option³ for MaineCare or state general funds and grants, they were not specifically carved out for this analysis.

Background Information

History

The last major assessment of children's behavioral health services in Maine was conducted in 1997 by the former Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).⁴ While the state has changed greatly in the intervening 21 years, many of the major challenges of that report are still relevant and will be echoed in the below findings and updated to reflect the current conditions of CBHS in Maine. The findings from the 1997 report include:

1. Lack of a system of care
2. Overutilization of high cost services
3. No single point of access – no clear roles or responsibilities of each state agency
4. Inequitable distribution of resources
5. No clear point of accountability
6. Gaps in services for transition-age children

In the intervening years since this report was released, Maine has undergone many system and organizational changes. The state has seen major shifts from government-centered provision of services to almost exclusive use of the private provider sector. Services that were previously funded under flexible streams are now almost exclusively limited to those reimbursable under MaineCare. The authorization and utilization management functions for behavioral health services transitioned from OCFS to an Administrative Services Organization (ASO), currently contracted to KEPRO.

In 1998 and 2000, class action lawsuits were filed against DHHS regarding children's behavioral health services.⁵ In the initial suit, filed in 1998, DHHS agreed to expand case management services through privatization and developed new behavioral health services to address concerns about access to community-based services. DHHS was found in compliance with the terms of the suit and it was settled in 2000. In the second lawsuit, filed in 2000 (*Risinger v. Concannon*), the state was required to develop a

³ <https://www.maine.gov/dhhs/ocfs/cbhs/eligibility/katiebeckett.html>

⁴ Maine DMHMRSAS. (1997) A Plan for Children's Mental Health Services Retrieved from <https://www.documentcloud.org/documents/4495895-PLAN.html>

⁵ Stone, M. (June 7, 2018). Maine's History of Serving – and Not Serving- Children with Mental Health Needs. Bangor Daily News. Retrieved from <https://bangordailynews.com/2018/06/04/mainefocus/maines-history-of-serving-and-not-serving-children-with-mental-health-needs/>

system to track children who request behavioral health services and assure that children receive timely and consistent access to services. In response, DHHS enhanced the Enterprise Information System (EIS) to track this data, the lawsuit was resolved by agreement of all parties in 2007, and DHHS reached full compliance in 2008, with federal oversight ending in 2009. However, recently, renewed attention was paid to behavioral health services as families and children were again experiencing issues with timely access to services.

Demographics and Prevalence of Children's Behavioral Health Concerns and Treatment

Demographically, the state's median age gradually crept up as the state's population continues to shrink, which contributes to the state's economic stressors and broad workforce shortages. In 2017, children under 18 in Maine comprised 19 percent of the state's total population, while nationally, 23 percent of the U.S. population⁶ were children under age 18. The total Maine child population slowly decreased over the past 10 years. Census data indicates that between 2008 and 2017, the Maine child population decreased by just over 10 percent, while nationally the child population decreased less than one percent.⁷ In 2017, the Kaiser Family Foundation reported that 31 percent of children in Maine were enrolled in the MaineCare program (Medicaid). While other states range from between 20 percent (North Dakota) and 56 percent (New Mexico), Maine is more closely aligned with New Hampshire (32 percent), Virginia (27 percent), and the national average (39 percent).⁸

Exact data on the prevalence of behavioral health concerns among children under 18 was difficult to obtain; however, a national survey indicated that during 2015-2016, 29 percent of parents of children ages 2-17, (65,786 children) reported that a doctor told them their child had autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.⁹

A 2014-2015 national survey conducted through the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 12.5 percent of Maine adolescents ages 12-17 experienced a major depressive episode, a rate that steadily increased since 2011-2012 when it was 8.9 percent.¹⁰ However, only 52.8 percent of adolescents with major depression reported that they received treatment for depression.

The Maine child and teen suicide rate increased 30 percent between 2012 and 2017 to 6.9 per 100,000 deaths, exceeding the national average of 5.4.¹¹ More recently, the 2016-2017 National Survey of Children's Health found that 52.2 percent of Maine children ages 3-17 with a mental/behavioral condition received

⁶ Population Division, U.S. Census Bureau. Source: Annie E. Casey KidsCount Data Center. Retrieved from <https://datacenter.kidscount.org>

⁷ Population Division, U.S. Census Bureau. Source: Annie E. Casey KidsCount Data Center. Retrieved from <https://datacenter.kidscount.org>

⁸ Kaiser Family Foundation Health Insurance Coverage of Children 0-18. Retrieved from <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&selectedDistributions=medicaid--other-public--uninsured&sortModel=%7B%22collId%22:%22Medicaid%22,%22sort%22:%22desc%22%7D>

⁹ National Survey of Children's Health (NSCH). Retrieved from <http://childhealthdata.org/learn/NSCH>

¹⁰ Substance Abuse and Mental Health Services Administration. (2017). Behavioral Health Barometer: Maine, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-ME. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹¹ Maine KidsCount (2017). Maine Department of Health and Human Services, Office of Data, Research and Vital Statistics and Center for Disease Control and Prevention, National Center for Health Statistics.

treatment or counseling.¹² The same survey estimated the prevalence of children ages 3-17 with Autism in Maine at 3.2 percent (estimated 6,789 children) and ADHD at 11.7 percent (estimated 24,509 children).

Service Array and Utilization

The service array for children’s behavioral health services in Maine encompasses services provided by medical professionals, schools, behavioral health service providers, crisis providers, hospitals, respite providers, natural supports, and agencies outside of the state. The below graphic (Figure 3) depicts the service array and illustrates the escalation of services in terms of intensity and restrictive setting from prevention and early intervention, to home- and community-based treatment, to out of home or institutional settings. This graphic depicts ongoing, flexible interventions, including respite, mobile crisis, and family and peer supports as wrapping around these services to support children in various service levels where these supports are available. Targeted Case Management (TCM) and Behavioral Health Homes are depicted as a doorway by which higher levels of care are often accessed. Although children access these services in any order and may utilize multiple services at once, the visual shows the service array from least to most restrictive.

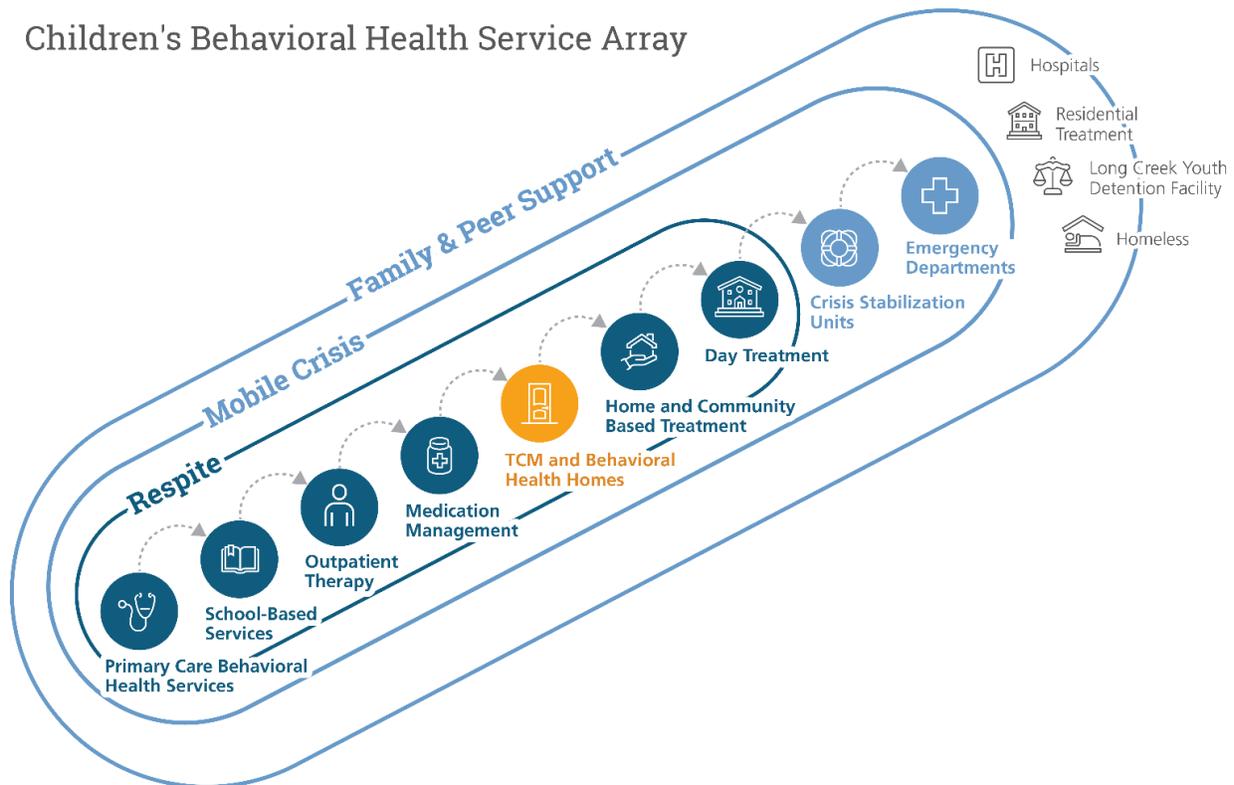


Figure 3. Children's behavioral health service array

¹² Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration’s Maternal and Child Health Bureau (HRSA MCHB). Retrieved from www.childhealthdata.org CAHMI: www.cahmi.org

In state fiscal year 2018, 33,339 units of MaineCare services, including crisis, outpatient, TCM, Rehabilitative and Community Support Services (RCS or commonly referred to as “Section 28”), Home and Community Treatment Services (HCT), and Private Non-Medical Institutions (PNMI or commonly referred to as “residential services”) were provided to children.¹³ This total included children receiving more than one service. Many additional children likely received behavioral health services through their private insurance, embedded in their doctor’s office or school, or out of pocket.

Table 1 below shows the number of unduplicated children receiving behavioral health services by service type annually between state fiscal years 2016 and 2018.¹⁴ The data indicates relatively stable levels of children receiving Section 28 and residential services, and shows declines in outpatient, TCM, and HCT. The decreasing number of providers delivering HCT may have contributed to this decline, whereas the wider adoption of behavioral health homes, a value-based case management service that can continue when children are in residential services, may account for the drop in TCM.

Service Type	SFY 2016	SFY 2017	SFY 2018
Crisis Residential (Crisis Stabilization Units) ¹⁵	702	665	694
Crisis Resolution (Mobile Crisis) ¹⁶	2,641	2,476	2,617
PNMI (includes out-of-state) ¹⁷	548	502	541
HCT ¹⁸	3,591	3,125	2,617
RCS (Section 28)	3,908	3,795	3,730
TCM	10,633	8,515	6,319
Outpatient ¹⁹	20,516	19,845	19,147
Behavioral Health Home ²⁰	1,761	4,980	7,592
Total	44,300	43,903	43,257

Behavioral health homes (BHH) utilize a multidisciplinary team to manage a child’s medical and behavioral health needs and the provider receives a per member, per month (PMPM) reimbursement. Figure 4 below shows the steady increase in the number of children (under 21) enrolled in BHH each month. While the enrollment in BHH increased, stakeholders stated there is some “churn” between BHH and traditional TCM, and providers may transfer cases between the services based on the child’s need, provider’s capacity, and profitability of the service. Specific data on this practice was not available. The Office of MaineCare reports this “churn” decreased since the BHH model became more widely utilized by providers and preferred by families.

¹³ “Units of service” are defined by KEPRO as ¼ hour or per diem depending on the specific service type. This is an unduplicated count of children within each service type – however children may have received more than one service.

¹⁴ The project team received service utilization data by service type for FY2016-2018 for outpatient services, TCM, RCS, HCT, and PNMI services. Children may have received more than one service type in a year.

¹⁵ Includes procedure code H0018 HA.

¹⁶ Includes procedure code H2011 HA.

¹⁷ Includes procedure codes H0019 with modifiers (CG, HE, SE, U9, US) and S9485.

¹⁸ Includes procedure codes H2021, H2033, and G9007 with modifiers (this includes FFT and MST).

¹⁹ Includes procedure codes H0004 (outpatient counseling), H2000 (evaluation), and H2010 (medication management) with modifiers.

²⁰ Behavioral Health Homes include an unduplicated count of all BHH members who were under age 21 as of the end of each fiscal year.

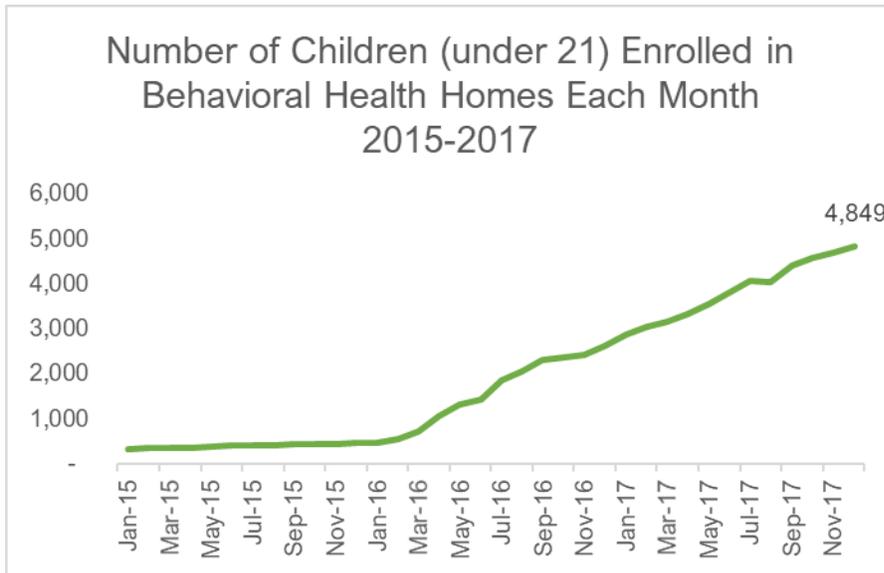


Figure 4. Number of children enrolled on BHH monthly

CBHS Funding

In Maine, children’s behavioral health services are funded through three primary sources – MaineCare (the state Medicaid program, a portion of which is matched through Federal Medical Assistance Percentage or FMAP), the Community Mental Health Block Grant (a federal grant), and state general funds. In 2013, Maine ranked number one in the nation for the percentage of state spending (inclusive of Medicaid and state funds) allocated to mental health services – 5.6 percent of total state expenditures or \$345 per capita.²¹ This figure is now five years old and included expenditures related to both adult and child mental health services, as well as services provided in jails and prisons. It is possible that the expenditures were weighted heavily on the adult population. Larger state expenditures on mental health may indicate a greater volume of services, or more intensive, expensive services; however, more spending does not necessarily indicate better services or outcomes.

In data provided by DHHS, as of June 2018 there were 103,882 children under the age of 21 who were enrolled in MaineCare. During SFY 2018, 30,856 children (29.7 percent) received at least one children’s behavioral health service. This figure has remained fairly consistent with the previous percentage of children receiving CBHS in SFY 2017 (28.9 percent) and SFY 2016 (28.6 percent).

Figure 5 below highlights the annual expenditures for CBHS based on data for state fiscal years 2016-2018.²² Expenditures included MaineCare, Community Mental Health Block Grant, state general funds and Now is the Time-Healthy Transition (NITT) grant funds. Maine relinquished unspent NITT SAMHSA grant funds in 2016, a federal grant awarded by SAMHSA and continued the program using other sources of funding.²³ There may be additional system of care expenditures that are not captured in this figure, such as

²¹ National Association of State Mental Health Program Directors (NASMHPD), National Research Institute (NRI), “State Mental Health Authority Mental Health Expenditures and Total State Government Expenditures” for 2012 and 2013” Table 20. Retrieved from <http://www.nriincdata.org/RevExp2013/T20.pdf>

²² This figure represents expenses associated with MaineCare and contracted services only. Contracted services include crisis stabilization and mobile crisis, out-of-state room and board, respite, family and peer support, and other services. There are additional CBHS expenses not reflected in this chart including payroll and miscellaneous administrative costs.

²³ Maine DHHS (September 9, 2016). Press Release: DHHS Statement Regarding the Now is the Time- Healthy Transition Grant. Retrieved from https://www.maine.gov/dhhs/archivednews_autosearch.shtml?id=704159

the expenses incurred by the school system, corrections, public health, primary care services, and other community providers. The expenditures associated with MaineCare are inclusive of the annual FMAP and only include the services listed above in Table 1 (crisis, PNMI, HCT, RCS, TCM, and outpatient). Notable exclusions from Figure 5 include BHH (reported separately in Figure 7 below), day treatment, emergency departments, and inpatient psychiatric hospitalization. The state general fund expenditures in Figure 5 only include contracted services, not expenditures associated with administrative costs.

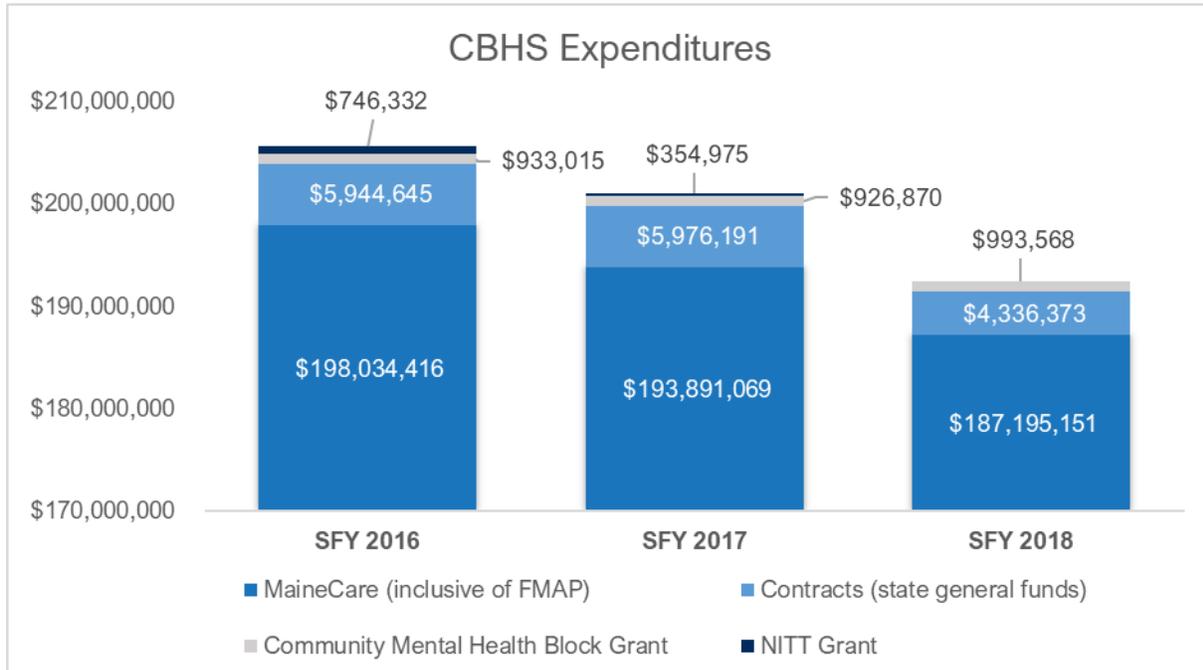


Figure 5. CBHS expenditures

State general funds and the Community Mental Health Block Grant were typically utilized for contracted services delivered in a more flexible manner than other services reimbursed by MaineCare, which must meet medical necessity. Table 2 lists major contracted service types supported by the more flexible sources, but is not exhaustive.

State General Funds	Community Mental Health Block Grant
Crisis Stabilization	Family and Peer Support
Family and Peer Support	Portland Identification and Early Referral Program
Homeless Youth Services	Youth Self Help and Peer Support
In and Out-of-State Room and Board	
Respite	
Transitional Living Program	

Maine relies heavily on MaineCare to fund almost all direct treatment services for children’s behavioral health, and in recent years, has seen a decrease in the total MaineCare expenditures associated with the services described previously in Table 1 and shown in Figure 6 below. Without complete data on all service types, it could not be determined whether total expenditures for the system of care follow this same trend.

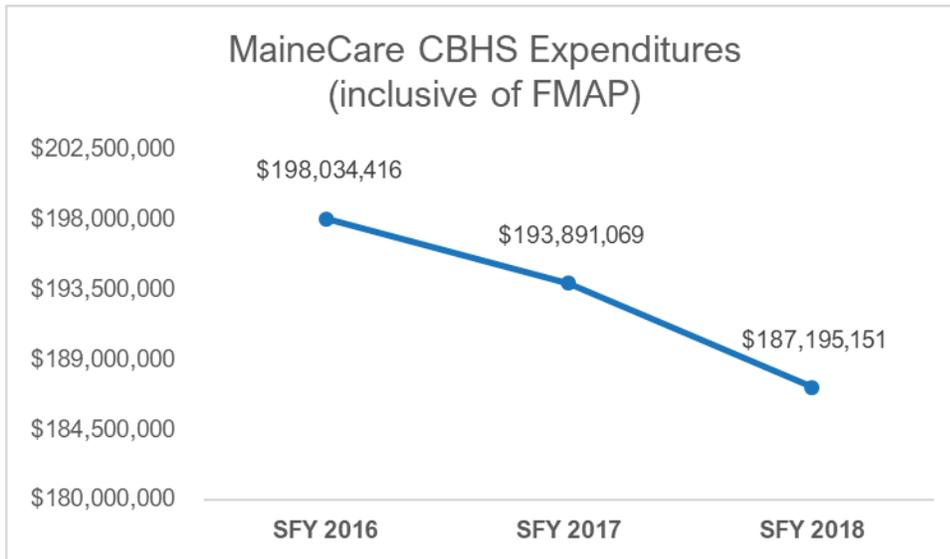


Figure 6. MaineCare CBHS expenditures

The expenditures associated with BHH (Figure 7) indicate this is a growing service for children's behavioral health.

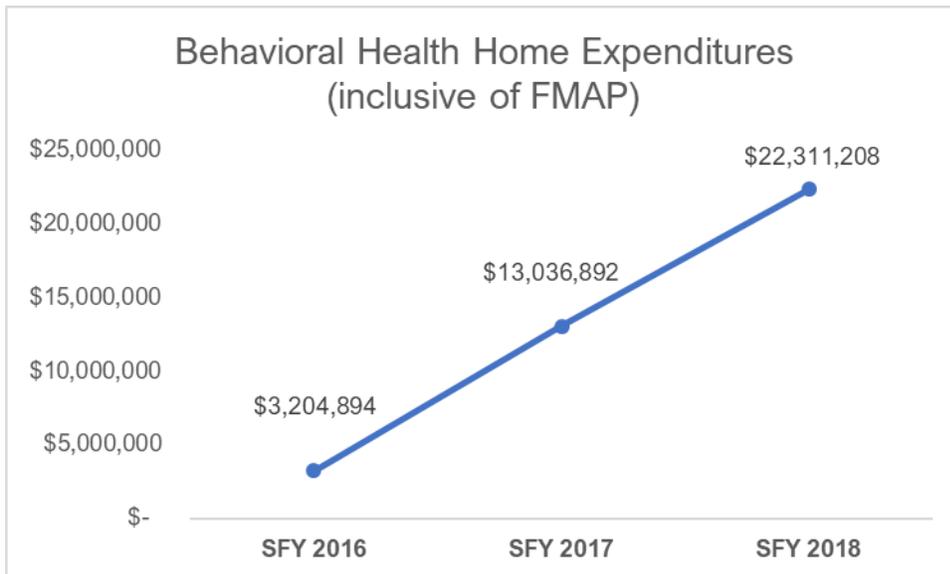


Figure 7. Behavioral Health Home MaineCare expenditures

Expenditure data for crisis stabilization and mobile crisis, TCM, HCT, outpatient (OPT), RCS (Section 28), and PNMI (residential) MaineCare funded services are reported below in Figure 8. Expenditures associated with Section 28 and residential services have remained relatively high and consistent over the past three years, while expenditures on TCM and HCT have declined, and outpatient and crisis services have remained relatively flat and low. These expenditures are consistent with the trends in the total number of children receiving services.

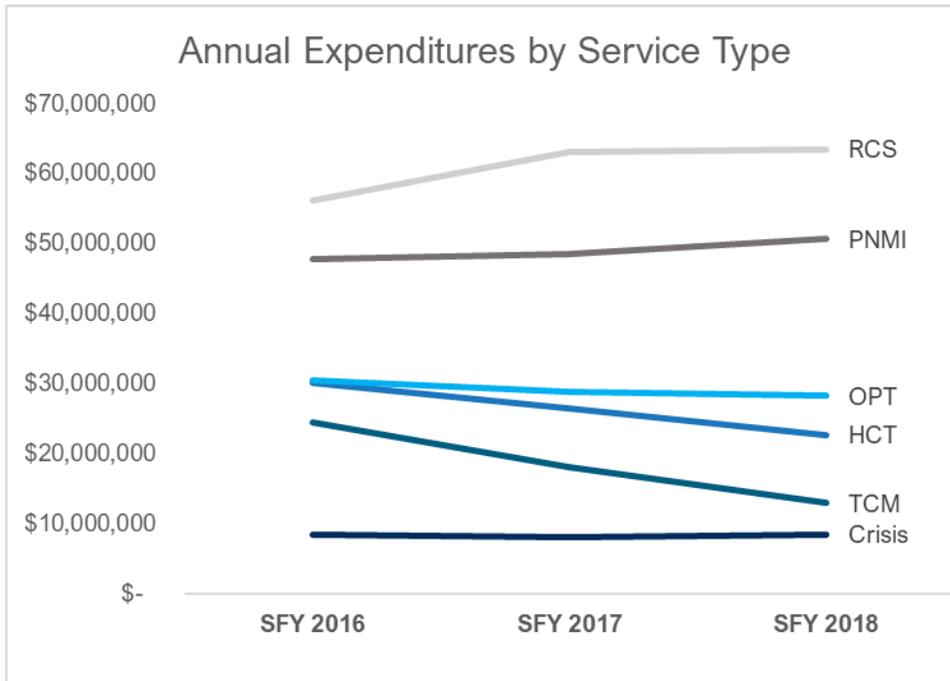


Figure 8. Annual MaineCare expenditures by service type

Without data on the total units of each service billed to MaineCare, the total quantity of behavioral health services provided to children was not calculated. However, Figure 9 shows the average expenditure per patient served by service type. Residential services (PNMI) was the most expensive service type. While the total number of children receiving residential services declined annually, the expenditures associated with that service increased. This increase may be due to several factors including:

- longer length of stays in residential services;
- increased and more expensive out-of-state residential services; and/or
- increased cost associated with upstaffing requests from residential providers.

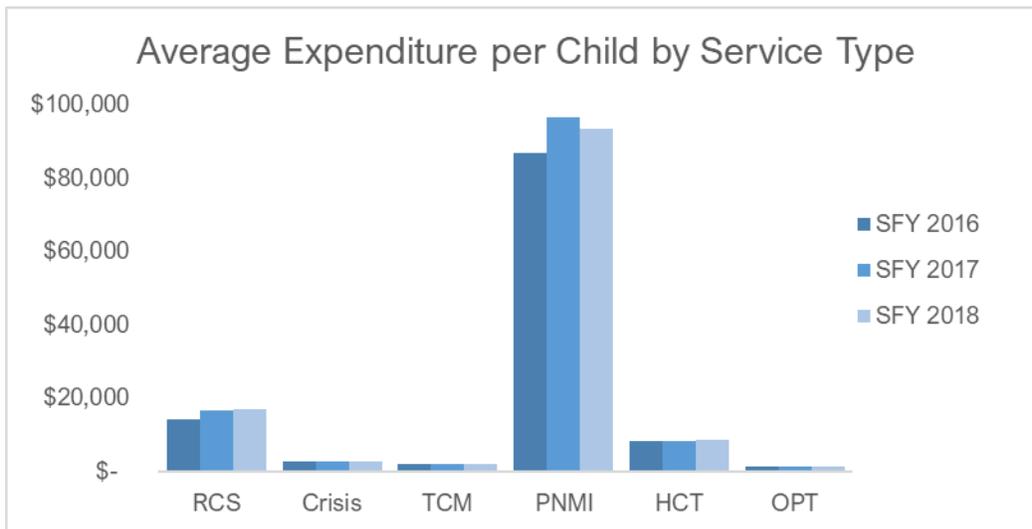
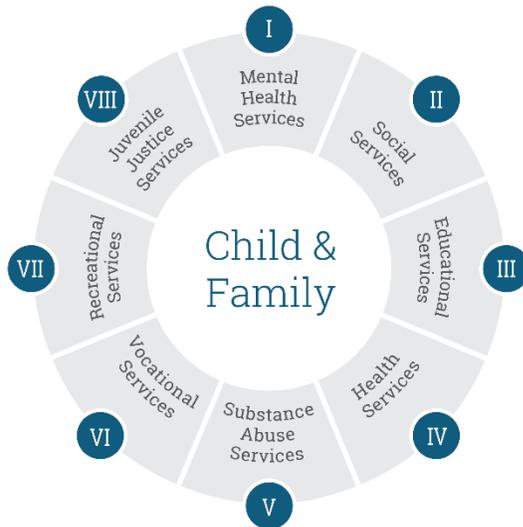


Figure 9. Average expenditure per child by service type

II. SYSTEM OF CARE GUIDING PRINCIPLES

System of Care Framework



From Stroul, B. & Friedman, R. (1986 rev ed). *A system of care for children and youth with severe emotional disturbances* (rev. ed., p. 30). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health.

Figure 10. System of care framework

The concept of a system of care for children receiving behavioral health services has existed for over 30 years and is often used to shape discussions about policies, programs, and processes that impact children and families. The system of care guiding principles were cited in the 1997 review of children’s behavioral health services. SAMHSA heralds this framework (see Figure 10) and its guiding principles as a concept to shape efforts to reform child serving systems, coordinate care, and promote individualized services. The System of Care is defined as:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.²⁴

PCG believes that this definition and the 13 updated Guiding Principles (titles developed by PCG) provide a useful framework for this assessment. These principles can be the measuring stick by which Maine evaluates if it

is truly ensuring that the system is family driven and youth guided, with an emphasis on culturally and linguistically competent community-based services whenever possible. These principles should also inform the criteria by which potential recommendations are evaluated for their potential success.

System of Care Guiding Principles
<p>1. Develop Access & Comprehensive Service Array</p> <p><i>Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.</i></p>
<p>2. Provide Individualized & Strengths Based Services</p> <p><i>Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.</i></p>
<p>3. Focus on Effective Practices</p>

²⁴ Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

System of Care Guiding Principles

Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

4. Utilize the Least Restrictive Setting

Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5. Engage Authentically with Families and Youth

Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

6. Integrate Child-Serving Systems

Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

7. Coordinate Services

Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

8. Target Services for Young Children

Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

9. Connect Young Adults to Services

Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10. Intervene Early

Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11. Practice Continuous Quality Improvement

Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12. Protect and Empower Families and Children

Protect the rights of children and families and promote effective advocacy efforts.

System of Care Guiding Principles

13. Ensure Dignity and Accommodations

Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

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III. STRENGTHS

Throughout this assessment, feedback received from families, providers, and state staff was there are many dedicated, tireless, and talented professionals working with children across Maine. Some professionals who were interviewed devoted their entire careers and have decades of experience working with some of the most vulnerable children and difficult cases. Families described they develop close, trusted relationships with providers, particularly those who work in their home, and come to see them as important supports for their child. While the system pressures can be tremendous on service providers, state employees, advocates, and others, there were many people who care deeply about these children and families and want to see the system of care improved. Families described positive relationships with service providers as:

I am truly blessed with the people who work with and for my foster son. He has a great group of people working for him and us.

Having Specialized 28 gives my daughter time to grow without me there and me time to breathe while she is with someone safe. Not all the providers they gave us could I say that about. However, the two we are ending with are light years ahead of the others and work well with my daughter.

Respite has helped our family because we have been able to take other children to doctors appts without everyone having to go. My husband and I have been able to have a little time away. I have been able to attend to my own mental health needs like therapy and psychiatric appointments. We have had HCT services several times when things were terribly bad. They helped to get a plan in action and to help us commit to the plan. We have four sons and the oldest two are the ones with mental and behavioral challenges. I am not sure where we would have been without (this provider).

There is desire, across all sectors of the service system, to make the system of care more accessible and effective for children and families.

Additionally, there is a strong foundation for family engagement. Survey results showed families rated the following two items an average of 3.7 out of 5, indicating that service providers are respectful and encourage children's participation in treatment:

Services are provided in a way that respects my child's culture and way of life.

My child is encouraged to share his/her thoughts, opinions, and concerns.

DHHS employees noted a similar strength on the survey with regard to families and children being treated as partners in service delivery. Families also showed a high degree of resilience and willingness to work collaboratively with provider and OCFS staff to find the most appropriate services for their children and resolve challenges.

Service providers also acknowledged the relationships and dedication of DHHS and OCFS staff with one saying, "The people who work for OCFS are some of the best people I have ever worked with they truly care about the kids and programs that serve the youth."

Many of the families interviewed in this assessment had a deep commitment to helping meet their children's behavioral health needs and sacrificed their careers, moved to new communities, and advocated relentlessly to improve services.

Another strength is the number of Maine's promising practices and innovative service delivery mechanisms. These include, but are not limited to:

- Provider investment in training and supervision to deliver evidence-based practices (EBPs) including Multi Systemic Therapy (MST), Functional Family Therapy (FFT), and Applied Behavioral Analysis (ABA).
- The development of value-based purchasing and BHH to provide comprehensive case management under the Affordable Care Act. As one stakeholder described, *"the BHH model allows individuals and families to access services and supports more quickly. Families do not have to "wait" to speak with their care coordinator. This also improves families support networks and familiarity with other providers."*
- The development of Accountable Communities across the state to reduce health care costs and improve quality. Relevant quality measures for CBHS include depression screening, follow-up for children diagnosed with ADHD, and follow-up after hospitalization for mental illness.
- Efforts in juvenile justice to de-institutionalize the population and focus on community corrections as well as develop performance-based contracts for MST.
- Trainings developed and offered by OCFS CBHS trainers to child welfare staff and providers on the system of care and accessing behavioral health services are well received and useful.
- Health care systems have been flexible in using nurse practitioners and telemedicine to address shortages in child psychiatry.

Local communities formed collaborations, including services providers, families, state agencies, and other stakeholders to share information and develop interventions. This collaborative process was described by a stakeholder as *"focused on prevention and effective intervention to minimize existing and future negative impacts on the child the family and the community. These collaborations are essential and often are needed due to the lack of appropriate resources and levels of care for the full range of children's behavioral health issues."*

IV. FINDINGS

This section details five major findings related to *Access, Proximity, Appropriateness, Quality, and Coordination*. These findings are based on the quantitative and qualitative information obtained during the assessment and validated during Town Hall Meetings with stakeholders as well as DHHS. The issues reported were shared by multiple stakeholders and reflect commonly held beliefs or widespread experiences with children's behavioral health services in Maine.

Finding 1. Access: Children's behavioral health services are not available immediately (or at all).

Families, providers, OCFS staff, and advocates stated that access to behavioral health services is restricted because the demand for services exceeds the availability of services. Most statewide survey respondents disagreed or strongly disagreed that access to options are good enough to ensure children get the treatment they need. On average, families rated this question at 2.5 (out of 5), and service providers and DHHS staff rated this even lower at 2.4 and 2.3 respectively. Alternatively, youth rated their access to service options at 3.5, with 55 percent of respondents reporting access to service options was ranked at a 4 or 5 out of 5. This variance in perception could be the result of youth not being as actively involved in the process for obtaining services, or it may be the population of youth that were surveyed, as responses were gathered primarily from youth who currently receive services.

The issue of access appears across the spectrum of children's behavioral health services from respite, to home- and community-based services such as Section 28 and HCT, through higher levels of care, including residential treatment and inpatient psychiatric beds. This inability to meet the demand for services, specifically community-based services, resulted in growing numbers on waitlists, longer waits for services, and the use of services that are not always appropriately matched for the family. While KEPRO maintains the waitlists for home- and community-based services, OCFS staff bear the responsibility for monitoring the waitlist, looking for service providers, and triaging waiting families. OCFS staff stated that not being able to find appropriate services for children was among their greatest professional frustrations. The management of the waitlist itself has transitioned from an OCFS responsibility to KEPRO. Stakeholders and OCFS staff described that KEPRO staff do not have the relationships or understanding of the providers to manage the waitlist as effectively as OCFS did. For example, a child may be placed on the waitlist for HCT in Piscataquis County because they live in Dover-Foxcroft and there are no available providers in that county; however, less than an hour away there is a provider in Bangor (Penobscot County) who has capacity, but a match between family and provider is not made because KEPRO is only considering counties, rather than geographic proximity. The CBHS team at OCFS previously had four Resource Coordinators with in-depth knowledge of resources around the state, but now has two positions.

The access issues in CBHS have several root causes. First and foremost, Maine is facing a workforce challenge that significantly impacts CBHS and other professional health care services. The Maine Department of Labor cited a 3.2 percent unemployment rate as of August 2018, which was 0.7 percent lower than the national average for the same timeframe.²⁵ In July, Maine State Economist Amanda Rector noted that Maine's labor shortage is reaching a critical level and is expected to get worse.²⁶ In response to

²⁵ <https://www.maine.gov/labor/cwri/laus.html>

²⁶ WGME. (July 25, 2018). In Depth: Maine's Labor Shortage. Retrieved from <https://wgme.com/news/in-depth/in-depth-maines-labor-shortage>

the statewide workforce shortage, the Maine Legislature created the Task Force on Maine's 21st Century Economy and Workforce.²⁷ This task force focused on workforce issues impacting multiple sectors, including the health care industry, specifically nursing shortages. While the task force's recommendations are not specific to behavioral health services, if they are successful for nursing they may be a useful test case for behavioral health.

Nationally, many areas of the country are facing behavioral health workforce challenges. According to the National Council on Mental Health, currently, over 100 million Americans live in areas where there is a defined shortage of mental health professionals.²⁸ A few of the challenges noted by SAMHSA in recruiting and retaining sufficient behavioral health care workers include low salaries, high workloads, lack of applicants who meet the job requirements, and lack of training.²⁹

Numerous stakeholders indicated low salaries as a root cause for the challenges in retaining a behavioral health workforce in Maine. It was frequently stated that the wages in behavioral health, particularly home- and community-based and residential services, were not enough to entice workers to enter and remain in a field that can be stressful and potentially dangerous when working with aggressive children. The rate models included in the independent rate study conducted by Burns & Associates in 2016-2017, included an hourly rate of \$12.80 for non-bachelor's Behavioral Health Providers (BHPs), only slightly more than could be expected in a less strenuous job given the rise in state wages. Stakeholders described that the increased state minimum wage, from \$9 per hour to \$12 per hour at incremental increases through 2020, makes it difficult for low-paying behavioral health service providers to compete with the tourism industry or other less stressful occupations. Behavioral health providers often cited stagnant reimbursement rates as impacting their ability to successfully recruit, retain, train, and deliver consistent services. As one service provider described:

... it is hard to pay providers what they are worth which leads to high turnover and burnout. Families frequently report high levels of change among providers and lack of consistency due to the turnover. Providers are expected to do a lot with very little.

Maine engaged in an independent rate study by Burns & Associates in 2016-2017, which included a review of Targeted Case Management, Rehabilitative and Community Services, and Section 65 Behavioral Health Services including HCT. The report recommended a combination of 23 rate increases and 15 rate decreases with a 10 percent stop loss/gain. However, following this study, the Maine Legislature froze all children's behavioral health rate changes for two years. During that time, some providers have withdrawn from delivering services entirely such as HCT and Assertive Community Treatment (ACT) teams for children or closed their doors entirely in recent years because the market for these services was not sustainable. During the past legislative session, some rate changes were enacted, and no rate decreases were put into effect. This resulted in a state appropriation outlined in LD 925 Parts C, D, E, and I. The appropriation includes a two percent rate increase from state fiscal year 2008-2009 rates for all child and adult behavioral health services with some more complex services seeing more significant increases, although some only

²⁷ Task Force on Maine's 21st Century Economy and Workforce. (December 2017). Final Report. Retrieved from <http://legislature.maine.gov/doc/1984>

²⁸ Starkey, S. (August 2, 2018). National Council for Mental Health. House Bill Seeks to Address Mental Health Workforce Shortage. Retrieved from <https://www.thenationalcouncil.org/capitol-connector/2018/08/house-bill-seeks-to-address-mental-health-workforce-shortage/>

²⁹ Substance Abuse and Mental Health Services Administration. Recruitment and Retention Toolkit, How the Challenges of the Behavioral Health Workforce Affect Recruitment and Retention. Retrieved from <http://toolkit.ahpnet.com/Building-a-Recruitment-and-Retention-Plan/How-Challenges-Affect-Recruitment-Retention.aspx>

temporarily.³⁰ Medication management services under Section 65 will increase 15 percent; whereas Multisystemic Therapy (MST), Functional Family Therapy (FFT), and MST for problem sexualized behavior (MSTPSB) will increase 20 percent, although only for one year without additional funding being identified; and Section 28 services reimbursement rates will increase 28 percent. Under this appropriation BCBA's will also be able to provide direct services under a newly developed rate and the reimbursement rate for BHP services were increased.

One of the most pronounced examples of the workforce shortage is for RSC Specialized which requires a Board Certified Behavioral Analyst (BCBA). This specialized position comes with specific educational and training requirements, and there are few professionals with this credential in Maine, allowing them to be very selective in their employment because they are in high demand.

Staff turnover impacts the relationships and trust that children develop with providers and frustrates families. As one family described, *"the challenge is that every step of the way you are trying to re-educate people who are dealing with your child,"* and as voiced by youth in the youth survey, *"it is really hard for me to get to know new people. It is hard to have a good relationship with the people constantly changing."*

Additionally, access to outpatient therapy and medication management, particularly child psychiatrists is limited throughout the state. As one parent described,

I've been searching for an outpatient therapy provider to provide CBT (cognitive behavioral therapy) to my daughter for a year. I have not been able to find a provider who has availability in their schedule to serve her. She started this school year off having daily meltdowns and it required a meeting be held and a 504 plan be developed to address her needs at school. She has not been able to develop skills to manage her anxiety and now her behavior at school has declined.

The below map in Figure 11 highlights the severe statewide shortage of child and adolescent psychiatrists in Maine.³¹ In 2007, there were 61 child and adolescent psychiatrists in practice with an average age of 52, indicating that many may be close to retirement. This data does not indicate what percentage of these psychiatrists accept MaineCare patients.

³⁰ Per LD 925: "The rules must specify that the increase in reimbursement rates must be applied to wages and benefits for employees who provide direct services and not to administrators or managers." Retrieved from <https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0653&item=3&snum=128>

³¹ American Academy of Child & Adolescent Psychiatry. Practicing child and adolescent psychiatrists: Maine. Retrieved from http://www.aacap.org/app_themes/aacap/docs/Advocacy/federal_and_state_initiatives/workforce/individual_state_maps/Maine%20workforce%20map.pdf

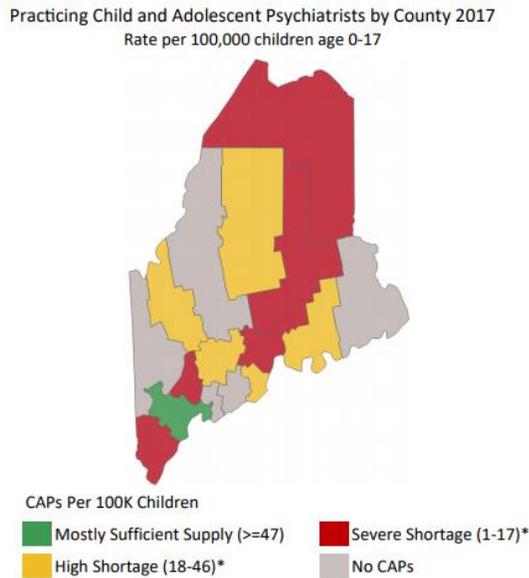


Figure 11. Practicing child and adolescent psychiatrists in Maine

Access to other supportive behavioral health services is also a concern in Maine. While some districts do offer school-based therapy and services, these services vary greatly depending on partnerships with community providers and internal expertise of school staff. Furthermore, it is difficult for families to engage in school-based services, and the setting may not be the most appropriate for more intensive treatments, such as for trauma. Respite services, when available, are helpful to families who need a planned, intentional break from their child with high needs. However, stakeholders and families stated that respite has been increasingly difficult to access. As one parent described:

(It) used to be fantastic when you could choose your own respite provider. (I) understand why they made the shift through the National Alliance on Mental Illness (NAMI) (wanted to make sure they were hiring appropriate people) but now there is too much red tape. It takes 5 weeks from initial application to phone call. And then they have to go through a process for orientation and to get certified. They don't really have a pool of available staff. You go on the website and search and there is nobody. Last time we searched there were only three people in our community.

Some of the challenges for recruiting and retaining respite providers are related to the requirements set by the Department of Labor, specifically that the provider must be a NAMI employee. This and other recent changes like additional processes for providers applying, limits on the number of hours they can provide respite, and tax implications have discouraged family members and others from signing up to be a respite provider. Without a robust array of outpatient and supportive services like respite, children with relatively minor behavioral health concerns may go untreated, their symptoms and behaviors escalate, and they require more intensive interventions.

When a child needs behavioral health services but is unable to access them because of a waitlist, or the services are simply not available, the child's symptoms and behaviors may escalate. This can lead to destabilizing behaviors, including regression, self-harm, and aggression, which, in turn, can escalate and cause school disruption, use of crisis services, and ultimately emergency room visits and possibly hospitalization or juvenile justice involvement. As heard from a youth from Oxford County who responded

to the stakeholder survey, PNMI placement was the result of being unable to receive Section 28-Specialized for two and a half years. When asked what the reason for an emergency room visit that discharged into a residential placement, the youth cited *“built up emotion and a lack of Section 28 services.”* Unmet behavioral health needs also stress family members and natural supports leading to frustration and burnout, which can further isolate the family and child from their community. When a child goes into crisis and enters an institutional setting like an emergency room, hospital, or residential facility, the experience of receiving these interventions can be scary and traumatic for the child, and, in turn, further escalate their symptoms and behaviors. As one provider described:

I don't see sufficient capacity for acute care for children with behavioral issues when home care fails--too often they end up residing in an Emergency Department for days at a time; not a therapeutic milieu, and one that exposes them to stimuli they should be avoiding.

Some children exhibit behaviors that escalate until they become involved in the juvenile justice system. As one parent shared:

My oldest son is currently doing well in his placement at (a substance use treatment program). But getting there was an absolute nightmare for our entire family. The barriers that were in our way right up until he became involved with (DOC) were insurmountable. It took my child being at risk of being incarcerated at Long Creek to get the help he needed. He does not belong at Long Creek and neither do most of the kids who are there. But there is no place else safe for them when they are out of control.

Unmet behavioral health needs start to form a bottleneck in the system of care where children get “stuck”, unable to access the services they need or return to a lower level of care as is desirable. Figure 12 below depicts examples of this bottleneck in the continuum of care resulting from a lack of access to timely services, starting with community-based services, and rippling into all levels of care. These were based on composites of actual children in Maine trying to access services.

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Figure 12. Continuum of care bottleneck effect

Increased Wait for Home and Community Therapy and Section 28³²

Throughout SFY 2016, an estimated 3,290 children waited to receive HCT. Of the 3,290 children waiting, 1,567 (48 percent) were on the waitlist for less than 31 days and nine percent waited over 120 days. By SFY 2018, the estimated number of children waiting was 3,293, but the change in the distribution of wait times was significant: 36 percent of children waited less than 31 days to receive services and 22 percent waited more than 120 days. Similar numbers of children were waiting for HCT in 2018; however, they were waiting longer because the capacity of providers had diminished. This data, provided by OCFS, is graphed below in Figure 13 and includes children waiting for any kind of HCT services, including FFT and MST.

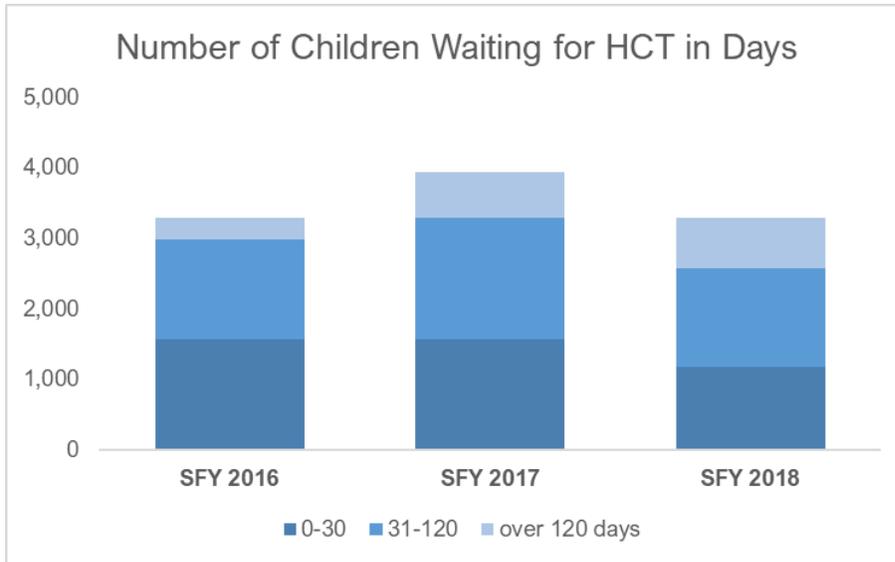


Figure 13. Number of children waiting for HCT in days

The wait for HCT is more pronounced for specific EBPs and may underrepresent the actual demand for these interventions because they are not available statewide. Authorization for MST or FFT under HCT is still approved by KEPRO, however referrals are made directly to these providers who maintain their own waitlists. Based on data provided to PCG from OCFS, while the number of children waiting for FFT and MST was less than 20 total in a given month, the majority of those who end up on the waitlist for services remain on the waitlist for over 120 days. We heard that this wait is mostly due to the limited number of providers delivering these EBPs. Specifically:

- 62 children waited over 120 days for FFT in SFY 2018
- 69 children waited over 120 days for MST in SFY 2018

The presence of waitlists is similar in other community-based MaineCare services such as Section 28 (Rehabilitative and Community Support Services or RCS) where demand exceeds capacity. Families frequently described waiting to receive RCS services (both Basic and Specialized) for lengthy periods of time. They also described that sometimes they were referred to other services, like HCT, because the provider had capacity to deliver that service even though it was not what was recommended based on child’s individual needs.

³² The data provided regarding waitlists for services is duplicative so the numbers presented are imperfect, but are consistent year over year allowing for monitoring of trends.

In SFY 2016, 1,527 children waited to receive RCS Basic services with an average wait time of 86 days. By SFY 2018 the number of children waiting to receive RCS Basic had increased to 3,733 with the average wait time of 101 days. The waitlist trends for RCS Basic can be seen below in Figure 14.

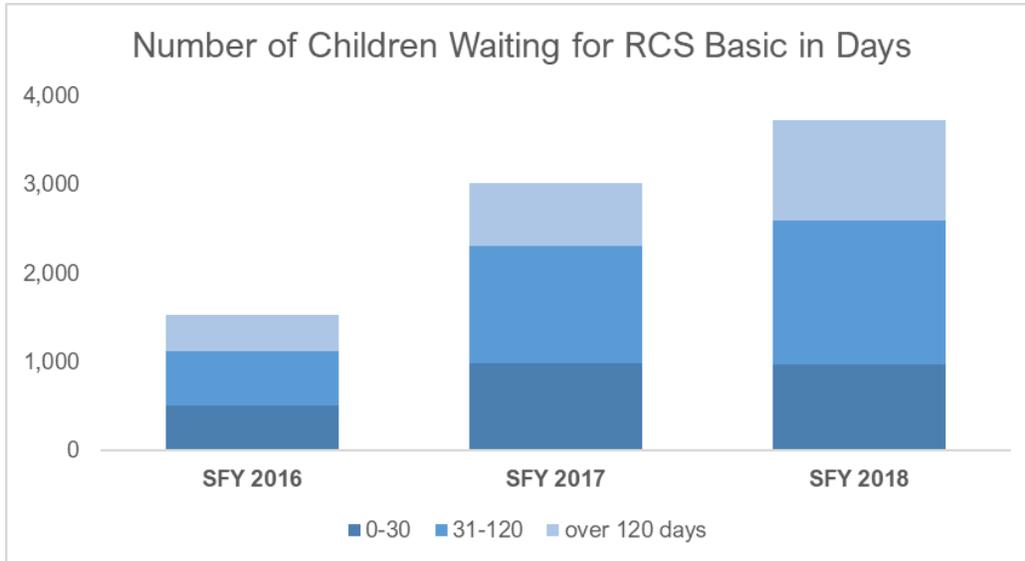


Figure 14. Number of children waiting for RCS Basic Services

RCS Specialized serves a much more specific population of children with Autism, so the waitlists are much smaller than those for RCS Basic. Per the data provided by CBHS, the waitlists and wait times for RCS Specialized appear to have decreased between SFY 2016 and SFY 2018. In SFY 2016, children waited an average of 215 days to receive RCS Specialized services. That number decreased to 152 days in SFY 2018 with 807 children waiting over 120 days. Figure 15, below, shows how the wait for RCS Specialized has changed. It was unable to be determined whether this decrease was due to shorter waits for RCS Specialized, children were removed from the waitlist because they accessed another type of service, or families were non-responsive when contacted by the assigned agency.

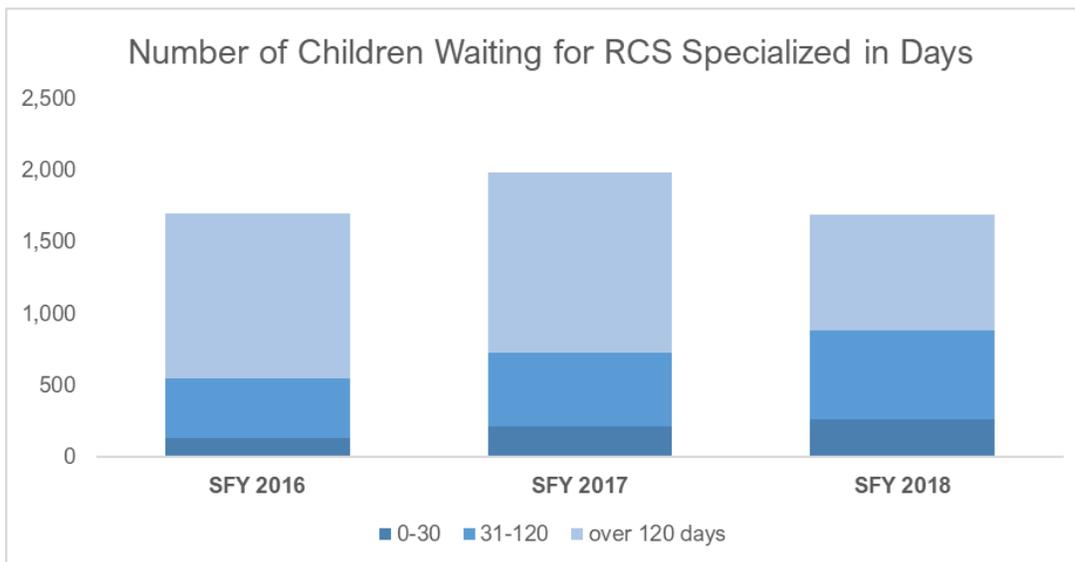


Figure 15. Number of children waiting for RCS Specialized Services

Families also reported that sometimes the quantity of services available, particularly RCS, did not meet their child's needs. For example, a child might be assessed and recommended to receive 24 hours per week of RCS, but the provider only has capacity to deliver 10 hours per week. While many families might feel that "some service is better than no service," this under-capacity is not fully captured in the data for waitlists; therefore, the figures reported above should be considered underestimates.

Increased Wait for Residential Services

While community-based services were cited as the most challenging to receive, Private Non-Medical Institution (PNMI) or residential services are also difficult to access when needed. Figure 16, below, shows how the average number of total days spent on the waitlist increased from SFY 2016 to SFY 2018 based on data provided by OCFS.

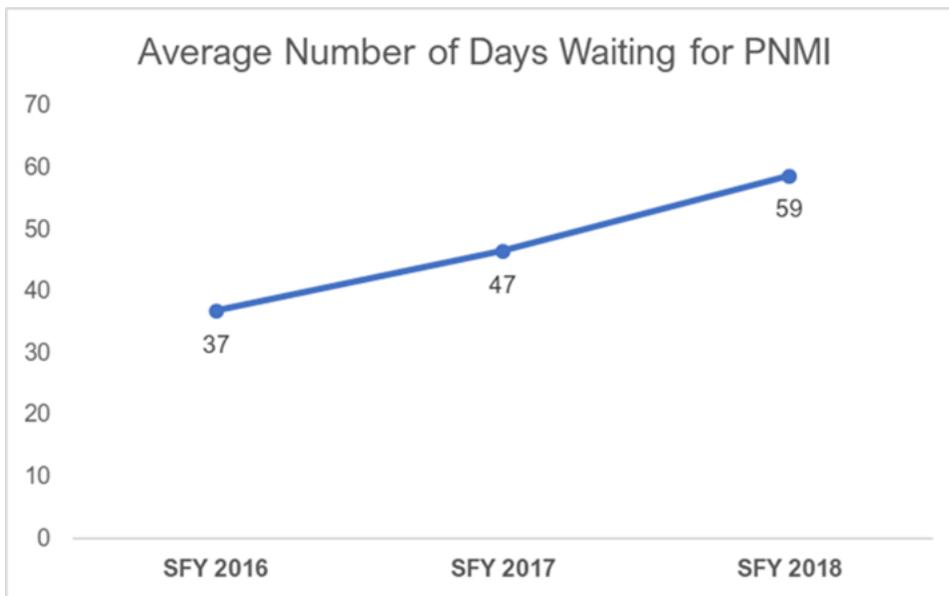


Figure 16. Average numbers of days waiting for PNMI

The waitlist for residential services is not a simple, straightforward matter of "first come first served." Rather, once a child is approved for residential services, the family then applies to a specific provider and is added to a waitlist at the agency. Children may be matched to a program based on their priority, but also based on the fit between their clinical presentations and the current milieu at the program, the staffing ratio available at the time, or other factors – not "first come, first served." Residential providers determine which applicants to accept at their program based on the clinical documentation provided in the application and an interview with the child. There is not an accurate day-to-day understanding of the capacity of the residential system because it varies based on the providers' staffing capacity and specific needs in the milieu. The waitlist for residential services may also not be an accurate reflection of exact statewide need at a given moment as families may be encouraged to apply for residential services as a contingency plan in case their child's symptoms or behaviors escalate and other less restrictive services are not available or adequate. If their child is selected from the waitlist, they may accept the placement or simply decline and be removed from the list.

While average wait times for PNMI have increased between SFY 2016 and SFY 2018, the number of unduplicated children receiving residential services decreased (1,037 in SFY 2016 down to 908 in SFY

2018 inclusive of out-of-state placements.) The decrease in the number of children receiving services may be attributed to one or more of the following:

1. a reduction in the capacity of residential services;
2. an increase in the average length of stay in residential services (increasing from 297 days in SFY 2016 to 340 days in SFY 2018); and/or
3. residential programs are accepting children with lower acuity than previously.

Historically, Maine has had very high utilization of residential services, particularly among the child welfare population, but after a focused effort, the state was able to significantly reduce these numbers and return more children to the community. As a result, many service providers reduced their capacity to provide residential services or closed businesses altogether. Residential services contracted further due to workforce shortages and challenges with maintaining operations under stagnant reimbursement rates. The rates developed for residential services were based on a very different population of children and business model prior to the changes in child welfare. Providers described the children requiring residential services now are overall more complex and challenging in their presentation and require smaller staffing ratios to ensure safety. While the total number of PNMI providers in the state has remained flat over the past three years (10 in SFY 2018), the number of out-of-state residential providers has increased from 16 in SFY 2016 to 24 in SFY 2018.

Longer lengths of stay in PNMI placements could also be limiting the number of children who can be served by PNMI programs. The average length of stay for children who have been discharged from residential services increased from 297 days (9.9 months) in SFY 2016 to 340 days (11.3 months) in SFY 2018 (an increase of 43 days). Residential services are supposed to be short-term (up to six months); however, longer services are often caused by lack of an appropriate service for discharge.

Increased Emergency Department Use and Psychiatric Hospitalizations

The lack of access to outpatient, home- and community-based, and residential services starts to compound itself and leads to children with unmet needs escalating into a crisis and ultimately to the emergency room and psychiatric hospital. While data specific to the increasing use of and length of emergency department visits was not available, we heard from many stakeholders, especially hospital staff, that the ED is becoming an increasingly common stop for children in crisis. This is due in part to the limitations of mobile crisis providers. Mobile crisis providers are supposed to respond to children in crisis in their placement or community, but it is not uncommon for crisis providers to have to triage multiple calls at once. Families and other providers described that wait times for mobile crisis can exceed five hours; however, data provided to PCG based on reports from the Maine Office of Substance Abuse and Mental Health Services (SAMHS) (which manages the crisis contracts) indicated that between July and September 2018³³ there were zero cases where children waited over four hours to be assessed face-to-face. One possibility to reconcile this discrepancy is that when a family calls mobile crisis they are told it may take longer to be seen in their home than to go to the ED directly. Stakeholders and OCFS staff described that the crisis system was designed and is managed for adult clients, not children, and as a result, children's services are less effective. Stakeholders stated that mobile crisis agencies are impacted by workforce shortages, but also by changes in their reimbursement rate structure. Whereas mobile crisis services used to be cost-settled³⁴ and covered the costs necessary to maintain capacity to respond to emergencies, as of April 2018 these services are

³³ OCFS provided the only available data they had on children's crisis services.

³⁴ "Cost-settled" means that the total contract value was divided over 12 months and paid monthly, and each quarter providers reconcile their actual costs.

now fee-for-service and agencies may have had to reduce staffing in response or experienced lost revenue. For example, one Crisis Stabilization provider had to reduce occupancy while they were serving a child with particularly high needs. Previously this provider would have been able to use contract funds to support this placement, however under the new contract structure they do not have this flexibility – contracts are now used only to cover under- or uninsured children. Oftentimes, families or residential providers are instructed to take a child in crisis to the emergency department, particularly if their other option is to wait for a mobile crisis provider to come to them. Between July and September 2018, an average of 45 percent of the initial face-to-face crisis assessments were conducted in the ED as opposed to the home or another community setting. Once in the ED, the child waits to be assessed by mobile crisis, and then waits for an appropriate discharge to a crisis stabilization unit, inpatient psychiatric bed, residential program, or home. During this assessment, many anecdotes were shared of children waiting days, even weeks, in the ED before they could be safely discharged home or to another setting. Of the 27 youth who responded to the stakeholder survey who stated they had experienced a recent emergency room visit, the average length of stay reported was 8.1 days, with the longest reported stay being 90 days. While this feedback represents a small sample of the population being discussed, it does provide insight regarding what is experienced by some clients. Based on data provided from SAMHS reports, between July and September 2018, 100 percent of crisis assessments were completed and a final disposition or resolution of crisis (by the mobile crisis team) was met under 14 hours, and an average of 94 percent assessments were completed under three hours. It is possible that the current reporting format is not accurately capturing how long children are truly waiting for a “disposition,” or their crisis to be resolved, or that during the brief period for which data was available, there were no cases of exceptionally long ED stays.

Accessing inpatient psychiatric hospitalization when needed is also a challenge for children. The total number of psychiatric beds available in the state is finite and hospitals use their clinical discretion to determine whether admission is appropriate. Stakeholders reported that hospitals lack transparency about admission criteria and sometimes refuse to accept admissions, even though crisis providers determine this level of care is appropriate. These children are then considered too high-needs for other residential settings. This results in some children being “stuck” in EDs, unable to go into inpatient care, and unsafe to return to a less restrictive setting, even if the child was in a residential program before the crisis. It is not uncommon for children to wait weeks, even months in hospital emergency departments because there is no available alternative. A step-down setting like a Crisis Stabilization Unit (CSU) may be appropriate for these children; however, stakeholders reported that CSUs are reluctant to accept these same cases because there is no discharge plan or supportive services available upon discharge. Children may also be diverted into the juvenile justice system when their behaviors escalate in the emergency department and result in assault or property destruction.

For children who are admitted into an inpatient psychiatric hospital bed, their length of stay may end up being longer than clinically necessary because there is no alternative placement or services available to support them to return home. In turn, these same children may be denied admission to residential programs because their clinical presentation in the hospital precludes them from a less restrictive setting. These children may also lack access to long-term treatment or educational services while they are waiting in inpatient hospitals. Figure 17, below, demonstrates that the number of children in in-state hospital placements (counted as last day of the month) has increased since SFY 2016, as has their average length of stay. In SFY 2018 the average length of stay for a youth in an in-state hospital was 29 days, whereas both Spring Harbor and Acadia described that as an acute care facility, their hospitals are designed for stays averaging between 7 and 12 days.

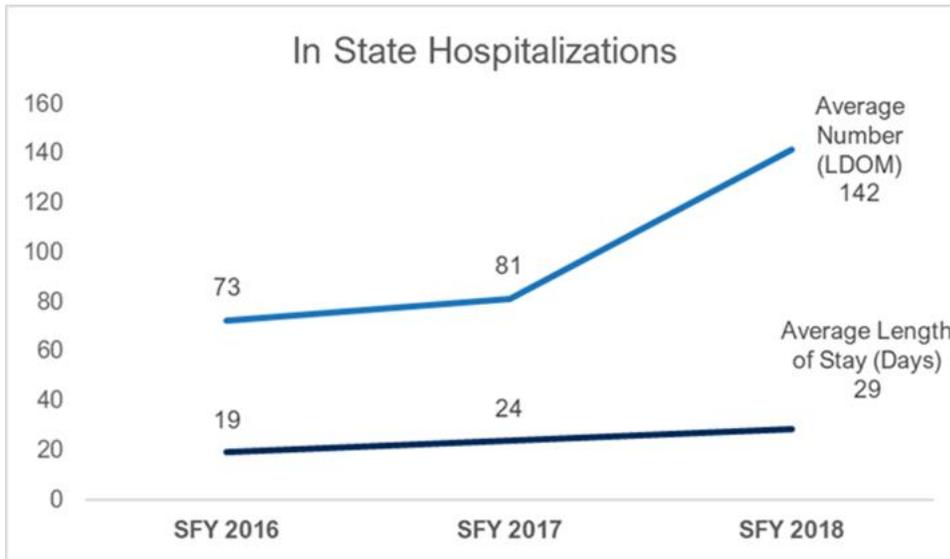


Figure 17. In state hospitalizations

Children in in-patient psychiatric hospitals also get “stuck” in longer hospitalizations because the process to apply for, be accepted, and wait for a residential placement is long. Figure 18, below, depicts the process for completing paperwork, filing, approving, and placing a youth through the Intensive Temporary Residential Treatment (ITRT) process with timeframes estimated by stakeholders. Based on the timeliness of processes and availability of residential placements, the entire process could take between three weeks to upwards of four months.



Figure 18. ITRT process and timeline

If there are no in-state residential services available or appropriate, the process can be even longer. An increasing number of children are being sent out-of-state for residential services (discussed further in Finding 2.) These children may be unable to receive services in state due to access, waitlists, being denied admission at all in-state programs, or, less frequently, a lack of specialized services. Case managers follow the same ITRT process depicted above and after being denied admission by all available in-state providers, the family and treatment team must pursue out-of-state options. For some children, this process can be relatively fast – a child who suffers from a severe eating disorder might move through this process quickly because there are no intensive residential programs available in Maine. For others, this process involves cumbersome and coordinated efforts to meet with and interview out-of-state residential providers. Stakeholders stated that oftentimes, the treatment team knows that an out-of-state placement will likely be necessary, but the ITRT process must be followed, resulting in delays.

Finding 2. Proximity: Behavioral health services are not always available close to the community where children live.

Maine is a predominately rural state with a population of just over 1.3 million people per 2015 census data, and 40 percent of that population residing in the greater Portland area. This makes Maine one of the least densely populated states (41 out of 50), while also being one of the geographically largest (12 out of 50).³⁵ Maine also has challenging geography to access, with many areas only minimally, and sometimes only seasonally, accessible by road and many sparsely populated coastal islands. These barriers result in access issues for children and providers struggling to meet the needs of the state's rural population. As one parent in Washington County described:

(there are) very few services available in our county, limited community supports, and limited funds for workers to take children to places where children can interact with others. No supports to help parents' expenses to get children to these places either. There (are) lots more available in the larger areas.

Rural Geography

Access issues are most clearly apparent in rural areas of Maine, where, in some parts, there are no children's behavioral health services providers at all. For home- and community-based services, providers from other areas try to serve these children by identifying staff who are willing and able to travel to and from families, sometimes upwards of two hours each way. Since reimbursement rates for home- and community-based services do not vary by region, rates may not sufficiently cover the cost of travel for providers serving these areas. Some service models also require a team of staff or highly trained clinicians, and an agency may not have sufficient demand to support full-time positions or compensate staff for their experience. For many providers, the cost of doing business in rural areas of the state is prohibitive. It is also difficult to recruit young professionals to live and work in rural areas of the state because urban areas present more desirable opportunities, including higher education.

The map in Figure 19 was developed using the Federal Health Resources and Service Administration's interactive data tool and highlights areas of Maine with mental health professional shortages for both children and adults.³⁶ Shortages are shaded in blue and constitute a significant portion of the state's geography. This data is consistent with regions in the state where providers and families indicated access issues to children's behavioral health services.

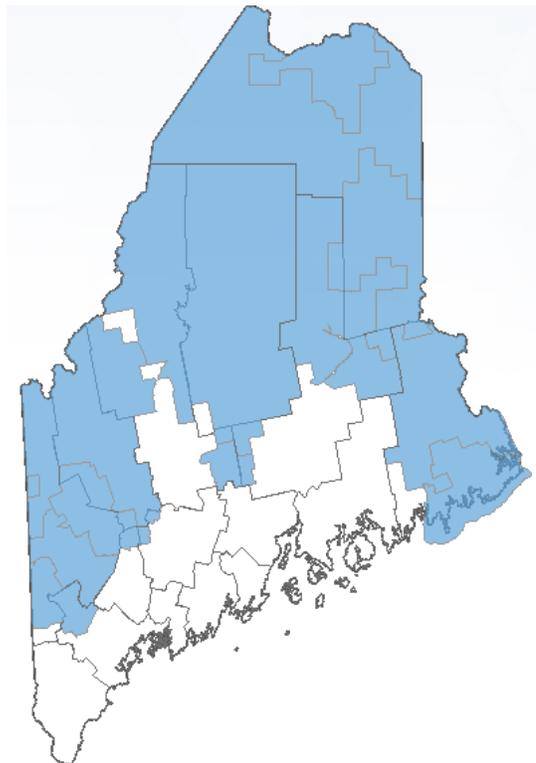


Figure 19. Mental health professional shortages

³⁵ Maine Population 2018. Retrieved from <http://worldpopulationreview.com/states/maine-population/>

³⁶ This data is inclusive of both adult and children mental health services. The health professional shortage area designation for mental health is based on a formula that accounts for population-to-provider ratio, poverty level, demographics, alcohol and substance abuse prevalence, and travel time to provider. Retrieved from <https://bhws.hrsa.gov/shortage-designation/hpsa-process>

Previous research conducted by the Muskie School of Public Service utilizing national survey data in 2010 found that children in rural areas of Maine have a small but significantly higher prevalence of mental health problems compared to children in urban areas of the state (5.8 percent versus 5.3 percent) and that these children in rural areas have a greater behavioral difficulties (59.1 percent) compared to urban children (53.7 percent).³⁷ While this study found that access to any behavioral health services did not differ for urban and rural areas, access to all needed mental health services was lower for rural children. The study also found that rural families spend six or more hours per week coordinating their child’s care. While this study is now based on data that is over a decade old, it provides a useful benchmark to conduct future analysis of rural behavioral health care access.

This study was unable to be replicated with current available information. However, the PCG survey asked families to rate the availability of services and report their responses (N=220) by county. Results are shown in Figure 20. Higher scores indicate greater agreement with the statement “My child has access to options that are good enough to make sure my child gets the treatment he/she needs”. Overall, respondents rated access very low, with no counties averaging above the median score of 3. Because sample sizes for some counties were relatively small (2 respondents), these results should be interpreted with caution. There is also some inherent bias in the sample because these families had access to this survey and presumably found out about the survey because they are engaged in services or at least aware of what could be available.

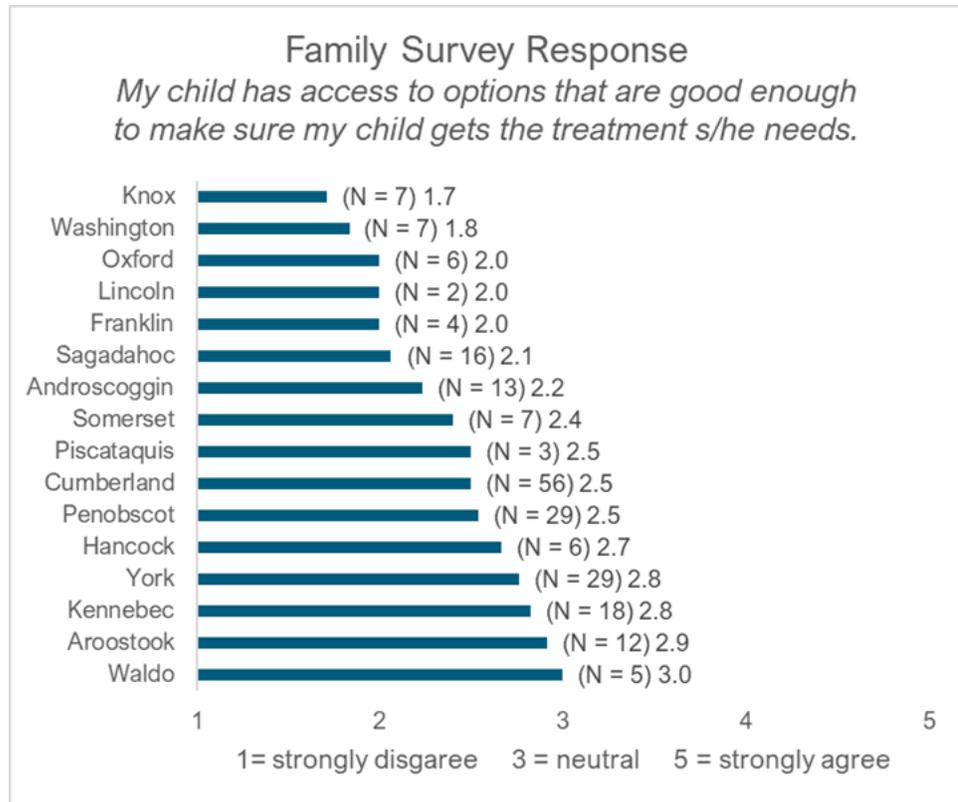


Figure 20. Family reported access to services (1=strongly disagree and 5 = strongly agree)

Out-of-State Placements

Throughout this assessment, a consistent concern was that too many children are being sent out-of-state for residential treatment. The actual number of children placed in residential programs in and out of Maine are captured below in Figure 21. As of September 27, 2018, OCFS reported that 55 children were in out-

³⁷ Lenardson, M. H. S., Jennifer, D., Ziller PhD, E. C., Lambert PhD, D., Race, M. S., Melanie, M., & Yousefian Hansen, M. S. (2010). Access to mental health services and family impact of rural children with mental health problems.

of-state placements. While most of these placements are in other states in the New England region, some children were placed as far away as Arkansas, Missouri, Illinois, and Utah.

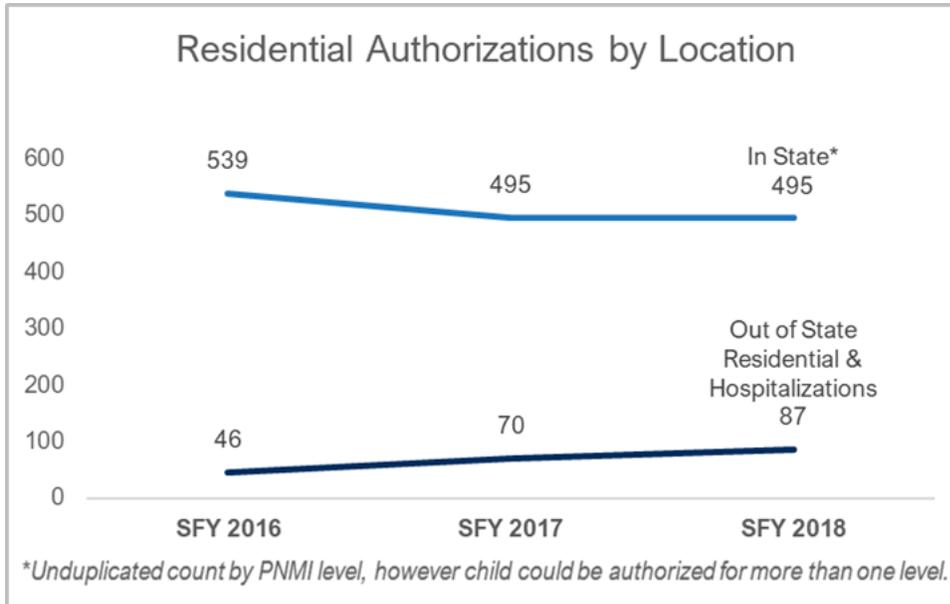


Figure 21. Residential authorizations by location

Children from Maine access residential treatment services outside the state for a variety of reasons, including:

- They require specialized treatment not available in Maine, for example intensive residential eating disorder treatment or services for the Deaf;
- Their behaviors or symptoms are so severe that no in-state providers feel they can manage them safely;
- No in-state placements are available at the time they require the service; or
- The level of residential care required, such as a locked facility (which may be a clinical determination or a requirement of the Department of Corrections) or Psychiatric Residential Treatment Facility (PRTF), is not available in Maine.³⁸

To be clear, not all out-of-state placements are inappropriate or could be avoided. For some families, living near the western border of Maine, a placement in New Hampshire is preferable to one in state because it is closer to where they live. However, the consequences of other types of out-of-state placements can have a negative impact on the child's emotional well-being and the family's ability to engage in treatment and maintain a relationship with their child. In this survey, 10 families indicated their child had to receive out-of-state services were currently considering an out-of-state placement. Five of these families indicated there were insufficient services in state or that no in-state provider would accept their child due to aggressive behavior, which they describe may have escalated because they were unable to access home- and community-based services. One parent stated that after waiting for in-state services for an extended period, they were forced to *"place (my child) in residential out of state because we feared for his and our safety."*

³⁸ MaineCare is currently developing a service definition for PRTF which will allow providers to offer this level of care in state.

These out-of-state placements are not always short term. One parent indicated their child was placed out-of-state for four years, and went on to say:

We have been trying since June to bring her home to live with us after we have given up on finding a residential placement here at home. We modified a bedroom to meet her needs as of now still can't find a day program in Maine. (A provider) said yes but has to hire an ed tech and as of today has not found one. My daughter has the right to be near her family and Maine has failed her.

There are also financial implications for this practice. For each placement, DHHS must negotiate the MaineCare treatment portion of the placement and the additional room and board expenses. There are also ancillary costs associated with routine or emergency medical and dental care, as well as transportation to the placement and between local service providers. Figure 22 shows the annual estimates for the room and board portion of the cost of out-of-state residential placements based on data provided by OCFS. This does not reflect the actual expenditures on room and board, nor does it include the MaineCare portion which covers the treatment services at the facility.

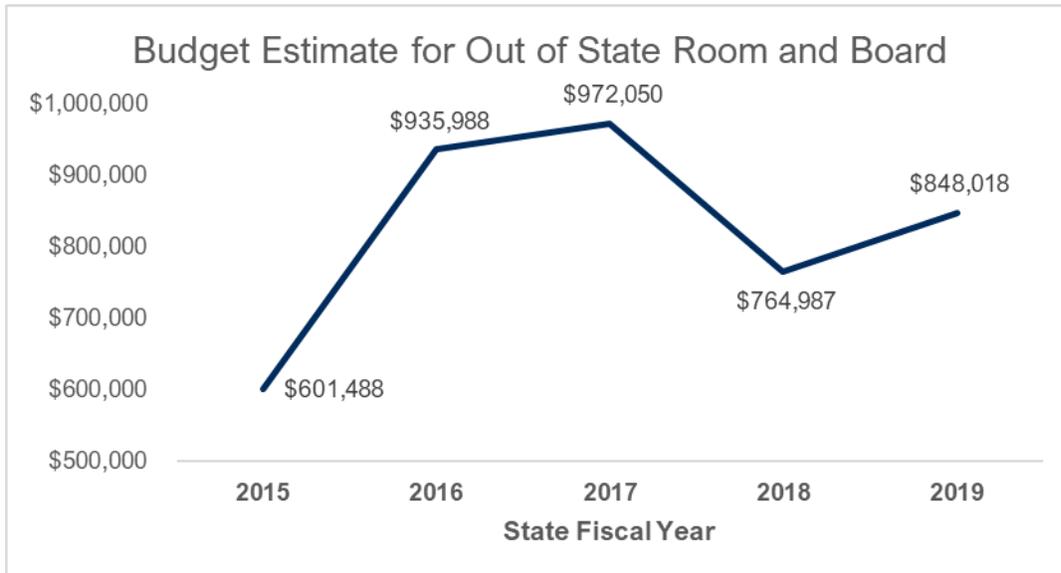


Figure 22. Budget estimate for out-of-state room and board

Over the past three years, children in Maine have also been admitted to out-of-state psychiatric hospitals in increasing numbers. While the numbers are still relatively small, Figure 23 demonstrates this trend as the average number of inpatients on the last day of the month. It illustrates that the average length of stay for out-of-state hospitalizations is also increasing.

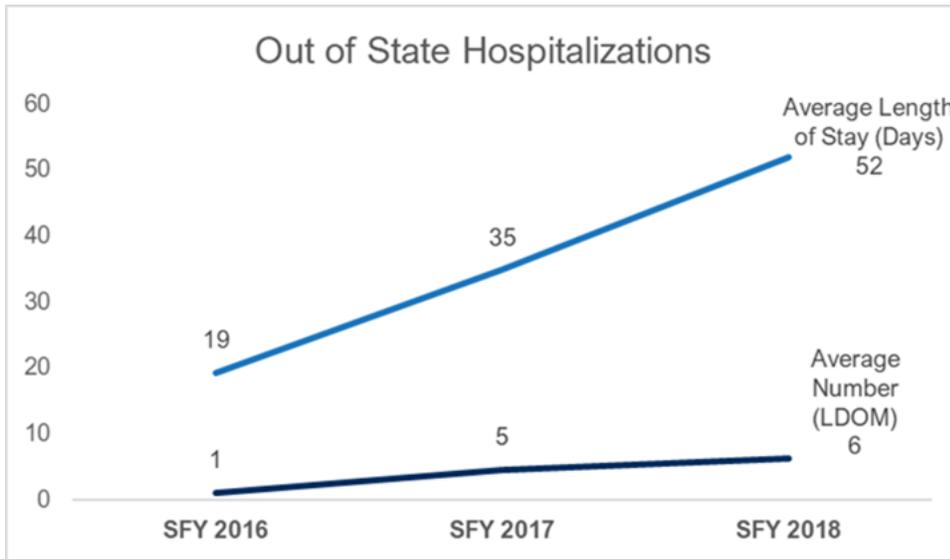


Figure 23. Out-of-state hospitalizations

Out-of-state hospitalizations occur when no in-state beds are available. Stakeholders frequently cited barriers to accessing psychiatric hospitalization as a challenge for Maine. Reasons discussed included:

- Limited numbers of psychiatric hospital beds for children, especially those with aggressive behavior;
- St. Mary's and Northern Maine Medical Center may receive lower reimbursement than Spring Harbor and Acadia Hospitals depending on length of stay;³⁹
- Reluctance to accept inpatient admissions for children who demonstrate aggressive behavior; and
- Reluctance to accept inpatient admissions without a clear discharge plan and available residential placement if applicable.

Until recently, Maine has not had a PRTF MaineCare service, so children requiring this level of care were sent to out-of-state facilities. While children should always be treated in the least restrictive setting possible, there will always be some children for whom a higher level of care, such as a Psychiatric Residential Treatment Facility (PRTF) will be most appropriate. A PRTF is a residential setting, which may or may not be locked, where children receive more intensive services under the supervision of a psychiatrist and other professionals. According to data from 2015, Maine was one of 16 states that did not have a PRTF level of care available.⁴⁰ However, recently Minnesota also added a PRTF service definition to meet the needs of children who were otherwise receiving services out-of-state.⁴¹

³⁹ St. Mary's and Northern Maine Medical Center are paid on fixed reimbursement structure per discharge based on the CMS Diagnostic Resource Group (DRG) for Acute Care Non-Critical Access Hospitals. Whereas, Spring Harbor and Acadia receive a negotiated inpatient rate "between eighty-five percent (85%) and one hundred percent (100%) of the hospital's estimated inpatient charges, less third party liability." MaineCare benefits Manual Chapter III Section 45, Hospital Services.

⁴⁰ Ajuonuma, P. (ND) Psychiatric residential treatment facilities: General requirements and conditions of participation. Retrieved from <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/PRTFGeneralRequirementsandConditionsofParticipation.pdf>

⁴¹ New Psychiatric Residential Treatment Facility to serve children with complex mental health conditions (July 20, 2018). Retrieved from <https://mn.gov/dhs/media/news/?id=1053-346826>

Family Engagement

Besides challenges accessing all needed services, rural families are impacted in their ability to fully engage in services with providers located far from their home. Parent engagement in mental health treatment is significantly associated with positive treatment outcomes, improved child functioning, school performance, and interpersonal relationships.⁴² When a child from Presque Isle is placed in a residential program in Portland, their family has to drive upwards of five hours one way to visit or participate in treatment and pay for overnight accommodations. When a child is placed out-of-state, the burden of that distance between child and family becomes increasingly difficult. As one parent reported, *“we desperately need more services in Maine. My daughter is being sent (out-of-state) and she and our family are traumatized by that.”* Families have recently become frustrated that previous MaineCare funding through Non-Emergency Medical Transportation is no longer allowable if the child is not in the vehicle, which is per the federal Centers for Medicare & Medicaid Services (CMS) rule. Both families and providers have expressed concern this will impact families' ability to engage in treatment and maintain relationships with their children.

Finding 3. Appropriateness: *When children do get services, it is not always the right service.*

During this assessment, stakeholders raised concerns that the available services may not be appropriate or effective in meeting the needs of children. The appropriateness of services is inextricably linked to the access issues previously discussed, and as one provider explained, *“even if the provider is doing an excellent job it is extremely hard when available resources for families are so limited. A need might be accurately identified, but there is frequently not a service to refer them to.”* Children are then referred to whatever services are available, even if they are not a good fit for the child or family's needs. One parent explained that her child with Autism was on a long waitlist for RCS Specialized, but was referred to HCT and received six months of services that had little or no impact on her child's goals and are now still waiting for RCS. Families start to experience a series of ineffective services which wastes resources and frustrates families.

Sometimes this misalignment between clinical need and service type is due to poorly developed service definitions. As some stakeholders explained, services like RCS Basic were developed to meet the needs of children with intellectual or developmental disabilities (I/DD), but the definition is broad enough to allow children with other mental health issues to qualify. The impact is two-fold – children who truly need RCS for I/DD issues must wait, and children with mental health issues are served by providers without the skills or evidence-based practices to treat their symptoms. Families and OCFS staff also described that sometimes families use Section 28 like respite care, which is otherwise limited, particularly if the assigned worker is not highly skilled.

To analyze the fit between the services provided and the clinical need of the children in those services, three years of MaineCare claims information regarding outpatient services, TCM, crisis services, RCS (both Basic and Specialized), HCT, and residential services utilizing diagnostic information on the claims was analyzed. While this is an imperfect analysis and does not account for children who have more than one major behavioral health diagnosis or inaccurate diagnoses, and may overinflate diagnoses where children receive large amounts of a service, it does provide a benchmark from which the fit between the intervention

⁴² A Review of Parent Participation Engagement in Child and Family Mental Health Treatment. June 2016. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4433419/>

or service type and the child’s primary need can be assessed. Table 3 shows the most common diagnostic categories associated with MaineCare claims between 2016 and 2018.⁴³

Table 3. Common diagnoses by service type

Outpatient ⁴⁴		TCM		Crisis ⁴⁵	
Adjustment Disorder	20.52%	ADHD	19.70%	Mood Disorder	38.36%
Anxiety	18.05%	Autism	14.84%	Anxiety	15.25%
ADHD	17.92%	Mood Disorder	13.62%	Adjustment Disorder	13.14%
Mood Disorder	16.85%	Adjustment Disorder	11.21%	ADHD	10.59%
PTSD	9.39%	Anxiety Disorder	10.99%	PTSD	9.80%
Autism	4.75%	PTSD	7.65%	Conduct Disorder	3.62%
Other Disorder	4.50%	Inadequate Diagnostic Information	5.11%	Autism	3.56%
Substance Use Disorder	2.39%	Other Disorder	4.86%	Other Disorder	3.29%
Medical Disorder	1.76%	Conduct Disorder	2.29%	Reactive Attachment Disorder	1.51%
Conduct Disorder	1.54%	I/DD	1.44%		
RCS		HCT ⁴⁶		PNMI ⁴⁷	
Autism	38.17%	ADHD	22.21%	Mood Disorder	28.09%
I/DD	15.88%	Mood Disorder	19.38%	PTSD	20.15%
ADHD	15.68%	Adjustment Disorder	13.13%	Autism	14.17%
Medical Disorder	6.58%	PTSD	10.42%	ADHD	11.73%
Mood Disorder	5.78%	Anxiety Disorder	10.41%	Other Disorders	10.22%
Anxiety Disorder	4.76%	Autism	8.62%	Reactive Attachment Disorder	4.75%
Other Disorder	4.09%	Other Disorder	4.54%	Anxiety Disorder	4.47%
Adjustment Disorder	3.69%	Conduct Disorder	4.04%	Conduct Disorder	4.35%
PTSD	2.57%	Medical Disorder	3.87%	I/DD	1.64%
Conduct Disorder	2.07%	I/DD	1.70%	Medical Disorder	1.36%
		Inadequate Diagnostic Information	1.41%	Psychosis	1.24%
		Reactive Attachment Disorder	1.03%	Adjustment Disorder	0.88%

Table 3 reveals support for the concerns described earlier about interventions and services not fitting the clinical needs of children. For example:

- Total Section 28 (RCS) claims for children with a non-I/DD or Autism diagnosis included PTSD (412 claims) and conduct disorder (332 claims). These children may benefit from a more appropriate evidence-based intervention for trauma (e.g. TF-CBT) or conduct disorder (MST).

⁴³ These percentages were calculated based on any diagnoses with over one percent prevalence and combined using DSM categorization.

⁴⁴ Includes procedure codes H0004 (outpatient counseling), H2000 (evaluation), and H2010 (medication management) with modifiers.

⁴⁵ Includes procedure code H0018 Crisis Residential and H2011 Crisis Resolution.

⁴⁶ Includes procedure codes H2021, H2033, and G9007 with modifiers (this includes FFT and MST).

⁴⁷ Includes procedure codes H0019 with modifiers (CG, HE, SE, U9, US) and S9485.

- Children with I/DD (30 claims) or Autism (344 claims) utilize crisis services in slightly lower numbers than residential services (PNMI) – (e.g. I/DD (41 claims) Autism (355 claims). This may indicate a tendency for families to underutilize crisis services for this population, as we heard from stakeholders, despite them having high needs, and therefore end up utilizing more intensive services like residential.

The diagnostic information associated with the above MaineCare claims may be indicative of a larger concern about the frequency and quality of comprehensive clinical assessments. During stakeholder interviews that included providers, some described the assessment process to diagnose a child and identify appropriate interventions is very paperwork-driven, rather than clinical in nature. Service providers described the treatment plans resulting from the assessment process are problematic:

The plans are very restrictive and are only approved if they focus on very specific behavioral goals. These are kids not widgets and the funding and use of the support workers needs to be more flexible and driven by the family and their case manager.

Another provider felt similarly stating that:

It is not that providers do not want to make plans as effective and meaningful as possible, however, there are so many regulatory requirements that the client can get lost in the documentation demands.

Families experience the assessment and treatment planning process as if staff are “just checking boxes.” As one parent explained, the assessment for her child to receive home- and community-based services was performed without the child being present and by a staff person with no professional education in psychology or social work, but rather law enforcement. Stakeholders also reported concerns that when determining the type of services and the quantity recommended for a child, providers fall back on what their agency has available to deliver, rather than what is clinically indicated.

Poor clinical assessments lead to problematic treatment plans, which are not individualized, goal-oriented, shared and understood by the treatment team and families, or even realistic. Some parents reported poor communication also led to the improper evaluation of children, and continually re-trying services parents believed did not work. As one parent described:

The goals would have been for (my child) to have some treatment that worked for him. He has never been properly evaluated so I am the only one who has paid close enough attention to him to understand how to help. In each place, (my child) has a different doctor, clinician, etc. so there is no consistency or consistent treatment or any treatment at all. They always say they are teaching him coping skills but after 25 times you would think they would change. We are not close to meeting goals at all.

Poor communication among providers can also diminish service effectiveness. One service provider shared, “There is not a whole person approach where providers connect with providers. Often, the treatment plans for each service aren't aligned.” As a child transitions between service providers, sometimes treatment plans do not follow or are not implemented, resulting in ineffective services. One parent of a child in residential services described this frustration as follows:

(My child) was hospitalized almost all of last year and they got her stable enough for residential and then (the residential facility) didn’t follow any of the recommendations of the hospital. (My child) needs to have her communication device on her at all times and [the provider] keeps it locked away most of the day and (my child) is non-verbal. Well, if you take away a kid’s only way to say something then of course you are going to see behaviors and it’s going to make her more frustrated and aggressive. Decreasing aggression and increasing communication were the goals and we are moving in the exact opposite direction. Trying to work with them is like talking to a wall.

Families also expressed challenges with being involved in their child’s treatment planning and services. During interviews, they reported that they are not treated by service providers as the expert on their child, and as one parent shared, *“I have to be pushy to stay involved.”* Similarly, another parent stated that her involvement is, *“100 percent at my urging, and not their inclusion.”* However, survey results were more positive with the majority of families rating this survey item *“Families and children are treated as partners throughout each phase of the process (e.g., assessment, planning, delivery and evaluation) when receiving behavioral health services, and their preferences are taken seriously”* as 3.6 out of 5. Service providers and DHHS staff felt similarly to families, rating this item at 3.6 and 3.5, respectively. Youth, however, rated that providers valued parents at 3.9 out of 5, with 71 percent stating that they agreed or strongly agreed with the statement: *“My family members are treated like partners by service providers and they get to help decide the type of treatments I need.”* However, the same youth reported an average 3.4 when asked about their own partnership with providers. This indicates that youth feel slightly less valued by providers themselves.

Finding 4. Quality: *The quality of behavioral health services is not consistent.*

Throughout the assessment, stakeholders including families, DHHS and state agencies, advocates, and behavioral health services providers raised concerns about the inconsistent quality of services for children across the service array. The statewide survey asked respondents to rate how much they agreed with statements about the quality of children’s behavioral health services on a scale of 1 (strongly disagree) to 5 (strongly agree). Tables 4 through 7 report how different stakeholders responded about the quality of services being provided, showing the variations in response (total number of respondents for each question indicated as N).

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<i>My child’s services are good enough for him/her do well in school. (N = 208)</i>	7%	29%	23%	20%	21%
<i>My child’s services are good enough to help him/her get along with our family. (N = 210)</i>	10%	35%	19%	21%	16%
<i>My child’s services help my child to stay out of big trouble (such as being sent to juvenile corrections or getting arrested). (N = 157)</i>	12%	33%	27%	18%	10%
<i>My child’s services help him/her to plan for the future as an adult. (N = 177)</i>	12%	22%	31%	20%	15%

<i>My child’s services help him/her to figure out how s/he can reach the goals s/he has set for when s/he grows up. (N = 184)</i>	8%	24%	31%	20%	17%
<i>My child’s services help him/her figure out what s/he needs to do to become a stable and productive adult. (N = 180)</i>	4%	27%	29%	23%	17%

Table 5. Provider survey responses

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<i>Behavioral health services are generally effective in helping children to be successful in school. (N = 628)</i>	6%	41%	31%	17%	5%
<i>Behavioral health services are successful in helping children to live and function well within their families. (N = 631)</i>	9%	47%	26%	15%	3%
<i>Behavioral health services are generally able to help children in avoiding the juvenile justice system. (N = 585)</i>	8%	44%	26%	17%	5%
<i>Families are overall, quite satisfied with the quality of their children’s behavioral health services. (N = 587)</i>	4%	29%	29%	25%	13%
<i>Behavioral health services are continuously evaluated and changed if they are not effective in achieving desired outcomes. (N = 616)</i>	7%	30%	22%	25%	16%

Table 6. DHHS survey responses

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<i>Behavioral health services are generally effective in helping children to be successful in school. (N = 53)</i>	4%	43%	34%	17%	2%
<i>Behavioral health services are successful in helping children to live and function well within their families. (N = 55)</i>	5%	40%	35%	18%	2%
<i>Behavioral health services are generally able to help children in avoiding the juvenile justice system. (N = 52)</i>	4%	40%	37%	17%	2%
<i>Families are overall, quite satisfied with the quality of their children’s behavioral health services. (N = 52)</i>	2%	15%	31%	38%	13%
<i>Behavioral health services are continuously evaluated and changed if they are not effective in achieving desired outcomes. (N = 50)</i>	2%	24%	32%	30%	12%

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<i>The services I get are good enough for me to do well in school. (N= 51)</i>	8%	24%	18%	27%	24%
<i>The services I get are good enough to help me get along with my family. (N = 50)</i>	8%	10%	18%	38%	26%
<i>The services I get help me to stay out of big trouble (such as being sent to juvenile corrections or getting arrested). (N = 49)</i>	4%	4%	16%	39%	37%
<i>The services I get help me to plan for my future as an adult. (N = 49)</i>	2%	20%	20%	31%	27%
<i>The services I get help me to figure out how I can reach the goals I have set for when I grow up. (N = 50)</i>	2%	18%	22%	26%	32%
<i>The services I get help me figure out what I need to do to become a stable and productive adult. (N = 51)</i>	6%	16%	18%	37%	24%

Family members and youth described their frustrations with poor quality of services and the impact that poor access, turnover, and inexperienced staff had on services for their family:

We stopped one service and then things slowly got worse. It took months to get him into more services. The initial service was not enough to meet his need and the HCT is not really helping either.

The HCT services we have had the people did not stay more than a month or two before they either got fired from the agency or they moved on to another position. He went through six BHPs and he now refuses to work with any BHP due to his previous loss and abandonment issues. He does not want to get close to anyone because “they just leave me.”

We have had multiple BHPs who lack the knowledge and experience to work effectively with children with behavioral needs.

Some residential placements for [remove provider name] are chaotic dangerous and disturbing. Need more staffing and have law enforcement presence.

Concerns about the quality of services can be attributed to numerous issues that were previously discussed, including workforce shortages and turnover. Sometimes staff working in the home with a child are well-intentioned, but inexperienced and poorly trained and supervised, and there is not sufficient emphasis on or progress with service plan goals. Additional factors impacting quality of children’s behavioral health services are discussed below.

Inconsistent Investment in and Commitment to Evidence-Based Practices

One way in which a system of care can ensure the quality of services and impact the efficacy of what is delivered is to identify, invest in, and support the use of evidence-based practices (EBPs). While the use of EBPs would not fix all of the issues in the system of care, nor should the application of EBPs be a “one size fits all” intervention, EBPs can be incredibly helpful to support providers achieve positive outcomes. Maine has historically favored a few specific EBPs and has generally demonstrated success when these modalities are implemented with enough training, funding, and high fidelity to the model. In 2007, the state began offering intensive wraparound services for children ages 5 to 18 with significant behavioral challenges and who are placed, or at risk of placement, in a residential setting or juvenile correctional setting. High Fidelity Wraparound is a national best practice for children with high needs and has demonstrated cost savings resulting from reductions in both inpatient and outpatient health care expenses.⁴⁸ In Maine, the program demonstrated a 28 percent overall reduction in average per child mental health expenditures, which was largely due to reductions in crisis services, residential services, inpatient hospitalizations, and Assertive Community Treatment (ACT).⁴⁹ However, despite these successes, the program was eliminated. In 2015, there was brief success bringing Cognitive Behavioral Therapy Plus (CBT+) training to providers; however, the ongoing implementation and fidelity to the model faltered without state support to address challenges with the model's developers.

Maine has also invested in Multisystemic Therapy including MST for Problem Sexual Behavior, Functional Family Therapy, and Assertive Community Treatment (ACT) for children.⁵⁰ During the assessment, it was found that when available, MST and FFT have typically been successful with helping families and children achieve positive outcomes. The Washington State Institute for Public Policy estimated the benefit to cost ratio for MST as \$1.62 and \$8.35 for FFT with juveniles on probation.⁵¹ MST has been particularly successful in Maine due to support from the Department of Corrections, which pays incentives for providers who achieve positive outcomes in their program. FFT was also described as a successful EBP, but is only being provided by two agencies currently with limited capacity. ACT was an intensive 24/7 service provided by a team comprised of a clinician, social worker, and other staff. These teams supported children in their home and community and helped prevent or support step-down from psychiatric hospitalization, residential placement, or crisis stabilization services. ACT services for children were briefly available, and providers have since discontinued citing inadequate reimbursement to support the staffing required for the model. Applied Behavioral Analysis (ABA) is available for children receiving Section 28 Specialized and is particularly beneficial for children with Autism; however, this model is not widely available due to shortages of qualified BCBA's. For EBPs to be successful and achieve the best possible outcomes and return on investment, providers require master-level training, ongoing coaching and supervision, fidelity monitoring,

⁴⁸ Snyder, A., Marton, J., McLaren, S., Feng, B., Zhou, M. (2017). Do high fidelity Wraparound services for youth with serious emotional disturbances save money in the long-term? *The Journal of Mental Health Policy and Economics*, 20, 167-175.

⁴⁹ Maine DHHS, Office of Continuous Quality Improvement Services. (July 2011). *Wraparound Maine Summary: Mental Health Services Use and Cost Study*. Retrieved from https://nwi.pdx.edu/pdf/HHS_QI_Data_SnapshotV3_I3a.pdf

⁵⁰ OCFS reports that other EBPs for children and families are available in Maine, however capacity may be limited. These include: Cognitive Behavioral Therapy (CBT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Applied Behavioral Analysis (delivered under RCS Specialized services), Aggression Replacement Therapy (ART), Child Parent Psychotherapy (CPP), Eye Movement Desensitization and Reprocessing (EMDR), Incredible Years, Dialectical Behavioral Therapy (DBT), Matrix Model Intensive Outpatient, and Triple P. No providers are currently available to provide ACT as of this report.

⁵¹ Washington State Institute for Public Policy (May 2017). When calculated benefits exceed calculated costs, the benefit to cost ratio is positive. Retrieved from <http://www.wsipp.wa.gov/BenefitCost>

and reimbursement rates that will support the model to be implemented as intended. In all of these respects, Maine has struggled to fully support evidence-based practices.

Without the widespread use and support of EBPs, most outpatient and home- and community-based service providers are left to develop their own interventions and models of treatment or seek training on their own. Under MaineCare any “willing and qualified vendor” can deliver services per federal law and providers must attest that they know this policy and will delivery services accordingly when they enroll as a provider. However, without specific requirements to complete trainings or deliver EBPs with fidelity, providers are not held to a high standard of expertise. Stakeholders often referred to HCT as if just receiving a service was the goal; however, HCT is a modality in which to deliver specific interventions or treatments. EBPs like MST and FFT have been successfully embedded within the HCT MaineCare service definition, but for most children receiving HCT, the quality, skill level, and specific clinical interventions they receive varies and is unregulated. While the HCT service definition does require a licensed clinician, families referred to this person as the “supervisor” and most of the face-to-face services are delivered by a less skilled Behavioral Health Professional (BHP). Stakeholders described that clinicians in rural areas of the state lack training and often provide ineffective interventions without any oversight or consequences. Without state infrastructure and funding, many of these providers cannot pursue training on their own.

Similarly, while RCS Specialized services do require a BCBA to lead the treatment planning and provide guidance to the BHP as to what interventions or skills will be most effective with a child, it was reported that often the BCBA acts more like a remote supervisor and is not involved in the child's day-to-day services. The BCBA may not even have met the child in-person and relies on Skype or telephone to maintain monthly contact with the family.

Limited Authority and Ability to Monitor Services

Under previous leadership, OCFS operated a quality assurance unit that was staffed with employees responsible for monitoring services, developing relationships with providers, and conducting regular quality assurance reviews across several service areas. Following organizational restructuring, this unit was eliminated and its functions ceased. When DHHS transitioned the administrative responsibilities from OCFS to the Administrative Services Organization (ASO), currently provided by KEPRO, the agency's relationships with behavioral health service providers were weakened. OCFS's authority over providers was further diminished when all contracts for services were transferred to the Office of MaineCare. Currently, providers are responsible to KEPRO who authorizes services and manages utilizations, MaineCare who ensures program integrity and adherence to service definitions and policy, and the Division of Licensing and Certification who monitors basic safety standards. OCFS no longer develops contracts with MaineCare providers that stipulate any performance requirements, outcomes, or quality assurance. Apart from Behavioral Health Homes, contracts with providers do not require outcomes or assign any financial penalty or incentive. In a fee-for-service system, providers are not incentivized to nor compensated for investments in additional training, quality assurance, or improved outcomes. Families are keenly aware that OCFS lacks authority in this area, as one described:

My child does not receive all the services for which she qualifies. The department does not provide what is needed nor do they oversee the providers or hold them accountable for the services they contract them to provide.

Notable exceptions are the contracts funded through state general funds and Community Mental Health Block Grant, including crisis services and family and peer supports. The Maine Office of Substance Abuse

and Mental Health Services (SAMHS) maintains control over the crisis provider contracts and specifies that 85 percent of individuals will have no psychiatric hospitalizations 30 days following the discharge from a Crisis Stabilization Unit, but there is little accountability if providers do not meet performance expectations due to limited oversight and lack of clear recourse options. Reports for family and peer support contracts include both some output measurements (e.g. number of families who attend a workshop) and performance measurements (e.g. youth self-reported improvement in functioning).

Maine also developed four Accountable Communities (ACs) across the state that were formed when a group of providers participated in a shared savings model to managed care. The program allows providers to be flexible in how care is provided and managed, and requires quality measures related to the physical and behavioral health of members. The current measures include three indicators related to children's behavioral health including:

- Screening for Depression: Percentage of members age 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool.
- Follow-up Care for Children with an ADHD Diagnosis: Percentage of children aged 6-12 years newly prescribed ADHD medication who have at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.
- Follow-Up after Hospitalization for Mental Illness: Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

While ACs are a promising step toward a more wholistic strategy of value-based purchasing, enrollment of children in AC has lagged because ACs are not available statewide and even in communities where they operate. Not all pediatric or family medicine practices have joined an AC where available, and therefore the children receiving care at these practices are not members. Approximately 260,000 children are enrolled in MaineCare in a given month and recent data indicates that 30,305 members of the ACs were 0-21 years of age – representing approximately 11 percent statewide.⁵² While ACs are responsible for members' physical and behavioral health, they can currently exclude children's residential PNMI from their costs, thereby eliminating an incentive to avoid that level of care.

Despite the lack of a MaineCare contractual obligation to engage in performance evaluation, review, or quality assurance, OCFS does monitor some providers directly, but does not have sufficient staffing levels or skills to perform quality assurance on all MaineCare behavioral health services. Currently, a very limited team conducts periodic reviews of residential service providers based on the frequency and nature of the program's Reportable Events.

⁵² CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports: January 2014 - August 2018 (preliminary), as of October 24, 2018. AC child enrollment data provided to PCG from Office of MaineCare 11/1/18.

These reviews are reactive in nature, not proactive or even routine. The monitoring is in response to the most serious Reportable Events including:⁵³

- Dangerous situations
- Death
- Medication related events
- Neglect
- Physical/verbal abuse
- Restraint
- Rights violation
- Serious injury to customer
- Sexual abuse/exploitation
- Suicidal acts/attempts/threats

OCFS staff reported particular concern with the current level of oversight provided to residential programs. Children in residential facilities are more vulnerable as they are placed away from their families and they often have complex needs. Stakeholders frequently cited that inconsistent or inadequate monitoring and oversight of residential services contributed to the poor quality of services resulting in failed services when a provider cannot safely maintain a child. The quality assurance process is almost entirely voluntary on the part of providers and when a Corrective Action Plan is warranted, OCFS has no authority to hold providers accountable for any issues identified.

When safety or quality issues are discovered, OCFS and families have little recourse to force improvements unless the issue violates licensing or MaineCare requirements. Even when there is possible recourse, the current service shortage means that withholding referrals or closing programs will only exacerbate access issues and increase waitlists, leaving children without services and/or keeping them stuck in more restrictive levels of care than necessary. Families also have little recourse because leaving a service provider, even one providing poor treatment, they will have to assume a place on a waitlist for another provider, if one is even available.

OCFS also lacks a robust, integrated data system to pull provider level information, specific child demographics, MaineCare claims, and other data to conduct detailed analysis and drive continuous quality improvement. Much of the data available is spread across a fragmented system and OCFS staff report the data managed by KEPRO lacks internal quality controls and requires significant clean-up before it can be analyzed. While OCFS has developed spreadsheets to monitor different indicators, the process is still highly manual and therefore prone to error or inconsistency.

Finding 5. Coordination: Coordination with other child-serving agencies and transition to adult services is inadequate.

Coordination

Children's behavioral health services that are funded through MaineCare, state general funds, and block grants are just one part of the larger system of care that supports children and families. The partnerships between child-serving agencies on the individual child, local community, and statewide level are critical to the success of services and positive outcomes for children. Children with behavioral health needs are rarely served by just one agency or department, and resources are best maximized when they are integrated, not

⁵³ <https://www.maine.gov/dhhs/ocfs/cbhs/provider/reportable-events.shtml>

delivered in siloes. While there are certainly strengths across the system care, overall collaboration and coordination was frequently cited as inadequate.

While OCFS staff are deeply invested in identifying resources and supporting specific cases that are high needs, their role as a state agency has shifted with the changing landscape in MaineCare. OCFS is no longer responsible for providing direct services to most children in the system of care. That coupled with the lack of authority over providers discussed in Finding 4, OCFS is left with an unclear responsibility for coordinating care and troubleshooting when the system of care is faltering. Providers also described that previously they felt like OCFS treated them as partners and acknowledged their clinical expertise, but in recent years relationships and communication has broken down at the state and local level and the dynamic is more adversarial now. Since OCFS discontinued quarterly meetings with providers and the annual KEPRO conference, providers think there is less transparency with OCFS and opportunities to provide input. Residential providers specifically expressed frustration that they are not supported by the state when they accept children with high needs who are frequently in crisis.

Coordination within children's behavioral health services and between different providers is a source of frustration for families, OCFS staff, and providers. For example, stakeholders described there is a lack of coordination when children are in crisis and that families and children find themselves repeatedly sharing information with mobile crisis and emergency department staff. Sometimes this uncoordinated response is exacerbated when there are "too many cooks in the kitchen." Families may be working with multiple case managers for multiple children, in addition to a Juvenile Community Corrections Officer (JCCO), school social workers or psychologists, HCT or RCS teams, psychiatrists, an OCFS Program Coordinator, and the MaineCare Care Coordination Unit (CCU). Each one is doing their best, trying to ensure children access the right services, but the result can be inefficient and confusing for families. Family respondents rated this statement: *The different agencies working with my child (for example, DHHS, service providers, juvenile corrections) work well together as a team to make sure that my child's services go the way they are supposed to* at an average of 2.8 out of 5 indicating that the majority tend to disagree or strongly disagree that agencies are working well together on behalf of children.

Specific areas where coordination has been a challenge include schools, juvenile justice, and child welfare. A state level stakeholder reported that the coordination between the Department of Education and DHHS is weak. As a result, Day Treatment, a Section 65 MaineCare service, was described as "orphaned" because neither agency takes ownership to ensure that services are available, appropriate, and high quality. The funding to support the educational components of Day Treatment is the responsibility of the local school district, which is often where a child receives residential services, rather than the responsibility of their home school district. This policy burdens school districts with concentrations of residential programs and further impacts the coordination that will be required for the child to return to their home school. While the relationships between behavioral health services and schools could not be evaluated in depth, stakeholders did express that collaboration between schools and home-based services could be improved and that there are areas around the state where educational and treatment services are more thoughtfully integrated, which could serve as a model.

Children with behavioral health issues frequently come to the attention and responsibility of juvenile justice when their behaviors become aggressive or destructive, resulting in injury to others or property damage. Among the thirty law enforcement and corrections stakeholders who took the survey, they rated agency collaboration at an average of 2.7 indicating this is an area for continued improvement. During the interviews, behavioral health providers and the juvenile justice system were described as operating

separately at both the individual child level and at the state level where leadership resides in separate Departments. When possible, the OCFS Program Coordinators visit juvenile justice offices and the two clinicians located at Long Creek Juvenile Corrections Facility were described as very useful to ensure coordination with detained youth. Stakeholders stated that the practice of criminalizing behavioral health conditions is problematic, but the system of care has not agreed on a process to handle aggressive behavior or a strategy to prevent this from occurring.

Coordination between behavioral health and child welfare is imperative because the overlap between children’s behavioral health services and child welfare is substantial. Table 8 details the average percent of children in DHHS custody (at some point during the year) who received at least one of the listed behavioral health services during SFY 2016-2018. Outpatient, Residential Services, and Targeted Case Management were the most commonly utilized behavioral health services among children in DHHS custody.

Table 8. Average percent of children in DHHS custody who received CBHS (SFY 2016-2018)

Service Type	Percent
Crisis⁵⁴	8%
PNMI (includes out-of-state)	5%
HCT⁵⁵	13%
RCS (Section 28)	6%
TCM	18%
Outpatient⁵⁶	45%

A review of the annual Child Protective Services (CPS) report reveals that many children come to the attention of child welfare due to behavioral health concerns. For example, in 2017, 23 percent of reports accepted for assessment had a child behavioral health risk factor such as "ADD/ADHD," "severe acting out behavior by child," and/or "emotionally disturbed child" noted. Assessments may indicate more than one risk factor for child welfare and may not fully capture the prevalence of behavioral health issues or the impact of trauma. Consistent with national trends, OCFS estimated that the prevalence of behavioral health issues in foster care is quite high and the majority of children in child welfare custody enter with, or are referred to, behavioral health services for treatment.

Data regarding the number of children who receive behavioral health services and who are also in DHHS custody at some point during the year was examined. For most behavioral health services, the number of children in DHHS custody varied between 4 and 12 percent in SFY 2018. For example, of the 2,454 children who received crisis stabilization or mobile crisis services, 217 of these children were in DHHS custody. Notably, of the 541 unduplicated children who received at least one day of residential (PNMI) services during SFY 2018, 22 percent (120 children) were in DHHS custody. This number was higher in SFY 2016 (27 percent) and SFY 2017 (25 percent). This finding indicates that children in child welfare custody are

⁵⁴ Includes procedure code H0018 Crisis Residential and H2011 Crisis Resolution.

⁵⁵ Includes procedure codes H2021, H2033, and G9007 with modifiers (this includes FFT and MST).

⁵⁶ Includes procedure codes H0004 (outpatient counseling), H2000 (evaluation), and H2010 (medication management) with modifiers.

heavily utilizing deep end services like residential treatment, which further emphasizes the critical importance of the behavioral health and child welfare system working collaboratively.

In September 2018, the United States DHHS Office of Inspector General (OIG) produced a report concerning the medication management and treatment of youth entering foster care.⁵⁷ This OIG report found that out of the 3,527 children in foster care in Maine, 1,155 of them (32.7 percent) were treated with psychotropic medications.⁵⁸ The report also found that although Maine requires a treatment plan for children in foster care, 28 percent did not have treatment plans. Additionally, the report found that 26 percent of medication plans were not reviewed quarterly as required and that 11 percent of children in foster care did not receive medication monitoring by a prescribing professional. The lack of monitoring by a prescribing professional may be a result of the statewide shortage of child psychiatrists in Maine. This report highlights the importance of behavioral health providers and child welfare staff working together collaboratively to ensure these children receive needed treatment and that medication is appropriately monitored and the need for service quality measures particularly around the use of psychotropic medication.

Transition to Adult Services

Youth with behavioral health needs, particularly conditions that are expected to carry into adulthood, need to have a thoughtful transition between the child system of care and adult system that begins well before they reach the age of 21. However, OCFS staff, stakeholders, and families stated that the transition between child-serving agencies and adult services is not coordinated and some youth slip between the cracks. OCFS tracks the annual number of youth who are eligible to transition to services through the Office of Aging and Disability Services (OADS), a number which has increased from 315 in SFY 2016 to 396 in SFY 2018 (see Figure 24).

Other youth, not captured in this data, require a thoughtful transition from child to adult mental health services under SAMHS.

The survey asked several questions about transition services and found that most respondents, on average, did not agree or strongly agree that services help children plan for the future, for adulthood, or for other types of transitions (see Figure 25).

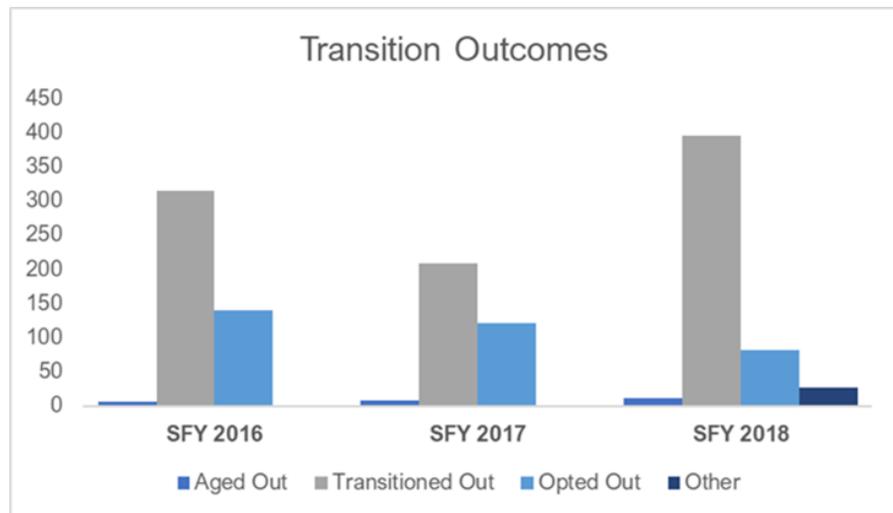


Figure 24. Transition outcomes

⁵⁷ U.S. DHHS OIG Report: Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication. OEI-07-15-00380. Sept. 2018.

⁵⁸ OCFS cannot confirm nor deny this number.

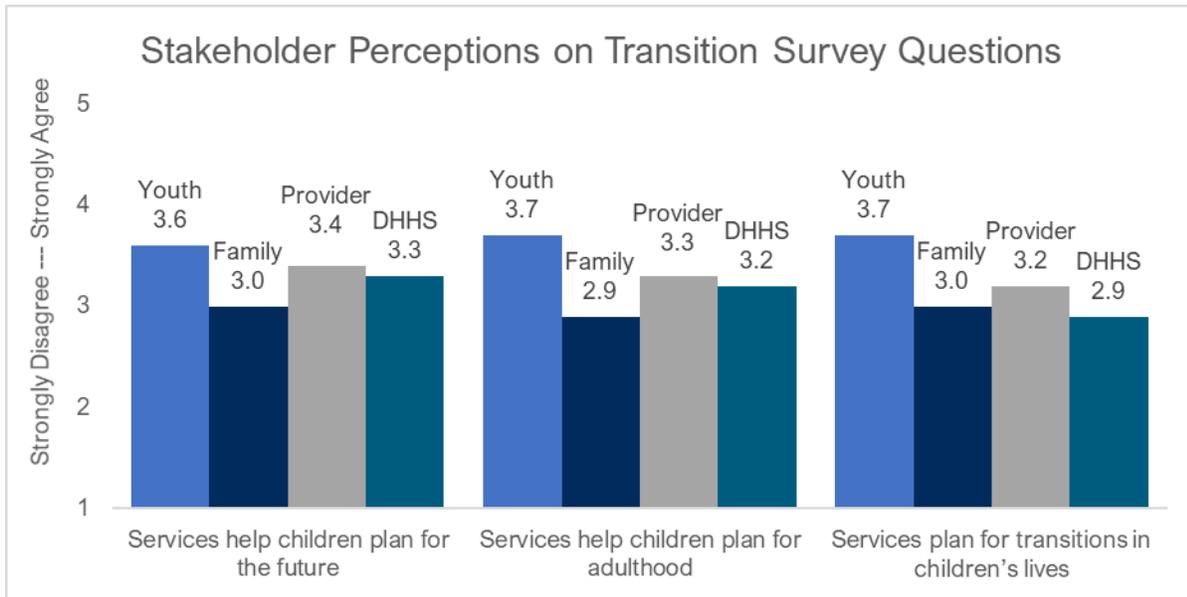


Figure 25. Stakeholder perceptions on transition survey questions

Transitional services between the child and adult system of care is lacking because providers are not required, incentivized, or measured on their performance in the delivery of transitional services. While some providers may see it as their responsibility to help ensure youth continue to receive support, others may be unaware of the adult services available, or may not have the staff capacity to do the extra legwork to coordinate a handoff. Families are often left on their own searching for answers on how to access services in the adult system of care. Funding for transitional living arrangements like group homes has been eliminated, leaving just homeless youth programs that are not appropriate and cannot accommodate all the youth who require support. Stakeholders expressed that youth who are aging out of residential services are particularly vulnerable to falling between the cracks because their residential providers are focused on treatment services rather than teaching life skills, their families are not willing to take them back in, and they are not ready to live independently. As one service provider described:

We need to deal with children who are 16 to 21 more effectively so as they move through the residential placements they aren't left with no good options once they reach age 18. Living on the street is not the best option for a child after successfully navigating the residential system.

As another stakeholder pointed out, youth with intellectual or developmental delays also require a more planful transition process based on their developmental age, rather than chronological age. While OCFS staff cannot manage the responsibility for individual case planning and transitional services for all youth across the system care with the existing resources available, they have developed a webpage specific to transition to adulthood which includes resources to support families, youth, and case managers.⁵⁹ The resources available include:

⁵⁹ DHHS OCFS Transition to Adulthood webpage: <https://www.maine.gov/dhhs/ocfs/cbhs/transition-adulthood.shtml>

-
- An intake and eligibility guide for adult development services (voluntary case management) for adults with I/DD or Autism (March 2018)
 - MaineCare Policy Summary of services available through the Office of Aging and Disability Services (May 2015)
 - An early notification form for youth transitioning to adulthood to notify OCFS of youth 16 years of age or older with I/DD who need assistance transitioning to adulthood (July 2018)
 - A 40-page *Guide to Transition Services in Maine* which focuses on services specific to youth who received special education services

While these resources may be helpful for families and youth with I/DD or Autism, they are of little value if the public and providers are unaware of them, and they may not be specifically tailored to the needs of youth with mental health or psychiatric needs. Transition from the child-serving system to adult services requires careful planning and support by both systems to ensure that youth maintain MaineCare eligibility and access appropriate and effective services.

V. RECOMMENDATIONS

Goals

In this section of the report we present 24 recommendations to address the findings detailed in the previous section of this report. The overall goal of these recommendations is to improve the children’s behavioral health system of care through services that are built upon the thirteen *System of Care Guiding Principles* discussed in Section II. In particular, these recommendations are intended to emphasize services that are the least restrictive, most effective, and safe; address issues as early as possible; and ultimately lower costs and reliance on intensive interventions in Maine.

Figure 26 below is a graphic to represent the “pillars,” or foundation, of a robust, high-quality service array for CBHS. We present these pillars as essential components of a system of care – if any pillar is weak or insufficient, the entire service array will be poorly supported. When the pillars are strong, the services provided will lead to positive outcomes for children and families. As we detail our recommendations we suggest that the reader consider how each recommendation can support one or more of these pillars to build a successful system of care.

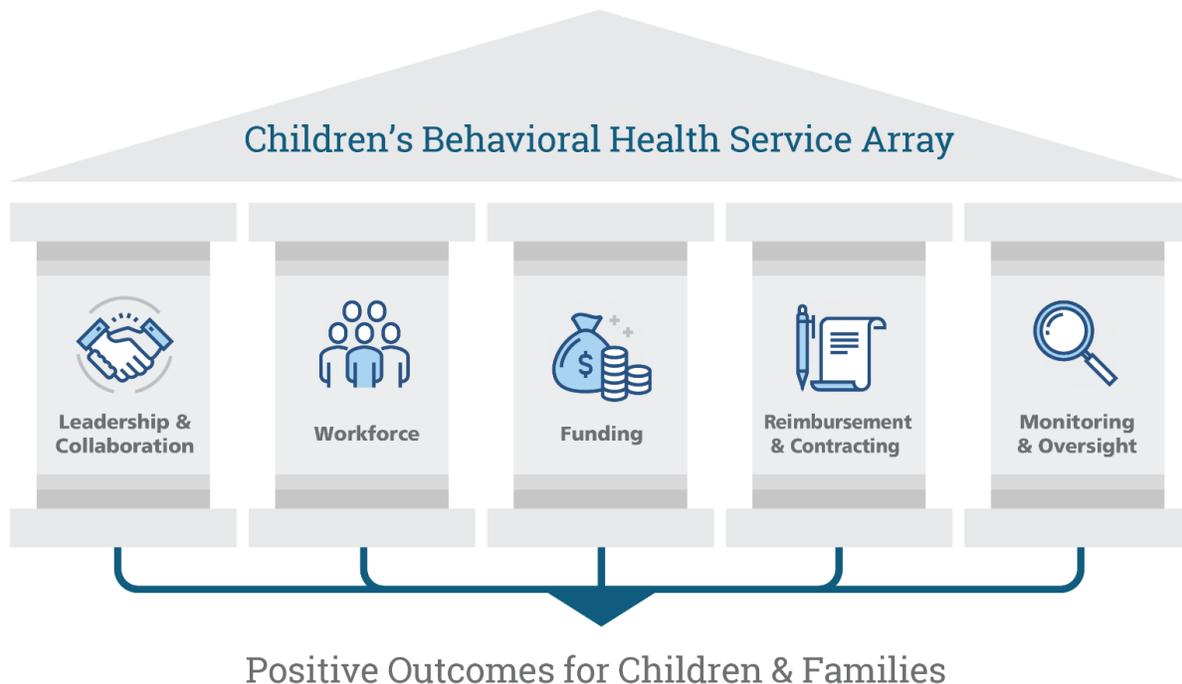


Figure 26. Pillars to support the system of care

Figure 27 details a proposed model for an effective, well-supported continuum of care for children’s behavioral health services in Maine. We have found that states with high-quality children’s behavioral health systems of care are able to support services along this continuum, including investments in early detection and early intervention, to decrease reliance on treatment services. When we presented this model during Town Hall Meetings we pointed to areas along this continuum where the findings described above indicate areas for improvement. Our recommendations are developed with an aim to support this full continuum of care in Maine.

Model Children’s Behavioral Health Services Continuum of Care

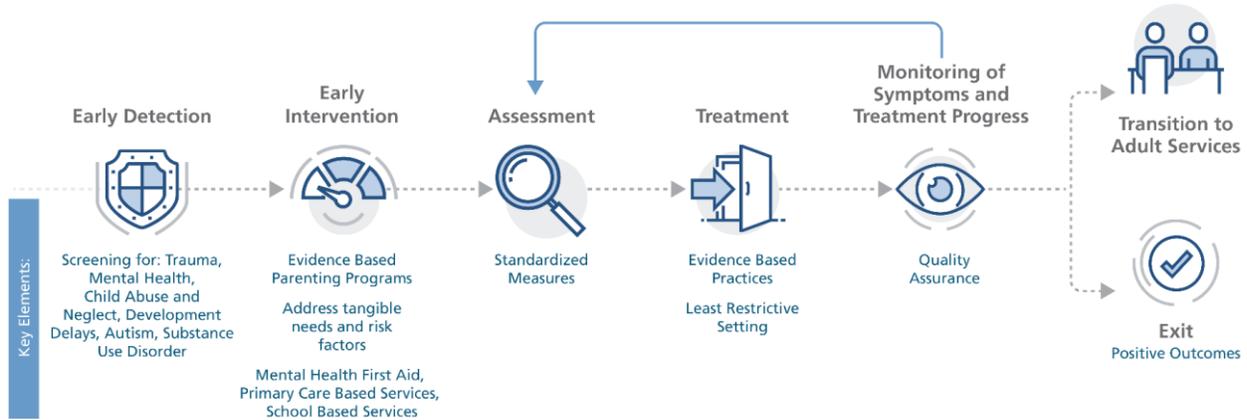


Figure 27. Model children’s behavioral health services continuum of care

The 24 recommendations detailed below are organized based on the group who would be primarily responsible for implementation (DHHS or the larger CBHS System of Care) and the estimated timeframe to implement the recommendations (short-term: under six months or long-term: over six months). Individually some of these recommendations are smaller “quick wins” for DHHS to implement, while others require collaboration among the system of care to be successfully implemented. Taken as a whole, these recommendations represent major system-wide changes to children’s behavioral health services.

1. Develop a strategic plan and vision for CBHS that engages all system of care stakeholders and builds off this CBHS assessment and recommendations.

Responsibility: DHHS
Timeframe: Short-Term

This assessment of children’s behavioral health services presents an opportunity for Maine and DHHS to develop a comprehensive strategic plan to address the findings presented and lay out a path forward to implement selected recommendations. A strategic plan is particularly beneficial at this time because OCFS and the CBHS team have undergone significant role and responsibility changes in recent years. A strategic plan and vision will provide OCFS with an opportunity to consider how CBHS functions as part of the larger organization and Department; the roles of its staff; and its relationship to families, providers, and other stakeholders.

A strategic planning process would allow DHHS and OCFS to:

1. Clearly define the purpose of CBHS within a much larger network of stakeholders to achieve the CBHS mission;
2. Establish realistic goals and objectives that are consistent with the CBHS mission and a clear, outcome-driven vision;
3. Create a defined timeframe within CBHS’s capacity for implementation of recommendations; and
4. Develop a sense of collective ownership of the work towards achieving the organization’s vision.

The implementation and ongoing monitoring of the recommendations that follow need to be established in the strategic plan to ensure success and sustainability. For example, if Maine were to invest in a specific set of evidence-based practices (EBPs), who will be responsible for the statewide training? Who will be responsible for monitoring fidelity? Do existing staff have the capacity to support these functions, or is there a need to expand the capacities of the Department? These conversations will be critical to development of a productive strategic plan.

While CBHS leadership has already begun conversations around the development of a strategic plan, OCFS should establish a committee to serve as the principals for the development of the strategic plan. These leaders should represent a healthy mix of those with the authority to make decisions, as well as those who are frequently immersed in the direct service components of the work (both at CBHS and provider agencies), advocates including Disability Rights Maine, and finally the children and families who are impacted by the CBHS system. This allows the process to capture a wide variety of perspectives on the strengths and challenges of CBHS at present and goals for the future.

The following key elements should be included when developing a strategic document:

Vision
What do leadership and other stakeholders want children's behavioral health services to look like, in concrete terms?
Mission
What is CBHS contributing to this vision? The mission and vision can be incorporated into one statement if that feels more appropriate once developed.
Objectives
What will CBHS do to move the Department closer to alignment with the previously agreed upon mission and vision? Specific objectives should be measurable, either qualitatively or quantitatively.
Strategies
Specific steps to address each objective, with details on the sequence of activities and the consideration to the various processes and stakeholders involved in achieving and measuring each objective.
Timeframe
Development of a roadmap for implementation of individual steps and activities within the plan, as well as a timeframe for the longevity of the entire plan.
Communication Plan
Identifying a process by which the strategic plan will be shared with stakeholders and how stakeholders will be engaged in implementation. This may include the development of a public website to share information about the process, the final plan, and eliciting feedback. For example, see Connecticut State Plan: https://www.plan4children.org/
Ongoing Fidelity
Details for how the plan will be monitored, discussed, and shared with new staff and how leadership will uphold objectives throughout the life of the full plan.

Strategic plans should be concrete, but they should also be flexible, as the goals of the administration and leadership are fluid based on the changing nature of government services.

2. Establish advisory committee(s) that leverages child-serving agencies and stakeholders to improve outcomes for children.

Responsibility: DHHS
Timeframe: Short-Term

As discussed in the findings, coordination and communication between system of care stakeholders including DHHS, providers, and other government agencies could be strengthened to improve outcomes for children. The development of state-level committees and meetings will provide consistent mechanisms to facilitate communication and will also allow for state agencies to be more thoughtful and coordinated in the way that children's services are administered and funded. DHHS should develop, or re-establish, one or more of the groups described below.

Children's Cabinet

A Children's Cabinet is a council of commissioner-level leadership across the agencies and departments that are responsible for serving children and their families including education, juvenile justice, public health, social services, and behavioral health. Children's Cabinets can effectively improve coordination and communication, allow opportunities to strategize regarding the use of resources and the alignment of priorities, and provide accountability across the system of care. A Children's Cabinet may be responsible for driving policy and practice that best supports the objectives and strategies outlined in specific agency strategic plans.

Similar to other types of committees, a Cabinet should be driven by a common purpose or goal. While the objective might be clear – how to best support children and families – the key area of focus for a Cabinet may be more specific (see examples from other states below). Leadership should be identified for key administrative functions (i.e. there should be a Chair who is responsible for leading meetings). Regular meetings should be scheduled and attended by members. A Children's Cabinet should develop a mission and vision for comprehensive children's services across the state, as well as identify any strategic objectives for Maine.

A Children's Cabinet is not new to Maine and is already established in state statute (Title 5, Part 22, Chapter 439).⁶⁰ In 1995, the sitting Governor established an executive Children's Cabinet that served as an avenue for coordination between DHHS, Department of Corrections, Department of Education, and other advisors as appointed by the Governor. While the Children's Cabinet did not have decision making power per se, their responsibility was to promote communication between child-serving agencies and coordinate resources. The Cabinet was cited as being responsible for over \$40 million dollars in coordinated revenue; they worked to maximize resource availability across all agencies, rather than operating in siloes, and focused on strategizing new sources of funding.⁶¹ The Cabinet was disbanded due to administrative and priority changes.

Other states have used Children's Cabinets to focus on specific priorities and have empowered them to drive policy, control funding, and direct services. For example, New Mexico has focused on economic development, using the premise that better economically supported parents will be better equipped to raise

⁶⁰ Title 5, Part 22, Chapter 439: Children's Cabinet. Retrieved from <http://legislature.maine.gov/statutes/5/title5sec19131.html>

⁶¹ Maine Governor's Children's Cabinet Brochure. Retrieved from http://forumfyi.org/files/Maine_Brochure_READ_0.pdf.

self-sufficient children.⁶² In Louisiana, the Children's Cabinet oversees the "Children's Budget", which is a funding source used to implement initiatives that support children's services in the state.⁶³ The Cabinet can make recommendations for line items that should be included and works together to prioritize those recommendations, driving funding priorities and innovative solutions each fiscal year. A Children's Cabinet can also be responsible for the development of more localized committees as needed. For example, in West Virginia the Children's Cabinet has developed localized committees that perform needs assessments for communities struggling with access to services and can prioritize solutions presented by these communities to best serve those that are the most underserved.⁶⁴ In Virginia the Children's Cabinet has a full-time Executive Director, meets monthly, and has been responsible for increasing access to prevention services, improving health, nutrition, early childhood programs and other supports.⁶⁵

Children's Mental Health Oversight Committee

Maine state law establishes the Children's Mental Health Oversight Committee (Title 34-B, Chapter 15, Section 004),⁶⁶ however the Committee has not convened in recent years. Per state statute, the committee is comprised of legislators, Commissioners, families, providers, and advocates. The members outlined in statute must present a combination of experience and background, including clinical insight, education, cultural affairs, and criminal justice. The Oversight Committee is designed to serve as a platform to discuss possible rule changes, review data and monitor outcomes and service quality (e.g. tracking transition supports for youth moving from the children's system to adult services), and review challenges and recommendations for improvement to the Legislature.

The Children's Mental Health Oversight Committee, unlike a Children's Cabinet, includes the perspective of stakeholders who are entrenched in the frontline of services, from providers to family members themselves. This provides an opportunity to identify and address the most compelling challenges within the system of care and to leverage different agencies to identify collaborative solutions. The Children's Mental Health Oversight Committee could provide DHHS a forum to discuss the systemic challenges that have resulted in the findings described in this report and work collaboratively with other state agencies and communities to prioritize improvements. The statute also establishes a "clinical best practices advisory group" comprised of mental health professionals who advise the Committee on best practices and could provide expertise on other recommendations.

While the Children's Mental Health Oversight Committee focuses on ongoing systemic challenges, they may not focus on the specific details around the day-to-day operations of the CBHS system of care the way that specific meetings discussed below might.

OCFS-Stakeholder Group(s)

Establishing groups to convene OCFS and community stakeholders provides an opportunity for DHHS to demonstrate transparency, engage stakeholders in problem-solving, and communicate the Department's plans to others. While less formal than committees or cabinets, these groups provide an opportunity for DHHS and stakeholders to prioritize communication and collaboration. An endorsement of these meetings

⁶² New Mexico Children's Cabinet. <http://childrenscabinetnm.org/>

⁶³ Louisiana Children's Cabinet. <http://gov.louisiana.gov/page/childrens-cabinet>

⁶⁴ A Governor's Guide to Children's Cabinets. Retrieved from <http://forumfyi.org/files/GOVGUIDECHILD.pdf>.

⁶⁵ Gaines, E., Allen, O., Patel, N., Logan, N. (2017, December). 2017 State Policy Survey: Child and Youth Policy Coordinating Bodies in the U.S. Washington, D.C.: The Forum for Youth Investment. Retrieved from http://forumfyi.org/files/ccn_survey_report_2017.pdf

⁶⁶ Title 34-B, Chapter 15, Section 004: Children's Mental Health Oversight Committee. Retrieved from <http://legislature.maine.gov/statutes/34-B/title34-Bsec15004.html>

by the state, and encouraging CBHS to take the lead in establishing the framework for these meetings, will ensure that meetings happen and are productive. While face-to-face meetings are preferential, OCFS could also leverage technology, such as video conferencing or even phone conferencing, to facilitate participation.

OCFS may wish to establish specific groups for different service types, allowing for focus on more specific areas of concern. These groups should leverage existing meetings by formalizing the process as described below. These groups are not intended to address specific cases or replace the Child and Family Treatment Team (CFTT), but rather focus on systemic issues and matters of policy or practice. For example, four groups that may be beneficial could focus on:

- Residential services
- Crisis and psychiatric hospital services
- Transition services
- Data and evidence-based practices

A common concern about these types of groups is that meetings can quickly become unproductive and bureaucratic, taking members away from their responsibilities without any benefit. For these meetings to be successful, it is important to have buy-in from participants and a clear purpose.

The following steps are recommended to establish and formalize sustainable groups:

1. Identify Members	Group leaders are responsible for establishing who should develop the charter.
	Members should include a mix of representatives to ensure that there is collaboration in the development of the meeting structure.
2. Develop Group Charter	The charter should be a formal document that details the purpose of the group, the anticipated schedule, the length of members terms, and the processes needed for the group to have specific tasks approved.
	For more informal standing meetings, the charter may simply be an identification of who needs to be involved, who is responsible for leading, goals of the meeting, and schedule.
3. Establish Group & Schedule Meetings	A methodology for recruitment of full membership should be established in the charter.
	Hold the first meeting and ensure that all members agree to the commitment associated with being involved with the group.
	Establish initial priorities of focus and goals. If necessary, adapt on an ongoing basis as is indicated by the Charter.

3. Hire a full-time on-site OCFS Medical Director.

Responsibility: DHHS
Timeframe: Short-Term

Prior to 2015 OCFS had a full-time, on-site Medical Director that supported programs across the agency, including CBHS. More recently OCFS was unable to identify a psychiatrist to fulfill this role and instead hired a part-time contractor based in Massachusetts. OCFS staff and stakeholders report that this has impacted the Medical Director's ability to engage with staff and providers, oversee and monitor services, develop relationships with providers, and provide consultation on specific cases.

"A Medical Director is foundational to assuring quality care, managing risk and providing clinical credibility to SMHA's (state mental health agencies). – The National Association of State Mental Health Program Directors, Medical Director Council"

As of 2009, 39 states employed full-time Medical Directors for mental health services.⁶⁷ In a survey distributed to state agency medical directors through the National Association of State Mental Health Program Directors (SMHPD), they reported the following responsibilities as Medical Director.

- Provide expertise to stakeholders at all levels of the Department about clinical program and policy related issues.
- Provide oversight to any clinical function the Department may serve directly or any quality assurance efforts that are led by the Department, specifically around clinical functions such as diagnosis, level of care, or medication management.
- Play a role in the identification and implementation of evidence-based practices that best serve the Department's goals.
- Consult on especially challenging cases on a regular basis.
- Oversee the clinical workforce, including recruitment and retention of clinical staff employed by the Department, and support contractors in strategies for addressing their behavioral health workforce challenges.
- Serve as a "link" for the Department into other networks of medically-trained behavioral health staff (networks and associations of specialized psychiatrists).

Given the national shortages of child and adolescent psychiatrists, and the severe shortage in Maine in particular, finding a full-time in-state Medical Director in Maine is a challenge. DHHS must have adequate support for this position to attract and retain a qualified medical professional who can fulfill the responsibilities detailed above.

⁶⁷ The Role of the Medical Director in a State Mental Health Authority: A Guide for Policy Makers. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.215.6588&rep=rep1&type=pdf>

4. Amend current service definition for Section 28 (Rehabilitative and Community Services) to focus on effective, targeted interventions for I/DD and Autism.

Responsibility: DHHS
Timeframe: Short-Term

While access to Section 28 services has been increasingly restricted due to provider capacity and community demand, we were unable to determine how much of this shortage and the resulting waitlists for Section 28 are the result of inefficient interventions versus the result of children not being matched with clinically appropriate services. The use of Section 28 and its efficacy will be impacted by other recommendations in this report, including the use of data to “hot spot” trends in services (Recommendation 11), investments in evidence-based practices (Recommendation 11), expanded capacity for respite services (Recommendation 6), independent clinical assessments (Recommendation 8) and the development of performance-based contracting (Recommendation 17).

DHHS should amend the current service definition for Section 28 services to focus exclusively on children with I/DD and/or Autism, where skill-building interventions and Applied Behavioral Analysis (ABA) can be most beneficial. The service definition should also explicitly require service providers to utilize evidence-based practices with demonstrated success for the targeted individualized needs of the child whenever possible.⁶⁸ The family is an integral part of the child’s success in treatment and should be required to participate in parenting-skills and skill-development sessions with the service provider. While this is currently the policy, in practice we heard that many providers work with the child alone, allowing the parent some “respite”. While there may always be clinical exceptions where these requirements are not appropriate, these expectations should be laid out in both the service definition and contracts (particularly performance-based contracts) with a pathway for exceptions to be documented on the child’s individual treatment plan when submitted for authorization. Furthermore, DHHS should examine whether the professionals and educational requirements for BHPs delivering Section 28 services should be more aligned with the requirements for other BHPs (such as HCT and Day Treatment) to increase the available workforce. Additionally, there may be policy recommendations or administrative changes that can support more job-sharing among other para-professionals, including EdTechs and adult behavioral health or physical health providers. Changes in professional qualifications should be done in conjunction with the larger strategic plan for the behavioral health workforce (Recommendation 16).

These recommendations may result in fewer children being determined eligible for Section 28 services, but those cases should be more appropriately referred to other interventions such as HCT, outpatient therapy, or other evidence-based practices. Families may also feel that they are losing some support if services are limited and focused more on rigorous clinical interventions that require their participation. However, a more appropriate avenue for this type of support is respite, not treatment services. In order for these recommended changes to Section 28 to be successful, providers who deliver Section 28 services, particularly BCBA’s, need to be reimbursed adequately for their expertise. Furthermore, the current waitlist for Section 28 services would need to be carefully re-evaluated for clinical fit as the focus and eligibility of these services changes.

⁶⁸ Glassheim, B. (2009). A Guide to Evidence-Based Practices for Individuals with Developmental Disabilities. Saginaw County Community Mental Health Authority. Retrieved from <https://www.sccmha.org/userfiles/filemanager/292/>

An additional strategy to expand access for Section 28 is to develop a MaineCare service that supports group-based interventions for children with common behavioral health issues, for example, Autism. With national shortages of BCBA's – many states are using group models to provide interventions and expand capacity through skill development with families and non-licensed behavioral health staff. In many other states, families of children with Autism can attend center-based programs that provide group skill development provided by a BCBA. The family attends and learns the same skills that can be applied at home while the para-professional working with the family in-home may also receive training. These services may be provided in addition to other in-home services, in lieu of them if families are waiting for other services that are unavailable, or simply if families prefer a group-based intervention. One parent we interviewed for this assessment described that she attended a program in Florida and found this intervention helpful at reducing her own feelings of isolation while also increasing parent accountability and engagement in treatment and consistency in services between parent and provider. While families will still travel to center-based programs, it does provide a more cost-effective intervention for programs utilizing high-demand services of BCBA's. Research has also shown that center-based ABA may actually be more effective than home-based interventions.⁶⁹ This type of service could be supported through a MaineCare service for center-based group treatment.

Across the country, most states provide or ensure that services to children with I/DD, Autism, and mental health conditions are integrated and that providers can demonstrate competencies in working with children with a variety of presenting issues. The National Federation of Families for Children's Mental Health under SAMHSA suggests a number of best practices for individuals with co-occurring disorders, which are fairly common – studies have found between 39 to 50 percent of people with I/DD also have mental illness.⁷⁰ The National Technical Assistance Center for Children's Mental Health also provides a useful guide, *Effective Strategies Checklist for Children and Youth with Developmental Disorders and Challenging Behavior*, that emphasizes an integrated approach to I/DD and mental health.⁷¹

Other child-serving systems of care, for example New Jersey, have moved to serve all children through "one door" regardless of diagnosis or presenting issues to reduce duplication and increase care coordination. The CMO (Recommendation 8) should be at the helm of the cross-agency collaboration, particularly with DOE and OADS as these children approach adulthood, to coordinate services. An additional national best practice that may be of interest in Maine is START (Systemic, Therapeutic Assessment, Resources and Treatment).⁷² This model, developed at the University of New Hampshire, has been implemented across the country and specifically with child populations in North Carolina⁷³ and New York.⁷⁴ This evidence-informed approach serves children over 6 years of age and adults with intellectual and developmental disabilities who present with a behavioral or mental health concern and is similar to High-Fidelity Wraparound, but for co-occurring I/DD and mental health specifically. The program uses a person-centered approach to provide training, consultation, and technical assistance on the use of positive

⁶⁹ Dixon, D. R., Burns, C. O., Granpeesheh, D., Amarasinghe, R., Powell, A., & Linstead, E. (2017). A program evaluation of home and center-based treatment for autism spectrum disorder. *Behavior analysis in practice*, 10(3), 307-312.

⁷⁰ Fletcher, R. (ND). Emerging best practices for people with an intellectual/developmental disability co-occurring with serious mental illness. SAMHSA. Retrieved from: <https://www.nasmhpd.org/sites/default/files/TAC-Emerging%20Best%20Practices%20for%20People%20with%20an%20Intellectual%20or%20Developmental%20Disability%20Co-Occurring%20with%20Mental%20Illness.pdf>

⁷¹ <https://guchdtcenter.georgetown.edu/publications/Effective%20Strategies%20Checklist%20FINAL.pdf>

⁷² <https://www.centerforstartservices.org/>

⁷³ <https://www.ncdhhs.gov/assistance/nc-start>

⁷⁴ <https://opwdd.ny.gov/ny-start/home>

behavioral supports and other interventions and tools. The program may include crisis services, therapeutic coaching in home, respite, and other supports.

5. Revise the waitlist procedure for home- and community-based services to ensure optimal client/provider assignment.

Responsibility: DHHS
Timeframe: Short-Term

While the waitlist for home- and community-based services (Section 28 and HCT, in particular) is unavoidable given that the demand for these services exceed provider capacity, the waitlist could be more optimally managed. Currently, when a provider has an opening to accept a new case off the waitlist they contact the MaineCare Administrative Services Organization (ASO) and are given the next available child waiting in their service area. This ensures that referral decisions are not made solely by the service provider, but it may not account for the provider's specific availability (daytime, evenings, weekends), specialized skills or models for certain diagnoses, or provider characteristics (age, experience, gender). This sometimes leads to a poor clinical match – for example, if a 20-year-old female staff member who is available mornings and specializes in working with young children is assigned an aggressive adolescent male who needs after school services and a male staff member. This leads to frustration for the family who believes they will get services but now must wait longer at the assigned agency until an appropriate staffing match can be made. Meanwhile, the provider has an employee that is underutilized and could be working with other children on the waitlist.

Develop a working group with the ASO, representative providers, and DRM to develop a process for providers to systematically communicate with the ASO what their availability is when accepting new children off the waitlist. This will allow the ASO to review the waitlist and make more appropriate assignments, resulting in better clinical matches and hopefully an expedited process. DHHS should maintain, or require the ASO to maintain, records of the provider requests and assignments so that this data can be analyzed to understand true capacity and also identify if there are specific children or characteristics of children on the waitlist who are not getting timely assignment to a provider. DHHS should require providers to document when they take a child off the waitlist but cannot immediately serve the child, either because the child's needs do not match the available staff or staff do not have the hours available to meet the child's needs (for example, the child is authorized for 15 hours per week but assigned staff can only work eight). In special circumstances, KEPRO could authorize more than one provider to serve a child based on the appropriate level of need, however the providers will need to be required to meet regularly in the Child and Family Treatment Team and communicate frequently on the child's needs and services. DHHS should also consult with SAMHS and OADS about how they have managed their waitlists and provider-client assignment to maximize the clinical match and chances for a positive outcome.

Require providers requesting cases off the waitlist to include all available areas where staff can serve a child – not limited to zip code. When providers request a case from the waitlist, the ASO should closely examine whether an assignment can be made based on proximity for the provider, even if that crosses the provider's assigned zip codes or county lines.

Conduct further analysis of the current waitlist for home- and community-based services. While the waitlist for Section 28 and HCT in Maine may be populated with children who are in dire need of services, there may also be some inaccuracies due to children receiving other services, moving to a different area, or no longer needing or desiring services. When Ohio was facing similar issues with their waitlist for waiver

services, the state conducted a study to better understand the nature of the waitlist, including the demographics of those waiting and the specific needs of individuals.⁷⁵ The study involved analyzing waitlist data and surveying individuals or caregivers on the waitlist about their need. The study revealed that many individuals waiting did not have unmet needs or could be served through other services outside of the waiver.

Additional strategies may help Maine have a more accurate waitlist for home- and community-based services. For example, in Ohio families on the waitlist were contacted by mail asked to “opt in” to remain on the list, ensuring it is as accurate as possible. DHHS could also develop a more rigorous prioritization assessment that considers and weighs various factors including risk, diagnosis, comorbidity, duration of condition, past services, developmental stage, impact on daily functioning, other agency involvement, time spent waiting, natural supports, and/or child or family motivation.⁷⁶ The recommendation to have an independent, comprehensive assessment of child’s needs (see Recommendation 8) will also support more appropriate identification of services for individualized children’s needs and may result in changes to the waitlists for services.

6. Expand access to respite care services for families.

Responsibility: DHHS
Timeframe: Short-Term

Respite care is a valuable service for families who need a planned, intentional break from their child with behavioral health issues. While respite care is currently available in Maine and funded through the state general funds, it is underutilized because there are more families approved for use than there are approved and available providers. DHHS could leverage several strategies to expand access to respite care services and increase the pool of available providers. Below we outline several strategies.

Develop a MaineCare service definition for respite care services. Other states have developed Medicaid funded respite care services through State Plan Amendments or included them in their Medicaid waivers. Some states that have managed care Medicaid systems, like Ohio, offer a respite care benefit to its members through their health plan.⁷⁷ While a waiver would allow Maine to serve children up to 300 percent Federal Poverty Level, DHHS should not apply for a waiver just to expand capacity for one specific service, like respite, because it can also result in a lower federal match and an increased administrative burden. Rather, a 1915(i) Mental Health State Plan Amendment (SPA) for Home and Community Based Services can be developed to provide respite care to children with behavioral health conditions. A SPA has less administrative burden than a waiver and provides an opportunity for federal reimbursement. The drawbacks are that children must be MaineCare eligible and undergo an eligibility determination for the service, and providers must be enrolled with MaineCare. Simply adding a MaineCare funded respite care service won’t improve access of services, but does provide another pathway for federal reimbursement,

⁷⁵ Jamieson, B., Sahr, T., and Wilks, C. (2014). What are we waiting for? Waiver supported services needed by individuals and their caregivers. Retrieved from <https://ddc.ohio.gov/Portals/0/waiting-list-study-2-21-14.pdf>

⁷⁶ For an example of this prioritization strategy see: Hughes, A., Carrick, H., & Byrne, M. (2013). Using waitlist prioritisation criteria in a child and family psychology service: A case example. *The Irish Psychologist*, 39(7), 184-190. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1003.7451&rep=rep1&type=pdf>

⁷⁷ <https://www.paramounthealthcare.com/respite-care-807>

which could impact the rate that providers receive. Examples of states that have utilized a SPA for respite care include Indiana,⁷⁸ Maryland,⁷⁹ and Montana.⁸⁰

Explore the use of participant-directed respite care services. In the current system, families who want to access respite care in Maine may identify a family member, friend, or other support to provide respite for their child. The provider then goes through an application and training process and becomes an employee of NAMI, who contracts with DHHS. An alternative model is participant-directed respite care, where families are provided a voucher to hire family or friends and typically assume the responsibility to select, hire, train, and establish the rate paid to the provider. Multiple states use participant-directed care through their state general funds or Medicaid funded respite care services.⁸¹ Among the benefits cited, participant-directed respite care can increase access to potential providers, lead to cost-savings, and increase family control and satisfaction with services.

Amend definition of respite to allow for more flexibility with state general funds and contracts. Given the current shortage of family-based respite care providers, DHHS could expand “respite” to include other pro-social activities and planned intentional breaks, as other states have done. Some of these modifications may be reimbursable under a new MaineCare respite service depending on CMS approval. For example, respite could include:

- Camps, sports, clubs, and activities (and support to purchase equipment, pay fees, transportation, etc.)
- Center-based group respite provided by trained staff (like BHPs) at a provider office, child care center, school, or community center
- Supported employment or internships for older teens
- Funding therapeutic foster care or residential settings for brief overnight respite

7. Improve coordination for youth transitioning from child to adult behavioral health services.

Responsibility: DHHS
Timeframe: Short-Term

During our assessment families and other stakeholders noted that the transition between children's behavioral health services and the adult system could be strengthened. Families described that when their child was approaching adulthood they didn't know where to turn for information on preparing for transition or how to navigate services in a new delivery system. This sometimes results in young adults “falling through the cracks” because their MaineCare eligibility lapses or they don't know where to turn to for help. While OCFS has developed a website for transition services, it is primarily focused on the needs of young people with I/DD rather than mental health issues and through a framework of the services provided in the school system.

⁷⁸ <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-12-013-Att.pdf>

⁷⁹ <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-14-05.pdf>

⁸⁰ <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-13-036-Att.pdf>

⁸¹ Crisp, S., Maguire, E., Selkow, I., and Singer, E. (2011). Participant-directed respite guidebook. Developed by the National Resource Center for Participant-Directed Services for the ARCH National Respite Network and Resource Center. Retrieved from <http://www.appliedselfdirection.com/sites/default/files/Participant-Directed%20Respite%20Guidebook.pdf>

Strengthen existing resources for transition services by developing a role at OCFS that is primarily responsible for transition services. This role should establish strong relationships with SAMHS, OADS, DOE, and MaineCare as well as the providers serving the adult population across the full service array and system of care. While one single person at OCFS cannot (and should not) be responsible for case managing all young people transitioning to the adult system, this staff member should be responsible for educating other CBHS team members on the resources available as well as working closely with case managers, whether through the Care Management Organization (CMO) (see Recommendation 8) or other services. CMOs and case managers should also be responsible for understanding the nuances of the adult behavioral health system, including service eligibility and referral processes to ensure a “warm handoff” to the next case manager. Successful transition services can also be included as part of the outcome measures in performance-based contracting (see Recommendation 17). Additionally, the staff at SAMHS, OADS, and DOE have a responsibility to work with OCFS to facilitate transition from their end of services.

The OCFS webpage for transition services should be updated and regularly maintained with information for families and youth about the transition across the system of care, including services for youth with mental health conditions and I/DD or Autism. The webpage should be user-friendly and attractive to a young audience to encourage use, and it should be widely publicized with a simple web address and branding and link to social media platforms that youth are likely to use (Facebook, Twitter, Instagram, etc.) **OCFS may also want to develop a specific working group (see Recommendation 2) around transition services which includes youth or young adults and that engages providers across both systems of care to identify policy changes, programs, and other opportunities that can facilitate successful transition for young people.** Additional areas for this workgroup to explore include: allowing youth to access both child and adult services between 18-21, coordination between behavioral health and educational transition services under the youth's Individualized Education Plan (IEP), supporting families to understand all of their options for guardianship and Supported Decision Making, and empowering youth to be as self-sufficient and self-directed as possible in their own services.

Many states have developed robust transition programs for the needs of youth aging out of foster care, which can provide a useful framework for youth with behavioral health needs. For example, West Virginia has published a webpage called *It's My Move* that helps youth transitioning from residential programs to independent living.⁸² Transitional resources to support youth with special health care needs can also be integrated into a larger transition website or resource since physical and behavioral health are best addressed in an integrated approach; for example, see Wisconsin's website *Health Transition Wisconsin*.⁸³ An overarching framework that supports youth and families through the transition may be helpful to ensure that the process is self-directed and wholistic. For an example of a framework developed initially for individuals with disabilities, but can be used with all youth, see *Charting the LifeCourse* from the University of Missouri-Kansas City.⁸⁴ Other states have established annual conferences on transition services for youth or organizations specifically tasked with supporting transition for youth with mental health issues. At the annual *Children's Mental Health Symposium* in Virginia, participants learn about how to support transition in all aspects of a young person's life, including managing crises, education, employment, and treatment service.⁸⁵ In California, the state has funded the *No Stigma No Barriers Mental Health Project* to

⁸² <http://itsmymove.org/>

⁸³ <https://healthtransitionwi.org/>

⁸⁴ <https://www.lifecoursetools.com/>

⁸⁵ <https://www.regonline.com/builder/site/default.aspx?EventID=1951293>

increase youth engagement, reduce barriers, and increase access to mental health care for youth 16 to 28 through training, outreach, and advocacy.⁸⁶

8. Develop regional Care Management Organizations (CMOs) to provide intensive care coordination for children with moderate to high behavioral health needs.

Responsibility: DHHS
Timeframe: Long-Term

While there are currently Targeted Case Management (TCM) services provided to children with moderate to high behavioral health needs in Maine, more robust care coordination is needed to better match children and families to appropriate services, monitor their symptoms and treatment progress, and oversee the quality and effectiveness of services. A separate independent case management entity can provide focused attention on development of individualized treatment plans and consistent treatment plan monitoring through the Child and Family Treatment Team.

DHHS should develop regional Care Management Organizations that are competitively procured, available statewide, and cover regions to maximize efficiency and service coordination. These may also be implemented in a pilot program, potentially beginning with Accountable Communities.

CMOs should be designed to serve the following functions (additional functions may be added):

CMO Function	Description
Assessments	<i>Provide comprehensive assessments for children at intake and at periodic intervals to monitor progress and ongoing need for services, preferably with a tool that could be implemented system-wide, such as the Child and Adolescent Needs Survey (CANS) and other empirically validated assessment tools (see Appendix C).</i>
Treatment Plans	<i>Develop individualized treatment plans in collaboration with the CFTT and review plans periodically, including at regularly scheduled CFTT meetings.</i> <i>Treatment plans should:</i> <ul style="list-style-type: none"> • <i>Drive services and supports;</i> • <i>Document progress toward goals as well as any identified barriers;</i> • <i>Reflect the child’s plan for discharge or transition; and</i> • <i>Be monitored consistently for quality and progress.</i>

⁸⁶ <https://www.nostigmanobarriers.org>

CMO Function	Description
Child and Family Treatment Team	<p><i>Convene and facilitate the CFTT and address any barriers to participation in meetings. Consistent with best practices, the CFTT should:</i></p> <ul style="list-style-type: none"> • <i>Be family-centered and include natural supports as well as all professionals engaged with child;</i> • <i>Meet regularly in-person in the most family-centered location possible (school, home, etc.) and use technology or telephone to check in as a group at least monthly if in-person meetings can’t occur that frequently; and</i> • <i>Establish case management protocols and roles when there are multiple professionals and/or organizations involved with a family.</i>
Referrals	<p><i>Provide referrals to both MaineCare and non-MaineCare services, and:</i></p> <ul style="list-style-type: none"> • <i>Build and develop relationships with schools and other community-based organizations so that children and families can be referred to a range of services and supports that meet their needs in various settings;</i> • <i>Monitor services for effectiveness and ongoing appropriateness; and</i> • <i>Refer for additional or updated assessments as needed.</i>
Coordination	<ul style="list-style-type: none"> • <i>Maintain records of the child’s treatment and services.</i> • <i>Serve as the primary point of contact for the family, available 24/7.</i>

While the Care Management Organization is responsible for both case coordination and the independent assessment of the child’s needs, these functions do not have to be explicitly provided by different staff at the CMO. DHHS should consider developing staffing requirements that ensure that qualified individuals perform each of the CMO required functions – whether that is one person per child or multiple staff working collaboratively. Minimum education and training requirements should be established for each CMO function, and the service provider will need to be required to meet those when they assign cases. For example, Massachusetts allows for some flexibility for their care coordinators, who in addition to being CANS certified, must hold a: *Master’s degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.); or bachelor’s degree in a human services field and one year of relevant experience working with families or youth. If the bachelor’s degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Individuals with an associate’s degree or high school diploma must have a minimum of five years of experience working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems.*⁸⁷ Depending on the nature of and tools required in the clinical assessment, DHHS may require CMOs to have a more qualified staff person complete the assessment (for example, a licensed social worker) or require

⁸⁷ Simons, D., Pires, A.A., Hendricks, T., and Lipper, J. (2014). Intensive care coordination using high-quality wraparound for children with serious behavioral health needs: State and community profiles. Retrieved from <https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf>

that a licensed clinician supervises the assessment. DHHS must also ensure that these assessments are comprehensive in nature and not just procedural. Establishing standards in policy and additional quality assurance activities (see Recommendation 17) can help ensure the assessments are accurate and meaningful.

Additional recommendations include:

- CMOs should provide case management services, but not treatment services for the same clients, similar to the conflict-free case management model operated by Maine's OADS.
- DHHS should consider value-based financing options such as case rates or capitated per member/per month payments to the CMOs, to financially incentivize better outcomes (see Recommendation 17).
- DHHS investments and technical assistance to expand the adoption of electronic health records will support improved coordination between the CMO and other providers and may also be required to successfully implement performance-based contracting or improved quality metrics (see Recommendation 17).⁸⁸

Numerous jurisdictions have implemented care management models to provide intensive care coordination in their systems of care for children with moderate to complex needs. The underlying goals of these types of entities are to improve outcomes while serving children in the least restrictive setting and maintain cost effectiveness.

Activities and functions that are typically included in care management, similar to the CMO proposed for Maine, include:⁸⁹

- Wraparound implementation
- Development and management of regional networks of community based providers available to provide services to children and families
- Screening, assessment, and clinical oversight
- Utilization management and quality improvement
- Intensive care coordination
- Outcomes management
- Information management, including real-time data
- Training for staff, providers, families, and referring entities
- Access to family and youth supports and advocacy
- Care monitoring and review
- Access to crisis supports

Below are three states that have successfully implemented care management strategies for children's behavioral health services:

New Jersey.⁹⁰ New Jersey implemented regional CMOs as part of their children's behavioral health system of care transformation. Their children's behavioral health system is accessed through a single statewide

⁸⁸ For additional information of Federal opportunities to fund health information technology efforts see: CMS SMDL #18-006 "Leveraging Medicaid Technology to Address the Opioid Crisis" June 11, 2018. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>

⁸⁹ Center for Health Care Strategies (2011). Care Management Entities: A Primer. Retrieved from <https://www.chcs.org/media/CHIPRACMEPrimer.pdf>

⁹⁰ PCG can provide a presentation from New Jersey on their system of care upon request.

Contracted System Administrator (CSA), which performs the initial assessment, triage, and referral to services, including referrals to care management organizations for children with moderate to complex needs. The CMOs provide care coordination and wraparound care planning for children and their families and are responsible for facilitating access to a full range of treatment and support services. They facilitate and work within Child and Family Teams to develop individualized plans of care based on assessment. Through this model New Jersey has significantly reduced the number of children in behavioral health out of home placements and children placed out-of-state (from more than 300 to less than 5), although it is important to note that the CMOs are only one aspect of the system of care enhancements leading to improved outcomes.

Milwaukee County, Wisconsin.⁹¹ Wraparound Milwaukee (WM) provides a system of care for children with behavioral health needs. As part of the system of care, WM contracts with six community agencies for over 100 care coordinators who meet the child and family; conduct a strengths-based inventory; convene the Child and Family Team; and develop the treatment plan based on child/family needs, goals, and formal and informal support. They also help the family identify and obtain formal services through the provider network to meet mental health, social, and other support needs. Care Plans are reviewed and revised every 90 days. WM has been a highly successful model, with significant reductions in residential treatment and corrections. Similar to New Jersey, WM implemented additional system reforms in conjunction with the implementation of care coordinators.

Massachusetts.⁹² Under the MassHealth Children's Behavioral Health Initiative (CBHI) the Massachusetts Medicaid program provides intensive care coordination (ICC) services for children involved with multiple service systems, or for children with complex needs. The care coordinator facilitates the development of a care planning team, which utilizes assessments and other clinical information to guide the development of an individual care plan. The care planning team can include both formal supports, such as the care coordinator, providers, case managers from child-serving state agencies, and natural supports, such as family members, neighbors, friends, and clergy. Care coordinators work directly with the youth and family to implement elements of the plan, identify and assist the youth and family to obtain and monitor the delivery of available services, develop a transition plan when the youth has achieved goals of the plan, and collaborate with the other service providers and state agencies (if involved) on the behalf of the youth and family. The care coordinator also reviews whether services are being provided in accordance with the care plan, whether services in the plan are adequate, and whether there are changes in the needs or status of the youth and if so, adjusts the plan of care as necessary.

This recommendation elicited mixed responses from stakeholders during the Town Hall Meetings. Some stakeholders, providers in particular, were concerned that independent CMOs who do not provide other treatment services would reduce efficiency and inhibit coordination and access. Some families expressed that having a "one stop shop" was beneficial, particularly in rural areas of the state – whereas others described they liked an independent case manager. If the conflict-free provision proposed is ultimately adopted, it would be expected that CMO staff would overcome these concerns by developing strong working relationships with service providers and by being readily accessible to families as needed. The intent of the recommendation is to make the referral and treatment plan monitoring activities independent from the treatment to encourage objectivity. When OADS first proposed conflict-free case management for their services there were similar concerns, but through stakeholder engagement, the model was

⁹¹ <http://wraparoundmke.com/care-coordination/>

⁹² <https://www.mass.gov/files/documents/2016/07/nh/ps-tcm-icc-ps.pdf>

successfully implemented. DHHS should work with OADS to understand their lessons learned so the model can be developed and implemented successfully.

DHHS will need to develop clear roles, responsibilities, and service descriptions for CMOs, as well as definitions for how the CMO will intersect with the role of the Administrative Services Organization. As CMOs assume heightened responsibility for assessments and the CFTT, DHHS may need to amend MaineCare service definitions to include these requirements throughout other home- and community-based services. In order for CMOs to be successful and achieve positive outcomes, particularly if these are tied to reimbursement, DHHS will need to provide monitoring and oversight to ensure high quality. In other states where similar models have been implemented, a combination of fidelity or process monitoring is performed by oversight agencies as well as monitoring individual child outcomes. Some jurisdictions have created financial incentives for moving children effectively through the system of care by utilizing payment structures that share some risk with the CMO, such as case rates or capitated per member per month (PMPM) payments.

9. Review and align residential services to best practices and new federal quality standards.

Responsibility: DHHS
Timeframe: Long-Term

During this assessment, it was noted that length of stay in residential services, including out-of-state placements, is increasing, and the quality and oversight of residential programs is varied. To address these findings DHHS should review the existing residential contracts to assess the degree to which they support and align to best practices and federal requirements, evaluate how residential programs utilize effective and trauma-informed treatment models, and ensure that residential interventions meet the needs of children in Maine.

Mental health and child welfare experts have been encouraging more limited use of residential or congregate care. According to the American Orthopsychiatric Association, "group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting."⁹³ Secure attachments to consistent caregivers are critical for the healthy development of children and youth, especially for very young children. The term "residential interventions" is now more commonly being used to better describe the role for these services in the continuum of care.

Residential interventions need to be better defined including service levels, and target populations for residential programs. The result should be a clearly defined framework for when residential interventions are necessary, including:

- Required treatment models and/or interventions
- Staffing and supervisory ratios
- Staff qualifications
- Referral, acceptance, and denial procedures and no eject/reject policies

⁹³ Dozier, Mary, Roger Kobak, and Abraham Sagi-Schwartz et al. Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association. American Journal of Orthopsychiatry. American Orthopsychiatry Association. February 25, 2014. Retrieved from <https://www.apa.org/pubs/journals/features/ort-0000005.pdf>

- A process to review (and re-review) children referred out-of-state to identify service gaps and create models that meet their needs (if appropriate)

This framework should be built on the essential elements necessary for effective treatment. In July 2017, the Building Bridges Initiative released a guide to implementing effective short-term residential interventions.⁹⁴ The mission of the Building Bridges Initiative is, “to identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates, and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes.”⁹⁵ Their list of essential elements for effective short-term residential interventions is shown in Table 9 below and may be helpful for DHHS to develop a framework for residential interventions.

Table 9. Essential Elements for Effective Short-Term Residential Intervention⁹⁶	
Effective Leadership	<i>Leaders must be committed to embedding the principles and activities below into their organizations.</i>
Family and Youth Engagement and Inclusion	<i>Family engagement principles must be embedded in the organization including the beliefs that: youth belong with their families, families should be respected and engaged, interventions should be in the youth’s home and community, and out of home interventions should be as short as possible.</i>
Workforce Development	<i>Staff must be equipped with the skills, support, and tools to engage and work successfully with families, implementing a range of practices that correlate to achieving sustained positive outcomes post-residential intervention.</i>
Practice Strategies and Tools	<i>If the residential intervention has been effective and the practice strategies and tools appropriately utilized and integrated into the transition plan, then the transition back to the home, school, and/or community should happen more seamlessly. Programs that have reduced their lengths of stay and improved sustained positive outcomes post-residential discharge have shifted from a predominant use of practice strategies and tools focused on supporting the youth to a predominant use of practice strategies and tools focused on supporting the family.</i>
Using Data to Inform Practice	<i>Residential providers should collect, use, and share data within the organization and externally to demonstrate the effectiveness of their interventions.</i>

⁹⁴ The Building Bridges Initiative (BBI), was originally developed by Dr. Gary Blau, the chief of the child, adolescent and family branch of the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

⁹⁵The National Building Bridges Initiative, Advancing Partnerships. Improving Lives. IARCCA 66th Annual Conference – September 21, 2010 Presented by: Jody Levison-Johnson, LCSW, Vice President, Coordinated Care Services, Inc., Rochester, NY Raquel Hatter, President/CEO, Family & Children’s Service, Nashville, TN.

⁹⁶<http://www.buildingbridges4youth.org/sites/default/files/BBI%20Short%20Term%20Residential%20Intervention%20Guide.pdf>

Quality Improvement	<i>Residential providers must be able to demonstrate consistent high quality.</i>
Effective Fiscal Strategies	<i>Common fiscal strategies to implement change may include: Medicaid waivers and expanded use of Medicaid, performance-based/incentive contracting, reallocation of existing funds, private funds, and/or reinvestment strategies.</i>

Additionally, residential services need to be aligned to new Federal requirements for congregate care in child welfare. In February 2018, Congress passed sweeping federal child welfare financing reform with Family First Prevention Services Act (FFPSA). To draw down federal reimbursement for residential placements for children in foster care, under Title IV-E of the Social Services Act, residential programs must meet the requirements of Qualified Residential Treatment Programs (QRTP). QRTP requirements include:

- An assessment, performed by an entity other than the residential provider must be conducted and must indicate the need for residential placement;
- The program must have a trauma-informed treatment model;
- The programs must be licensed and accredited;
- If it is in the best interest of the child, the family must be involved in the child’s treatment;
- The program must provide discharge planning and family-based after care support for 6 months after discharge; and
- The continued need for residential placement must be documented.

These requirements will significantly impact Maine because, as reported above in Finding 5, of the 541 children who received PNMI services in SFY 2018, 22 percent were children in child welfare custody. While these requirements only apply to programs for which the state is seeking Title IV-E reimbursement for children in foster care, the QRTP requirements are notably similar to the best practices identified by the Building Bridges Initiative. Since residential providers serve children involved with the child welfare system as well as those who aren’t, these requirements should be implemented across the residential system to preserve federal foster care funding and to standardize quality. In particular, the requirements to utilize a trauma-informed model (however DHHS wishes to define that) and six months of family-based aftercare are notable QRTP requirements that align well with overall recommendations to improve the quality of services and continuity of care along the continuum of services. **DHHS could develop a MaineCare service definition for residential providers to provide time-limited support following discharge from residential services.** Massachusetts is one state that covers community based services to prevent congregate care placement and to support children returning to the community from residential services through the Rehabilitation Option in their Medicaid State Plan. While not every residential provider includes aftercare services, many who provide Continuum Services under the Caring Together Program⁹⁷ can provide both residential and home- and community-based services. While aftercare services were originally competitively procured in Massachusetts, under FFPSA all residential providers will be required to provide these services to be reimbursable for Title IV-E funding.

Additionally, family engagement in residential treatment is critical to the child’s success, and limitations on MaineCare reimbursement will impact the financial support available to families who must travel to residential programs. While there are no authorized uses of Medicaid for non-emergency medical transportation (NEMT) without the child present, **DHHS may request state general funds to support**

⁹⁷ http://togetherthevoice.org/sites/default/files/bbitraining/caring_together_powerpoint.pdf

transportation services in these cases. Funds could be used to provide a voucher to families to pay for their own transportation or gas, or they may be provided in a special contract to NEMT providers for family-only transportation to residential programs. For example, in Alaska the state Mental Health Trust utilizes funds from federal land revenue to support Alaskans with mental health issues, including their transportation needs.⁹⁸ Maine could also consider requiring residential providers to provide this transportation under their contracts provided that this cost is built into their reimbursement rate. While the exact cost of family-only transportation to residential providers is unknown, it is possible that if Maine chooses to cover this expense, it may be offset by savings resulting from other system of care changes (for example, a new MaineCare respite or peer support service).

Contracting and oversight practices should be strengthened and include monitoring activities to ensure that residential interventions are consistently safe, high quality, and effective. In particular, the contracts with residential providers should emphasize or require the use of effective evidence-based interventions for children in residential settings including, but not limited to, Positive Peer Culture, Boys Town Family Home Program and Teaching Family Model, The Sanctuary Model, and The Stop-Gap Model along with individual and group-based clinical evidence-based interventions.⁹⁹ DHHS should also use contracts with providers to establish discharge readiness criteria, including provisions around what constitutes a safe discharge; for example, providers may be required to hold beds for a reasonable period of time (7 days or so) when a child is hospitalized so that the child can return to the program following stabilization. Children should be matched with an appropriate residential program based on their clinical assessment conducted by the CMO (see Recommendation 8). The current residential rates assume that the programs operate with some level of vacancy, such as bed hold days, to offset the costs of these kind of situations. Additionally, contracts should specify referral acceptance and denial policies to promote transparency and consistency, and “no reject, no eject” policies as other states have done.¹⁰⁰ While the notion of “no reject, no eject” policies can be concerning to the provider community, other jurisdictions have successfully enacted these policies. Examples of performance measures that are related to “no reject, no eject” policies include:

- ✓ The ratio of acceptance to denial of referrals by agency
- ✓ The reason for denial by agency (when exceptions are granted and should be discussed during contract re-negotiations)
- ✓ Discharge location and level of care
- ✓ Re-admission to residential services within one year
- ✓ Measures of family and child satisfaction
- ✓ Measures of child functioning/well-being following treatment

To be successful, any “no eject, no reject” policy should be implemented in conjunction with the recommendations above; strengthen the treatment interventions offered at residential programs; and identify the necessary staffing levels, staff credentials, and staff training for program models. As noted previously, rates may need to be revised to ensure that they cover the costs of the models. Additionally, most states with these policies allow for programs to challenge a referral or request an exception to these policies in writing, with supporting documentation, and within certain timeframes – which DHHS would have

⁹⁸ http://dot.alaska.gov/transit/hs_funding_amht.shtml

⁹⁹ Pecora, P. and English, D.J. (2016). Elements of effective practice for children and youth served by therapeutic residential care. Casey Family Programs. Retrieved from <https://www.casey.org/media/Group-Care-complete.pdf>

¹⁰⁰ PCG can provide specific contract examples upon request.

full authority to approve or deny. Some states actively track and monitor these requests for the purposes of ongoing quality assurance and contract renewal discussions.

A stakeholder group should be created to inform (see Recommendation 2) the residential services redesign effort which includes families and youth advisors. This group should identify ways in which the state will support providers, such as through training and technical assistance to support implementation of EBPs and trauma-informed models of care. Additionally, when the framework for residential interventions is clearly defined and contract requirements are strengthened, the reimbursement rates for residential services will need to be reviewed to determine if adjustments are required to support the new program models.

DHHS should establish clear performance standards for residential services and may want to tie these to incentive-based payments. Desired performance measures for residential services should be driven by a logic model for these services and measured consistently across all providers delivering similar services or level of care. Providers should be held accountable for these measures based on contract requirements, provided that there is agreement between DHHS and providers on the validity of the data collected. In 2014, the Building Bridges Initiative published recommended residential intervention measures that fall into four high level categories of qualitative and quantitative measures, seen in Table 10 below.

Table 10. Residential Intervention Measures¹⁰¹	
System Level Measures	<i>For example, access/penetration, service utilization, cost. Generally, requires access to administrative and claims data from multiple providers.</i>
Provider Measures	<i>For example, practice information and the living environment. Examines the activities and nature of the provider organization including key practices. These measures can be supplemented by other licensing and credentialing data.</i>
Youth/Family Outcome Indicators	<i>For example, level of functioning, behavioral and physical health, employment and educational attainment, other family and community measures. These are measures that require the administration of some sort of assessment instrument, interviews with youth, families or data extraction from the clinical or electronic health record.</i>
Youth/Family Experience of Care	<i>For example, client and family satisfaction, feelings of engagement, hope for the future. These measures include youth and family opinions from surveys or interviews concerning their care.</i>

Some examples of provider measures proposed by the Building Bridges Initiative are included in Table 11 below. These serve merely as examples for DHHS to consider and would need to be tailored to be consistent with Maine’s system of care and the data that is available.

¹⁰¹ Dougherty, R.H. and Strod, D. (2014). Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures. Retrieved from <http://www.buildingbridges4youth.org/sites/default/files/BBI%20Building%20Consensus%20on%20Residential%20Measures%20-%20March%202014.pdf>

Table 11. Examples of Provider Measures for Residential Interventions

✓ Average length of stay in residential for discharges
✓ Re-admissions to 24-hour level of care 1-year post-discharge
✓ Number of restraints/seclusions divided by the number of youth in residential, per year
✓ Number of critical incidents per youth per year in residential
✓ Percent of admissions and discharges incorporating comparison of a youth’s medication orders during and after the residential episode
✓ Percent of youth discharged on multiple psychotropic medications
✓ Presence or absence of a child and family team
✓ Percent of informal supports on child and family team where one is used
✓ Percent of youth free from child-to-child injuries while enrolled in residential program, annually
✓ Percent of discharge type (Reunification or Goals Met, Against Medical Advice, Runaway, Administrative, Planned, Loss of eligibility, Managed Care Denial) for youth discharged from residential services
✓ Percent of youth with a post-discharge continuing care plan created and transmitted to a responsible adult in the post-discharge living environment
✓ Restrictiveness of Living Environment Score change between residential environment and discharge destination
✓ Post discharge exposure to maltreatment or abuse in the home, in the periods following discharge: as long as follow-up continues but no less than three months

One example of a state that has tied residential performance to payment is Tennessee. The Tennessee Department of Children’s Services (DCS) launched a performance-based contracting initiative in 2006. Payment penalties and bonuses are based on the number of days children are in institutional care, the number of permanent exits from state custody, and the number of children reentering care. Agencies showing improved performance receive a financial re-investment, which is based on the amount of state dollars “saved” due to their program improvements and the extent to which they have improved their baseline performance relative to savings, permanency, and re-entry. Agencies failing to meet their baseline expectations will be expected to submit a remittance of funds to the state. The state does consider individual provider performance, and if they demonstrate improvement over previous years on statewide standards, they are financially compensated for their progress. DCS phased in the model, adding more providers each year, between 2006 and 2009. By 2010, Tennessee had one of the lowest national rates for placing children in congregate care and the initiative has been budget neutral.¹⁰² Tying pay to performance is an excellent way to clarify expected outcomes and align the goals of all parties. DHHS could consider similar models from other states, replicate Tennessee’s model, or create a new model. Additional information on performance-based contracting will be discussed in Recommendation 17.

¹⁰² Dougherty, R.H. and Strod, D. (2014). Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures. Retrieved from <http://www.buildingbridges4youth.org/sites/default/files/BBI%20Building%20Consensus%20on%20Residential%20Measures%20-%20March%202014.pdf>

A web-based daily census system should be developed and implemented for children's residential services. One of the major challenges in accessing residential services for children is that DHHS lacks a comprehensive, real-time understanding of current capacity across residential providers. While residential services are approved through the ITRT application process and authorized by the ASO, separate waitlists are maintained by each residential provider. Additionally, while a program may be licensed for a specific number of beds, their capacity varies depending on staff availability and the acuity of the children in the milieu.

To address these concerns, DHHS should develop and implement a web-based daily census system for children's residential services, which will allow both DHHS and residential providers to track and monitor services and capacity. Residential providers would be contractually required to enter current client demographics (including acuity and staffing requirements) daily into a web-based portal. Providers would also enter current staffing capacity to calculate an accurate representation of their available beds for placement. The census must go beyond counting "empty beds" and consider the acuity of current children and staffing capacity in residential programs to determine true capacity. With this system DHHS would be able to look across the state to assess real-time capacity, and case managers could also have access to help them prioritize their applications for children requiring residential services. Additionally, the daily census system would create an opportunity to increase data-driven decision-making regarding statewide access and maintain the information needed to analyze trends across providers. Successful implementation of a daily census system will require strong collaboration between DHHS and residential service providers. It will also be critical to ensure that data is being entered consistently, accurately, and with integrity across all participating residential provider agencies. This system could also be expanded to include crisis beds, inpatient psychiatric beds, and PRTF beds.

There are a few examples where states have successfully implemented similar daily census systems or "bed registries," most commonly in inpatient psychiatric facilities but sometimes including other residential services (Minnesota and Tennessee).¹⁰³ According to a 2014 survey of bed registry use across the United States, 22 states and the District of Columbia had some type of bed tracking census database in place. In 2011 North Carolina piloted a voluntary bed registry with noted benefits including program continuity' expansion to distal regions; and the production of a database which was user-friendly, searchable, and easy to adapt to include other populations and needs.¹⁰⁴ Some of the challenges with the pilot included voluntary program participation, exclusion of crisis services, a lack of robust data analysis, and the lack of documentation of potential outcome-based measures (for example, reduction in emergency department wait times). North Carolina has now expanded the statewide bed registry to over 230 facilities across the adult and child behavioral health system.¹⁰⁵

Minnesota has had a similar bed tracking system in place since 2007, which includes hospitals, crisis, and children's residential services.¹⁰⁶ The partnership between Minnesota's Department of Human Services and Hospital Association was key to successful implementation. According to an initial third-party evaluation of Minnesota's system, participating hospitals reported positive outcomes such as the reduced time staff

¹⁰³ National Association of State Mental Health Program Directors (2018). Experiences and lessons learned in states with on-line databases (registries) of available mental health, crisis, psychiatric inpatient, and community residential placements. Retrieved from <https://www.nasmhpd.org/sites/default/files/TAC-Paper-2-NRI-RegistryPaper-508C.pdf>

¹⁰⁴ NC DHHS (2015). Strategies to increase child and adolescent behavioral health inpatient beds. Retrieved from <https://files.nc.gov/ncdhhs/SL%202014-10012F%203%28b%29%281%29%20Child%20%20Adolescent%20Beds.pdf>

¹⁰⁵ <https://www.ncdhhs.gov/bh-crsys>

¹⁰⁶ <https://www.mnmhaccess.com/>

spent trying to locate beds, reduction in the time clients spent in emergency rooms waiting for beds, and an increased number of clients being able to access beds closer to their home communities. Vermont reported similar findings regarding the success of its 2012 bed tracking system, where providers reported that the system made it easy to locate available beds, thus reducing the time needed to call multiple facilities to located beds.¹⁰⁷ Additionally, Vermont found that the demographic data stored in the system helped facilitate smooth transitions to other providers and eased the discharge planning process. Virginia implemented a statewide bed registry in 2014 following a high-profile tragedy when State Senator Creigh Deeds' son stabbed him and then fatally shot himself after he was released to the community, even though psychiatric beds were available. The bed registry is now established in Virginia's state law.¹⁰⁸

10. Improve the quality, responsiveness, and role of children's behavioral health crisis services.

Responsibility: DHHS
Timeframe: Short- and Long-Term

Crisis services play a key role in stabilizing children and minimizing the use of deep end services like emergency departments and psychiatric hospitals. Crisis services can also prevent out of home placement and placement disruptions. According to a recent brief from the National Association of State Mental Health Directors, key elements of a robust children's crisis continuum of care include:¹⁰⁹

Single point of access. A crisis hotline, available 24/7, and staffed by trained and qualified specialists is the most common way to access services.

Triage. This is typically done by the single point of entry above and includes assessment of the risk of harm and then tailoring the follow up from immediate response (usually within 1 hour) to a scheduled appointment (usually within 48 hours). Best practice includes a warm hand-off with a three-way conversation between the intake provider, the Mobile Response and Stabilization Services (MRSS) provider, and the family.

Mobile Response and Stabilization Services. These are designed to divert children from emergency departments and/or law enforcement responses and can provide intervention at school or at home, in settings that are less traumatic for children. Studies have found that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.¹¹⁰

MRSS include the initial crisis response, stabilization services that may last up to 8 weeks while the child is connecting to services, residential crisis services, and services that assist the child to transition back to the community. For example, Oklahoma employs behavioral health aides to build relationships with the

¹⁰⁷ <https://bedboard.vermont.gov/>

¹⁰⁸ <http://www.dbhds.virginia.gov/online-psychiatric-bed-registry>

¹⁰⁹ Manley, E., Simons, D., Zabel, M. (August 2018). National Association of State Mental Health Directors. Making the Case for a Comprehensive Children's Crisis Continuum of Care. Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

¹¹⁰ Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <https://store.samhsa.gov/system/files/sma14-4848.pdf>

child and provide stabilization services to the child and family following the incident that precipitated the crisis.

Effective MRSS systems include the following elements:

- ✓ Crisis is defined by the caller.
- ✓ Services are available 24/7.
- ✓ Able to serve children and families in their natural environments, for example, at home or in school.
- ✓ Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers.
- ✓ Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems.
- ✓ Connect families to follow-up services and supports, including transition to needed treatment services.

Community Collaboration and Coordination. Coordination and relationships between the MRSS provider and other child serving agencies are key for effective service delivery. Additionally, MRSS providers may train local law enforcement or other child serving agencies in trauma, crisis intervention, and/or suicide prevention. Community collaboration and coordination may be especially important in rural states, such as Maine. One study in North Carolina found that the success of mobile crisis teams in rural settings relies on developing positive relationships with community stakeholders such as hospitals, law enforcement officers, the departments of social services, magistrates, primary care doctors, homeless shelters, urgent-care clinics and other providers of behavioral health care. The goal of these relationships is to continually market services, make educational presentations, and facilitate meetings to regularly communicate about systemic challenges and develop ways to meet the needs of the community, particularly high-acuity clients.¹¹¹

Additionally, SAMHSA has identified key infrastructure elements for effective crisis services including:¹¹²

- Staff that are appropriately trained and have demonstrated competence in understanding the population of individuals served, including not only a clinical perspective, but also their lived experiences.
- Staff and leadership that understands, accepts and promotes the concepts of recovery and resilience, the value of consumer partnerships and consumer choice, and the balance between protection from harm and personal dignity.
- Staff that have timely access to critical information, such as an individual's health history, psychiatric advance directive or crisis plan. Such access is, in part, reliant on effective systems for the retrieval of records, whether paper or electronic.
- Staff that are afforded the flexibility and the resources, including the resource of time, to establish truly individualized person-centered plans to address the immediate crisis and beyond.
- Staff that are empowered to work in partnership with individuals being served and that are encouraged, with appropriate organizational oversight, to craft and implement novel solutions.

¹¹¹ Trantham, D., Sherry, A. (June 7, 2012). Mobile Crisis Management Teams as Part of an Effective Crisis Management System for Rural Communities". North Carolina Medical Journal (Vol. 73, no. 3). Retrieved from http://classic.ncmedicaljournal.com/wp-content/uploads/2012/05/NCMJ_73309_FINAL.pdf

¹¹² Substance Abuse and Mental Health Services Administration (2009). Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD.

- An organizational culture that does not isolate its programs or its staff from its surrounding community and from the community of individuals being served. This means that the organization does not limit its focus to “specific” patient level interventions, but also positions itself to play a meaningful role in promoting “indicated” strategies for the high-risk population it serves and “universal” strategies that target prevention within the general population. The intent here is not to dissipate the resources or dilute the focus of an organization, but to assure recognition that its services are a part of a larger spectrum and that it actively contributes to and benefits from overall system refinements.
- Coordination and collaboration with outside entities that serve as sources of referrals and to which the organization may make referrals. Such engagement should not be limited to service providers within formal networks, but should also include natural networks of support relevant to the individuals being served.
- Rigorous performance-improvement programs that use data meaningfully to refine individuals' crisis care and improve program outcomes. Performance improvement programs should also be used to identify and address risk factors or unmet needs that have an impact on referrals to the organization and the vulnerability to continuing crises of individuals served.

In the short-term, DHHS should continue to support crisis providers to receive training on how to safely manage and support children across the spectrum of behavioral health needs. When the crisis services contracts were expanded to include children with I/DD and Autism, some providers were well-skilled to work with that population, while others have struggled. Families may feel unsupported when trying to access crisis services and thus bypass them entirely or rely on residential treatment instead of lower levels of care because they are not confident in their ability to access crisis services if their child were to remain in the home. DHHS should leverage external trainers or contract with highly skilled providers to cross-train other crisis providers in working with children with I/DD or Autism statewide.

DHHS tracks some key data points for crisis services, such as wait times, however based on the limited reports we reviewed it appears that this data is either inaccurate or inconsistent with concerns we heard from stakeholders. **DHHS should continue to work with SAMHS, who administers these contracts, to increase the quality of crisis provider reporting and ensure that the information collected is meaningful to children's behavioral health services.** To monitor the timeliness, effectiveness, and cost effectiveness of crisis services, other states collect data such as: the number of face to face contacts, the timeliness of response, location of outreach, disposition of outreach, rates of diversion from inpatient psychiatric hospitals, and/or family satisfaction surveys. In collaboration with SAMHS, DHHS should review the current data collection and reporting practices to improve oversight.

Last spring the funding model for crisis services shifted from a cost-reimbursement model to a fee-for-service (FFS) model. Under the cost-reimbursement model, providers would have been reimbursed for their allowable costs on some periodic basis. Cost-reimbursement models allow for steady cash flow for providers, with little risk, regardless of how many children, youth, and families are served, and little financial incentive for cost effectiveness. Conversely, FFS models, which only reimburse providers for actual units of service, can create challenging cash flow issues for crisis service providers, as service volume may fluctuate month to month, while the provider must maintain the infrastructure to operate a 24/7 program. Other states have grappled with these challenges and have handled them in different ways. Possible solutions include:

- Crisis services may be paid via monthly capitated payments to support the staffing and infrastructure needed to operate the program 24/7. The difference between this model and cost-reimbursement is that the state can work with providers to develop and approve reasonable cost assumptions for running the program, based on historical utilization and costs, and then the provider must live within the capitated payments unless they can document significant changes in utilization and volume. This model has been deployed for crisis service in numerous jurisdictions and is also common in other types of emergency services like domestic violence programs.
- Crisis services may also be paid via FFS models, however FFS models need to consider historical utilization rates and should build in assumptions that the program will operate below 100 percent capacity. For example, in emergency shelter programs for children in foster care or children residing in acute behavioral health stabilization settings, the utilization rate assumed in the payment rate may be closer to 80 percent. This makes the FFS model less risky from a cash flow perspective.

States fund crisis services through a variety of funding mechanisms. In one study SAMHSA study, Medicaid was commonly utilized (Rehab Option, Clinic Option, and Waivers) as well as state general funds and Mental Health Block Grant funds.¹¹³

It is recommended that DHHS review the current fee-for-service funding model for crisis providers to determine if this is impacting their ability to adequately staff their programs and respond rapidly to families in crisis.

Finally, during this assessment stakeholders reported that the assessment process to determine whether a child warrants inpatient psychiatric hospitalization varies depending on the facility and providers involved. **DHHS could play a key role in brokering discussions and formalized agreements between crisis providers and hospitals on admission criteria and processes.** DHHS should request that hospitals document their admission and disqualifying criteria, in general terms, and share that with crisis providers conducting assessments. Without legal authority, private hospitals cannot be required to admit children to their inpatient psychiatric units, however developing Memorandums of Understanding could minimize frustration and help expedite discharge planning for children following a crisis. DHHS could also require crisis providers and hospitals to use evidence-based assessment tools, recommended by CMS,¹¹⁴ to determine the appropriate level of care such as the Child and Adolescent Level of Care Utilization System (CALOCUS) or Child and Adolescent Service Intensity Instrument (CASII).¹¹⁵

¹¹³ Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD.

¹¹⁴ CMS SMDL #18-011 "Opportunities to design innovative service delivery systems for adults with serious mental illness or children with a serious emotional disturbance." November 13, 2018. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

¹¹⁵ https://www.aacap.org/aacap/member_resources/practice_information/CASII.aspx

11. Develop a CBHS Data Task Force to use collect, analyze, and report on data that drives service decision-making in CBHS, including the role for evidence-based services.

Responsibility: DHHS
Timeframe: Long-Term

DHHS should develop a multi-stakeholder group (here called a *CBHS Data Task Force*) responsible for analyzing reports and data on service utilization, provider capacity and performance, community assets and gaps, and individual child and family needs. This data should inform the Task Force and DHHS' decisions about resource allocation, training, investments in evidence-based practices, quality assurance activities, development or modification of service definitions, and desired outcomes for performance-based contracting (see Recommendation 17). This recommendation should follow as one strategy to operationalize the goals of the CBHS Strategic Plan (see Recommendation 1) and may be an example of one of the examples of stakeholder groups described in Recommendation 2.

The CBHS Data Task Force can build on other initiatives at DHHS designed to measure and evaluate program impact and trends, for example, measures related to Behavioral Health Homes and other value-based purchasing strategies, federal performance standards in child welfare, and psychotropic medication use in children. Furthermore, the Task Force should lead the charge in at least two specific sub-recommendations: the development of a framework for investment in evidence-based practices, and the development of procedures to "hot spot" utilization trends in services.

Evidence-Based Practices

Investment in evidence-based practices in Maine has been intermittent with some major gains in the areas of MST, FFT, and ABA – but there is also model drift or total loss in other EBPs (MATCH-ADTC¹¹⁶, ACT¹¹⁷, Wraparound, etc.) While EBPs are not a "one-size-fits-all" approach, when appropriate, they do offer a structured, proven model for providers to deliver services to children with a positive return-on-investment (ROI). EBP implementation and fidelity monitoring has been correlated to improved staff retention, which could impact the state's workforce challenges.¹¹⁸ However, in order for EBPs to be successful in Maine, the state needs to develop a structured framework for investment that carries through from the identification of desired models through training and ongoing fidelity monitoring. Maine should be thoughtful in the selection of a few, strategic models to start and take a staggered approach in investments to build a successful framework for implementation. The CBHS Data Task Force should develop a framework to support the investment in EBPs across Maine that is rooted in analysis of current needs and assets. To develop this framework the Task Force should use data to:

1. Identify current EBP assets through a statewide provider survey (Where are EBPs available? What training or monitoring do provider receive? What is their capacity to deliver services with fidelity or to train others?)

¹¹⁶ Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

¹¹⁷ Assertive Community Treatment

¹¹⁸ Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: evidence for a protective effect. *Journal of consulting and clinical psychology*, 77(2), 270. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2742697/>

2. Identify desired target populations (Who would most benefit from EBPs? In what areas of the state? For what conditions?)
3. Identify resources available for training, monitoring, and fidelity of EBPs (What training is available in the state? Should Maine hire an in-house trainer? What contracts could be established with out-of-state trainers? What funding is available to support training? What investment can be required from providers?)
4. Identify a list of desired EBPs based on current assets, target population, and identified resources (1-3). This list should build on existing investments in EBPs like MST, FFT, ABA, and ACT and should also leverage models that could be available for Federal reimbursement under the Family First Prevention Services Act (FFPSA). Additional models that may be of interest to Maine include Attachment and Bio-Behavioral Catch-Up (ABC) because it supports young children and providers do not need to be licensed clinicians, and MATCH-ADTC and High-Fidelity Wraparound because there have been previous investments in these models in Maine with positive results.
5. Analyze if current service definitions are sufficient to deliver EBPs or if modifications are required and advise DHHS accordingly.
6. Analyze if EBP-specific reimbursement rates can or should be developed to support models to be implemented with fidelity and strong outcomes and if performance-based contracting can support these models. (The Maine legislature recently ordered an EBP-specific reimbursement rate study for TF-CBT).
7. Determine if a third-party should be responsible for maintaining an inventory or online registry of all trained providers. For example, in North Carolina the NC Child Treatment Program receives state general funds to support a platform for training, credentialing, and fidelity monitoring for Attachment and Bio-Behavioral Catch-Up (ABC), Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).¹¹⁹ CMS indicates that states can receive reimbursement for development and operational costs under Medicaid Information Technology Architecture (MITA) 3.0.¹²⁰

Utilization Trends

The CBHS Data Task Force should work with DHHS to obtain MaineCare claims data and other sources that will support “hot spotting” of different behavioral health utilization trends to inform decision-making. Tools like Geographic Information Systems (GIS) can help the Task Force overlay census data and other sources of information to conduct robust analysis. The Task Force should conduct geographical analysis of provider trends in treatment, diagnosis, prescribing habits, admission practices, and referrals. The data may reveal concerns with disproportionality, ethical issues, safety or clinical issues, or even best practices and areas of efficiency and success. The Task Force can utilize this data to guide areas where DHHS can provide additional quality assurance, training, oversight, or inquire about strengths to share with other providers. For example, Ohio was able to use data from the census and risk surveys with market data on

¹¹⁹ <https://ncchildtreatmentprogram.org/>

¹²⁰ <https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html>

prescription trends to correctly identify a “hot spot” where providers were appropriately treating elevated depression.¹²¹ Community Care of North Carolina has recently begun using data on psychotropic medication prescriptions to identify physicians who are high-prescribers and offer consultation regarding the appropriate use of these medications with children.

Other data can also be used to map out geographic variations in risk and protective factors for children's behavioral health that can be used to drive strategic planning statewide. For example, Philadelphia engaged in a GIS analysis of children's mental health by assessing risk and protective factors and mapping those with the greatest risk to areas where behavioral health services are located.¹²²

12. Facilitate access to services that can help families support children with behavioral health needs.

Responsibility: DHHS
Timeframe: Long-Term

Families and stakeholders reported barriers to full participation in treatment and supporting children with behavioral health needs. DHHS could undertake the following recommendations to improve family member engagement and support.

Develop a MaineCare service definition for parent-only therapy which allows providers to work with the parent/caregiver without the child present. The development of this service would allow providers to work with parents while a child is at school or placed in a residential program, crisis stabilization unit, hospital, or ED. This would also expand funding to support EBPs that require parent-only sessions like Parent Child Interaction Therapy (PCIT) and other parent skills development.

Develop a MaineCare service definition to explicitly support EBPs that enhance parenting skills. Examples of these EBPs include PCIT, Attachment and Biobehavioral Catch-up (ABC), the Incredible Years, and Triple P. During our assessment DHHS reported that MaineCare is currently exploring evidence-based parenting programs including Triple P, PCIT, and the Incredible Years for future rulemaking. Triple P is currently available in Maine for child welfare involved families with parental substance use disorders in conjunction with Matrix Intensive Outpatient Program (IOP) under Maine's Title IV-E Waiver program (Maine Enhanced Parenting Program or MEPP). As investments and capacity to deliver EBPs grows in Maine (see Recommendation 11) Maine should pay particular attention to models that support parents and families and ensure adequate reimbursement for providers to deliver these models with fidelity. Additionally, family engagement in these models can be enhanced through tangible supports including transportation, child care and coordinated through CMOs (see Recommendation 8).

Continue to build capacity to deliver Mental Health First Aid (MHFA). While MHFA is available in some areas of the state, it should continue to be an area of investment for Maine and provided to school professionals, health care providers, family members, and natural supports to help children manage behavioral health crises. MHFA can help community members identify and de-escalate mental health crises, reduce stigma around mental health, and increase the likelihood that individuals will receive support.

¹²¹ <https://www.healthmanagement.com/blog/depression-mapping-hot-spotting-reveals-potential-best-practices/>

¹²² Troung, Q. (2016). Place matters: Perceived neighborhood safety and social support during childhood and its impact on mental health in Philadelphia – a GIS analysis of children's population health needs and resources. Retrieved from http://www.scattergoodfoundation.org/sites/default/files/Place%20Matters_FINAL_10.16.pdf

Currently Maine statute requires schools to establish a mental health first aid training program, provided that the schools have received specific funding for this program.¹²³ Both NAMI Maine and some providers have also offered MHFA at free or reduced cost to community members and recently Mid Coast Hospital in Brunswick was awarded a SAMHSA grant to deliver MHFA trainings.

Expand access to peer and family support through MaineCare service. Peer and family support for children with behavioral health issues has been shown to increase a sense of collaboration, self-sufficiency, empowerment to take action, and recognition of the importance of self-care while decreasing internalized blame and family isolation.¹²⁴ While peer and family support is currently available through the Community Mental Health Block Grant, developing a MaineCare service definition under an SPA could expand funding opportunities. In 2007, CMS¹²⁵ announced that peer support services are an evidence-based practice, and, therefore, a reimbursable service for states that choose to incorporate them into their Medicaid State Plan and clarified in 2013 that these services can be provided to parents and legal guardians of Medicaid-eligible children.¹²⁶ More than 35 states have established statewide certification programs for peer specialists, and about 40 states have built these services into their Medicaid State Plans for reimbursement under the Rehabilitation Services State Plan Option. Clear definitions regarding supervision, care coordination, and training and certification are essential components to the service definition, but how they are defined varies by state in accordance with their needs. While expanding family and peer support services through MaineCare would allow the state to draw down some federal reimbursement for these programs, it would also require providers to be enrolled with MaineCare. In many states peer and family support is provided through multiple funding sources including Medicaid, state and local funds, grants, or private contributions. For additional information on the use of Medicaid for peer and family support see *Becoming a Medicaid Provider of Family and Youth Peer Support: Considerations for Family Run Organizations*.¹²⁷

13. Develop MaineCare funded out of home placement for children with behavioral health issues (aka Treatment or Therapeutic Foster Care).

Responsibility: DHHS
Timeframe: Long-Term

Currently children who need out of home care are sent to residential programs, when a less intensive family-like setting closer to their community may be more appropriate and effective, commonly known as Treatment Foster Care or Therapeutic Foster Care (TFC). Currently, TFC is available in Maine but only for children under DHHS custody.¹²⁸ This level of care was previously available in Maine to non-child welfare cases under Multidimensional Treatment Foster Care, but stakeholders reported that the program was unsuccessful because rates were insufficient to retain high quality providers, and the eligibility process through ITRT did not distinguish TFC as a less-intensive treatment than PNMI. Maine should develop a MaineCare funded service definition for this level of care which does not necessitate child welfare involvement and requires providers to follow an evidence-based model in their program.

¹²³ <http://www.mainelegislature.org/legis/statutes/20-a/title20-Asec6671.html>

¹²⁴ https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf

¹²⁵ <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>

¹²⁶ CMS (2013). Clarifying guidance on peer support services policy. Retrieved from <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf>

¹²⁷ https://www.chcs.org/media/Medicaid-FYPS-Considerations-for-FROs_FINAL_rev.pdf

¹²⁸ <https://www.maine.gov/dhhs/ocfs/cw/program-standards.htm>

Similar to other states, TFC is currently funded through child welfare in Maine, however a growing number of states are developing Medicaid service definitions for this level of out of home treatment through their Medicaid State Plan (under Rehabilitative Services), a Medicaid Waiver, or under Managed Care. In North Carolina, TFC is defined as a 24-hour service that includes intensive, individualized supervision and structure, is rehabilitative in nature, and includes maintenance of daily living skills, social skills, crisis management and support.

When building or expanding a service definition for TFC it's important for Maine to specify how services will be provided, for example under an EBP such as Treatment Foster Care Oregon¹²⁹ or Together Facing the Challenge,¹³⁰ and also require program quality measurements such as family participation in treatment, frequency of crisis visits, educational progress, juvenile justice involvement, and family reunification. TFC is most successful when the therapeutic family works with the biological family to transfer skills, support visitation, and have a plan for reunification. Additional supports including case management, medication management, outpatient therapy, and school supports can help ensure that children avoid crises and do not escalate to residential levels of care. Treatment Foster Care Oregon was developed in 1983 with two main goals: to create opportunities for children to live successfully in a family setting and to help parents provide effective parenting. The model aims to achieve its goals through focusing on five key areas: providing a consistent and reinforcing environment through encouragement and mentoring, providing a daily structure with clear expectations and consequences for children, ensuring a high level of child supervision, limiting access to problem peers while promoting opportunities to engage with prosocial peers, and creating an environment that ensures daily school attendance and homework completion. Treatment Foster Care Oregon has been able to demonstrate the following positive outcomes associated with the model: prevention or reduction of the time spent in institutional or residential placements; prevention of the escalation of delinquency, youth violence, and teen pregnancy; increases in positive academic engagement; increased attachment; and improved brain stress regulatory systems.

Treatment Foster Care is a less restrictive intervention than residential services and can also ensure that children remain closer to their home community if providers are well-supported across the state. TFC is also a more cost-effective intervention compared to congregate care, and the improved outcomes for children are well documented in the literature.¹³¹ The Washington State Institute for Public Policy conducted a benefit-cost summary of Multidimensional Treatment Foster Care in 2017 and found that beyond the initial investment in the program, the net benefits of the program produced cost savings over time (starting within the first ten years of investment).¹³²

It may also be beneficial for DHHS to develop a guide to levels of out of home behavioral health services, including residential substance abuse treatment, PRTF, and Treatment Foster Care if this service is further developed for behavioral health. This guide should outline the typical clinical and behavioral needs of a child at each level and describe the services that are available. While there will always be exceptional cases, it can be helpful for families, case managers, and providers to be on the same page about services when making a determination for level of care or recommended treatment. North Carolina has produced a

¹²⁹ <https://www.tfcoregon.com/>

¹³⁰ <https://sites.duke.edu/tffc/>

¹³¹ <https://aspe.hhs.gov/system/files/pdf/259121/TREATMENTFOSTERCARE.pdf>

¹³² <http://www.wsipp.wa.gov/BenefitCost/Program/20>

helpful example of this type of guide which can be used with families or in Care Review (see Recommendation 18).¹³³

14. Continue to review how Accountable Communities can support the behavioral health needs of children in Maine.

Responsibility: DHHS
Timeframe: Long-Term

Maine has established Accountable Communities (ACs) as part of the MaineCare value-based purchasing strategy aimed at reducing costs and improving health care quality and outcomes. Under this model organizations and groups of providers contract with MaineCare to participate in a shared savings model tied to an established series of quality measures. While ACs are a promising model to improve health care for MaineCare recipients, child enrollment in ACs has lagged. According to recent data provided by the Office of MaineCare Services, of the 56,705 total members enrolled in ACs, 30,305 (53.4 percent) are under the age of 21. Statewide, 103,958 children were eligible for MaineCare in August 2018, so approximately 29 percent of these children are members of an AC.

There are several ways that Accountable Communities should be leveraged to address the behavioral health needs of children enrolled in MaineCare.

Continue to expand the number of children enrolled in ACs. New members are enrolled to their local AC when their primary care or pediatric practice joins or forms a new AC. DHHS should continue to work with existing ACs to encourage more pediatric providers to join. DHHS should also continue to work to identify areas of the state that are currently not covered by ACs to ensure that this model is available statewide while also supporting existing ACs to be successful. Providers who want to join or develop ACs have to make substantial investments in data analytics and care coordination. DHHS should work closely with these providers, supporting them as needed in navigating how to become affiliated with an AC and emphasizing ROI as an incentive.

Ensure that ACs are responsible for the full service array of children's behavioral health services. Currently ACs can choose to exclude children's residential services (PNMI) from their capitated rate for care. This practice allows ACs to avoid the more costly, intensive services that children might require and does not incentivize them to utilize services to avoid these placements. DHHS should work to fix this loophole and require ACs to cover the full service array under CBHS.

Require ACs to maintain responsibility when children are in out of home treatment. When children who are enrolled members of ACs need to receive residential services or treatment outside of their home and AC catchment area, the "home" AC does not continue their responsibility for the management and costs of treatment, but rather transfers it to the new AC or the child re-enters the traditional MaineCare system. This practice has two consequences – the cost of out of home treatment and responsibility for quality is shifted away from the responsible home AC, and the coordination between the treatment provider and the child's home community of supports and services is weakened. DHHS should establish policy that requires ACs to maintain responsibility for children in non-permanent, out of home placements outside of their community.

¹³³ Durham SOC Care Review Levels of Residential Care. Retrieved from <https://www.alliancebhc.org/wp-content/uploads/Description-of-Residential-Levels-of-Care-Durham.pdf>

Identify additional quality measures relevant to children's behavioral health services. Currently ACs are responsible for three measures relevant to children's behavioral health services:

- Screening for depression
- Follow up care for children with an ADHD diagnosis
- Follow-up after hospitalization for mental illness

DHHS should work with ACs and providers to identify additional measures that would strengthen accountability, encourage access to less intensive services, and continue to drive towards improved quality. Additional quality measures might include: substance use disorder screening, behavioral health assessments for children in DHHS custody, screening for trauma and adverse childhood experiences, and behavioral health emergency department use.

15. Conduct further analysis on the coordination between behavioral health services and substance use disorder treatment for youth.

Responsibility: DHHS
Timeframe: Long-Term

Often youth who present with an active substance use disorder (SUD) have co-morbid psychiatric disorders including depression, anxiety, trauma, and conduct disorders, and the diagnosis and treatment planning for these conditions must consider both their substance use and mental health issues. The American Academy of Child and Adolescent Psychiatry has developed a *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders* which recommends, among other things, that youth with SUD should receive thorough evaluation for comorbid psychiatric disorders and appropriate treatment.¹³⁴

During our assessment stakeholders reported that there is limited coordination between behavioral health and SUD treatment providers. Often, these youth are also involved with juvenile justice resulting from behavior related to their substance use and may be court-ordered to participate in treatment. Youth may receive outpatient or residential SUD treatment in Maine, or receive SUD counseling through the juvenile justice system. At the same time, they may also be engaged with home- and community-based services, day treatment, or residential services. While an in-depth analysis of this overlap was not within the purview of this assessment, it arose as a significant area of concern for many stakeholders we interviewed. DHHS should conduct further analysis on the coordination of youth SUD treatment and behavioral health services.

An in-depth analysis of youth substance use treatment and behavioral health services could potentially explore:

- Communication between OCFS and SAMHS
- Opportunities for improved collaboration between SUD and behavioral health providers
- Establishing Memorandums of Understanding or other agreements
- Funding, oversight, and monitoring of youth SUD treatment
- Organizational changes to move youth SUD treatment under OCFS

¹³⁴ Bukstein, O. G. (2005). Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *Journal of the American academy of child & adolescent psychiatry*, 44(6), 609-621. Retrieved from [https://www.jaacap.org/article/S0890-8567\(09\)61641-5/pdf](https://www.jaacap.org/article/S0890-8567(09)61641-5/pdf)

- Evidence-based practices for comorbid SUD and behavioral health treatment
- Eligibility and referral pathways to residential services

In New Hampshire, NAMI led a process to develop a *Blueprint for Change* with recommendations for the state to develop an integrated service approach to meet the needs of youth and young adults with co-occurring disorders.¹³⁵ The final report developed specific recommendations in the following areas:

- I. Establish a conceptual framework for providers across disciplines to work from, standardizing terminology and identifying resources;
- II. Identify valid screening and assessment tools and evidence-based practices proven effective for adolescents and young adults; and
- III. Develop strategies to support and assist changes in the system that would facilitate the adoption and implementation of screening, assessment, and appropriate integrated treatments.

DHHS can look to this example, and others across the country, for best practices to develop coordinated SUD and behavioral health treatment for youth.

16. Develop a statewide strategy to address shortages in the health care workforce.

Responsibility: System of Care
Timeframe: Long-Term

During this assessment the shortage of a high-quality, consistent, and stable workforce in children's behavioral health was a frequent concern of nearly every stakeholder across the system of care. Indeed, the workforce shortages are not limited to CBHS or even behavioral health specifically, but the health care industry broadly and the state as a whole. Therefore, recommendations to address the workforce issues for CBHS cannot be the sole responsibility of DHHS, or government in particular, but requires coordinated effort across the health care sector. This is especially true because the labor market is not siloed – and changes in one sector or area of health care can impact the availability or participation of workers in other sectors as many lower-skilled professionals move between adult and child services and physical and behavioral health care. To that end, Maine should undertake the following approach to address the shortage in the behavioral health workforce.

Maine should engage the major stakeholders in the health care sector to develop a statewide, strategic plan to address workforce challenges. The stakeholders should include but not be limited to:

- DHHS
- Department of Labor
- Universities and community colleges
- Licensing boards
- Regulatory agencies
- Major medical systems

¹³⁵ Stearns, S., Cohen, M., & Kinsey, J. (2009). Reclaiming our future: A pathway for treating co-occurring mental health and substance use disorders in New Hampshire's adolescents and young adults. NAMI NH. Retrieved from <http://www.endowmentforhealth.org/uploads/resources/id42/NAMIReclaimingOurFuture.pdf>

- Representative providers
- Private insurers
- Families and service recipients

This type of collaboration will require strong executive and/or legislative support, and the particular expertise of an economist or labor expert may be helpful. Furthermore, any new statewide strategy should build on existing initiatives in the state. Maine has already undertaken several labor strategies to incentivize professionals to move to Maine, remain in-state, and work in the health care industry. Current strategies like *Live and Work in Maine* (otherwise known as The Opportunity Maine Tax Credit) may be better leveraged to target specific types of professionals or experience for the behavioral health field.¹³⁶

The strategic plan should pay particular attention to the challenges in rural areas of Maine. Recruiting and retaining a highly skilled behavioral health workforce is a greater challenge in rural areas of the state. However, young people who grow up in rural areas are more likely to remain in those areas if given the right opportunities. Nebraska has developed a specialized effort to target high school students in rural areas of the state and encourage them to enter the behavioral health field through the Ambassador Program.¹³⁷ While the program has many initiatives, one example is the Frontier Area Rural Mental-Health Camp and Mentorship Program (FARM CAMP).¹³⁸ For the past eight years, FARM CAMP has brought rural high school students together at a university to learn about careers in behavioral health. During the week-long camp students are exposed to the field through classes, talking with behavioral health professionals, case studies, and fun activities. After the camp ends the students maintain a relationship with program staff who provide mentorship and guide them towards opportunities in behavioral health after graduation. Maine could replicate this camp and other Ambassador Program activities through partnerships with universities, community colleges, and behavioral health providers.

Maine may be able to develop special internships to encourage students in rural areas of the states to pursue careers in behavioral health. For example, in Appalachian Virginia, Stone Mountain Health Services, a federally qualified health center, developed a partnership with two universities to provider internship training sites for psychology and social work students under an integrated behavioral health model with primary care. The program not only impacted the local behavioral health workforce but also resulted in increased behavioral health care access for the region.¹³⁹

Collect and analyze data on the current behavioral health workforce to understand capacity. Maine is not unique in its behavioral health workforce shortage, and throughout this assessment stakeholders reported that the challenges are present in both the child and adult behavioral health systems. Other states begin their strategic planning process through analysis of the current workforce, including its capacity and barriers to increased services across all health-related programs. This data can then be maintained and available in a public dashboard for analysis, policy planning, reimbursement changes, and other recommendations. Often this type of analysis is spurred by legislative action, as it was in New Mexico, Nebraska, and Washington described below.

¹³⁶ <https://www.liveandworkinmaine.com/>

¹³⁷ <https://www.unmc.edu/bhecn/programs/ambassador-program/index.html>

¹³⁸ <https://www.westernnebraskabehavioralhealth.com/FARMCAMP.en.html>

¹³⁹ <https://www.ruralhealthinfo.org/project-examples/772>

In 2011 New Mexico was facing a similar crisis in the behavioral health workforce and passed a legislative act to require a university to collect mandatory information from all health-related licensure boards at the time of their renewal and then analyzed this information to develop recommendations.¹⁴⁰ Data collected included education, training, specialties, average hours worked, percent of time in direct clinical activities, future plans for the next five years, and professional liability insurance costs. This information resulted in a centralized data sources that could be analyzed to inform statewide planning efforts. As a result of this study, New Mexico took a series of decisive steps to increase the workforce as shown in Figure 28 below.

Finding	Action(s)
Need for behavioral health workforce planning at the state level	<ul style="list-style-type: none"> • Behavioral Health Services Division developed 18-month strategic plan to address workforce issues • Behavioral Health Workforce Workgroup expanded to include statewide stakeholders
Need to integrate primary care and behavioral health in keeping with national trends	<ul style="list-style-type: none"> • Enhancement of behavioral health services by several state FQHCs • Pilots of behavioral Health Homes for individuals with SMIs and SEDs
Scarcity of independently licensed social workers and counselors in rural counties	<ul style="list-style-type: none"> • Behavioral Health Services Division initiated pilot of telehealth supervision to rural clinicians • Adjustment of clinical supervision requirements by professional licensing boards to improve access to high-quality supervision
Need to address shortages through improved recruitment of behavioral health professionals	Passage of New Mexico 2016 Senate Bill 105, reducing barriers to licensure of applicants licensed in good standing in other jurisdictions
Need to address shortages through improved retention of behavioral health professionals	Passage of New Mexico 2016 House Bill 54, making social workers and counselors eligible for rural practice state tax credits (currently undergoing financial and recruitment impact analysis)

FQHC, federally qualified health center; SMI, serious mental illness; SED, serious emotional disturbance.

Figure 28. Summary of state response to workforce analysis in New Mexico

Nebraska began conducting behavioral health workforce analysis through a legislative act in 2009 to create the Behavioral Health Education Center of Nebraska (BHECN)¹⁴¹, which is a partnership among the state legislature, universities, and community partners. The Center is tasked with conducting behavioral health workforce analysis, maintaining a public dashboard with workforce data, and issuing annual legislative reports summarizing their initiatives to address the shortage of licensed behavioral health professionals.¹⁴²

In 2007 the Washington State Legislature and Governor commissioned an assessment of the behavioral health workforce and utilized Federal Workforce Innovation and Opportunity Act (WIOA) funds to support the study.¹⁴³ It resulted in a report containing recommendations with an emphasis on integrated care as well as coordination of state agencies and resources, value-based purchasing models, increased training and supervision, expanding capacity through telehealth, and other workforce strategies.

Follow current workforce issues across the adult and children’s behavioral health system and develop comprehensive recommendations to improve the workforce. Because the workforce in Maine is fluid, strategies across the adult and child behavioral health systems will be more effective than those

¹⁴⁰ Altschul, D. B., Bonham, C. A., Faulkner, M. J., Pearson, A. W. F., Reno, J., Lindstrom, W., ... & Larson, R. (2018). State legislative approach to enumerating behavioral health workforce shortages: lessons learned in New Mexico. *American journal of preventive medicine*, 54(6), S220-S229.

¹⁴¹ <https://www.unmc.edu/bhecn/index.html>

¹⁴² <https://www.unmc.edu/bhecn/documents/FY16-17-legislative-report.pdf>

¹⁴³ Gattman, N.E., McCarty, R.L., Balassa, A., Skillman, S.M. (2017). Washington State Behavioral Health Workforce Assessment. Olympia, WA: Washington Workforce Training and Education Coordinating Board. Retrieved from <http://www.wfb.wa.gov/behavioralhealthgroup.asp>

done in siloes. When collecting data on the behavioral health workforce, Maine should develop minimum data set elements that capture provider demographics, licensure, education and training, area of practice, and other characteristics (see brief from the Behavioral Health Workforce Research Center *Table 1* for example data elements).¹⁴⁴

Other potential strategies to increase recruitment and retention of a highly qualified behavioral health workforce include:

- Targeted recruitment of underemployed groups like immigrants, veterans, and/or people with disabilities
- Expansion of broadband and cell phone coverage in rural areas to support rural workers
Assessment of salary comparisons to non-behavioral health career options
- Assessment of factors related to retention and job satisfaction through surveys or focus groups with current behavioral health staff¹⁴⁵
- Investments in high-quality supervision¹⁴⁶
- Investments in evidence-based practices and training to increase skill level¹⁴⁷ (see Recommendation 11)
- Increased utilization of psychiatric mental health nurse practitioners (particularly for medication management)¹⁴⁸
- Differential rates for providers in rural areas of the state to cover transportation costs and incentivize employees and programs (for example, Pennsylvania pays regional rates through their Medicaid State Plan)

For additional discussion on behavioral health workforce issues see the Milbank Memorial Fund Issue Brief on *Behavioral Health Integration and Workforce Development*.¹⁴⁹

17. Clarify roles, responsibilities, and mechanisms to ensure that children's behavioral health services are safe, effective, and high quality.

Responsibility: System of Care
Timeframe: Long-Term

This assessment revealed that children's behavioral health service quality and the experience of children and families varies depending on the service and the provider. There is no consistent mechanism for DHHS or other entity to oversee the quality of services across the service array on a consistent basis and most

¹⁴⁴ Beck, A. J., Singer, P. M., Ronald, W., Buerhaus, P., Tuohy, C. M., II, N., ... & Boulton, M. L. (2016). A minimum data set for the behavioral health workforce. Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA1_MDS_Full-Report.pdf

¹⁴⁵ Buche, J., Beck, A.J., and Singer, P.M. (2016). Behavioral health workforce challenges: Recruitment, retention, and work environment. Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2016/10/FA2P1_Workforce_Challenges_Policy_Brief.pdf

¹⁴⁶ Carpenter, J., Webb, C., Bostock, L., & Coomber, C. (2012). Effective supervision in social work and social care. *Bristol: Social Care Institute for Excellence*.

¹⁴⁷ Kadis, J. (2001). Workforce planning: how to recruit and retain mental health workers. *Ilru Exchange*, 2(1). Retrieved from http://www.nasuad.org/sites/nasuad/files/hcbs/files/23/1100/Vol_2_Iss_1.pdf

¹⁴⁸ Chapman, S. A., Phoenix, B. J., Hahn, T. E., & Strod, D. C. (2018). Utilization and economic contribution of psychiatric mental health nurse practitioners in public behavioral health services. *American journal of preventive medicine*, 54(6), S243-S249. Retrieved from [https://www.ajpmonline.org/article/S0749-3797\(18\)31603-9/pdf](https://www.ajpmonline.org/article/S0749-3797(18)31603-9/pdf)

¹⁴⁹ <https://www.milbank.org/wp-content/uploads/2018/05/Milbank-Memorial-Fund-issue-brief-BHI-workforce-development-FINAL.pdf>

monitoring is more reactionary than proactive. When providers do receive monitoring, it comes from different entities, which can be redundant or even contradictory. There is a lack of clarity and limited authority on the part of OCFS to monitor and oversee services. The result is that the system of care has limited oversight and opportunity for providers or system partners to receive feedback on their performance and outcomes or improve services.

DHHS should convene a workgroup from the relevant oversight agencies to review the current roles and responsibilities related to quality assurance for children's behavioral health services. CBHS services are overseen by a variety of entities, including licensing, program integrity, contract management, monitoring around children's rights, and incident reporting and investigation. Information gathered through any one element of the oversight process should inform the others through coordinated data sharing and policy. To accomplish this the workgroup should:

- Document gaps and areas of duplication;
- Identify opportunities for improved coordination, efficiency, and oversight, including how all of the agencies can work together to create the feedback loop in Figure 29 below;
- Identify the data sharing agreements that should be developed;
- Document new processes and staff and agency roles and responsibilities; and
- Make recommendations for the necessary staff and budget to improve oversight.

Figure 29 below captures the iterative ways in which mutually helpful information should be shared and coordinated. For example, as states have begun to collect data on restraints and seclusions, they have modified licensing standards to include provisions for behavior management policies that limit the use of restraint/seclusion, and they have modified provider contracts and performance expectations to do the same.

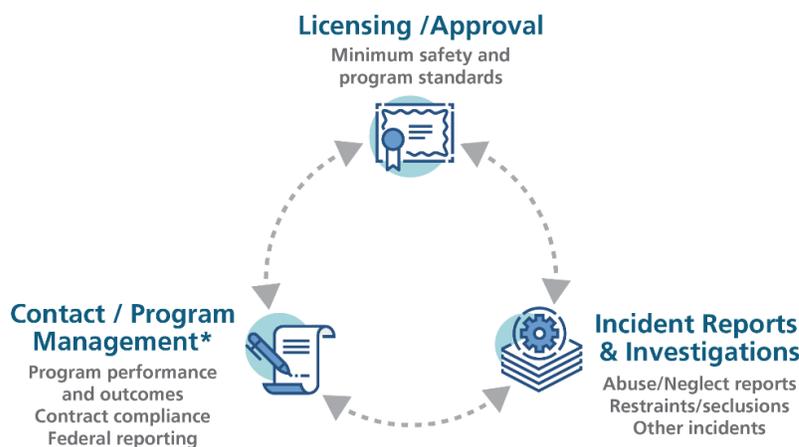


Figure 29. Feedback loop between monitoring entities

Strengthen provider contracts to create greater accountability for quality. Currently, there are few performance measures in contracts, and there is limited recourse for OCFS or families if they are not satisfied with services. Other state children's behavioral health systems have developed performance standards and have strengthened contracts with specific process and outcome standards providers are expected to meet. To accomplish this, **DHHS should develop a logic model that defines the expected inputs, processes, outputs, and outcomes and develop performance standards derived from the logic model.** Performance standards may include outcomes as well as processes that are associated with

positive outcomes. For example, participation in Child and Family Treatment Team meetings is a process that is associated with better outcomes for children, youth, and families, so it may be important to measure that. Measures will need to be appropriate for the type of service being offered and the population of children served. For example, one aim for the Care Management Organizations (see Recommendation 8) would be to connect children and families to appropriate services as quickly as possible and in the least restrictive setting. Examples of measures that may be appropriate for CMOs may include:

- ✓ Length of time from referral to service initiation
- ✓ Rate of inpatient hospitalization and/or out of home placement
- ✓ Rate of emergency room visits
- ✓ Family satisfaction with services
- ✓ Child and family functioning changes as measured by CANS or other assessment tool

These would be similar to measures in other states that utilize care management models. The measures can be established as benchmarks, such as “75 percent of children involved with a CMO will not experience an inpatient admission during their involvement or for 6 months following involvement.” Alternatively, baseline rates can be established with expected improvement over time.

The Kansas Mental Health Office at the Kansas Department of Social Rehabilitation contracted with the University of Kansas to develop a state-level performance management system, specifically for PRTFs.¹⁵⁰ The researchers collaborated with stakeholders to develop a PRTF program logic model. The program model outlined the inputs and resources of the system; the associated activities and processes expected of those resources; and ultimately the immediate, mid-term, and longer-term outcomes that would be anticipated. The program model is illustrated in Table 12 below.¹⁵¹ The research team ultimately developed a series of performance measures for PRTFs in three broad domains: Access, Process, and Outcomes detailed in Table 13, also below.¹⁵²

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¹⁵⁰ PRTFs provide out of home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting in Kansas. Retrieved from <https://www.kdads.ks.gov/commissions/behavioral-health/consumers-and-families/services-and-programs/prtf>

¹⁵¹ Kapp, S.A, et al. (2011). Building a Performance Information System for Statewide Residential Treatment Services. Kansas Department Social Rehabilitation Services, Division of Disability and Behavioral Health Services. Routledge Taylor & Francis Group.

¹⁵² Kapp, S.A, et al. (2011). Building a Performance Information System for Statewide Residential Treatment Services. Kansas Department Social Rehabilitation Services, Division of Disability and Behavioral Health Services. Routledge Taylor & Francis Group.

Table 12. Psychiatric Residential Treatment Facilities (PRTF) Kansas Program Model

1.0 Resources	2.0 Staff Activities	3.0 Program Processes	4.0 Immediate Outcomes	5.0 Intermediate Outcomes	6.0 Long-Range Outcomes
					
<ul style="list-style-type: none"> • Funding Staff <ul style="list-style-type: none"> ○ Leadership ○ Supervisors ○ Direct Care Workers ○ Mental Health Professionals ○ Drug/Alcohol Counselor ○ Medical Professionals ○ Activity Coordinator ○ Teachers ○ Chaplain ○ Support Staff • Clients • Facilities • External Community Agencies • Families • Case Workers 	<ul style="list-style-type: none"> • Individual therapy • Group therapy • Family therapy • Expressive therapy • Recreational therapy • Crisis intervention • Psychiatric consultation • Medication management • Medical care • Case management • Community activities • Residential care • Education • Clinical supervision • Staff development • Information collection 	<ul style="list-style-type: none"> • Screening, assessment, diagnosis • Treatment team formation • Treatment planning • Activities coordination • Ongoing treatment interventions • Regular treatment plan reviews • Information collection • Transition planning Discharge 	<ul style="list-style-type: none"> • Successful completion of treatment plan • Restraint and seclusion-free setting • Safe, secure therapeutic environment • Stabilize and modify behavior • Symptom reduction and management • Skill-building and self-regulation • Medication management • Functioning improvement • Substance abuse recovery • Increase self-efficacy • Secure least restrictive placement 	<ul style="list-style-type: none"> • Maintain less restrictive placement • Maintain connection with community services • Continue to maintain healthy behaviors • Continue to practice pro-social skills • Stabilize and maintain work or education • Maintain positive view of self-concept and abilities • Maintain high level of functioning in family, community, and independent living situation 	<ul style="list-style-type: none"> • Successful reintegration into community • Becoming a healthy and productive member of society that makes a positive contribution

Table 13. Psychiatric Residential Treatment Facilities (PRTF) Kansas Performance Measures		
Domain	Indicators	Measures
Access	Access to services	<ul style="list-style-type: none"> ✓ Length of time from referral/acceptance to admission ✓ Length of time from screening to admission ✓ The ratio of acceptance to denial of referrals ✓ The reason of denial by agency
	Follow-up care	<ul style="list-style-type: none"> ✓ Percent of parent or caregiver response to consumer satisfaction survey questions about availability and acceptability of services for child/youth
	Follow-up care	<ul style="list-style-type: none"> ✓ Average length of time for clients between discharge and next face-to face visit at community- based services
Process	Youth and caregiver’s participation in treatment	<ul style="list-style-type: none"> ✓ Percent of children/youth with caregivers satisfied with participation in treatment
	Treatment plan completion	<ul style="list-style-type: none"> ✓ Percent of children/youth with treatment plan completed at discharge ✓ Reasons for non-completion of treatment plan prior to discharge
	Serious occurrence	<ul style="list-style-type: none"> ✓ Total number of serious occurrences <ul style="list-style-type: none"> ○ Number of deaths ○ Number of injuries requiring medical care ○ Number of suicide attempts
	Use of restraint and seclusion	<ul style="list-style-type: none"> ✓ Percent of change in use of restraint, seclusion per month
	Length of stay	<ul style="list-style-type: none"> ✓ Length of stay by agency
Client Status Outcomes	Clients’ satisfaction with services	<ul style="list-style-type: none"> ✓ Percent of caregivers satisfied with services measured by the Ohio scales ✓ Percent of child/youth satisfied with services measured by the Ohio scales
	Improvement in clients’ functioning and symptom reduction	<ul style="list-style-type: none"> ✓ Two scores over a period of time (at admission and at discharge) in the Problem Severity domain in Ohio Scales ✓ Two scores over a period of time (at admission and at discharge) in the Functioning domain in Ohio Scales
	Restrictiveness of living environment	<ul style="list-style-type: none"> ✓ Percent of child/youth whose primary residence was listed at discharge as their own home or foster care in the FY ✓ Percent of child/youth who maintained the level of care at 90 days after discharge
	Return to PRTF	<ul style="list-style-type: none"> ✓ Percent of readmission to agency within 90 days

DHHS should explore which children’s behavioral health services would be well-suited to performance-based contracting. Medicaid has been increasingly shifting from traditional fee-for-service models to performance-based or value-based models for health care services, although this trend has been slower for behavioral health services. One example of where pay-for-performance is already being utilized in Maine is with behavioral health homes. In April 2018, a Pay-for-Performance provision for Behavioral Health Home (BHH) providers was

implemented, placing one percent of total BHH payments at risk pending performance on a quality measure. Table 14 below outlines different types of performance-based funding arrangements that DHHS could consider.

Table 14. Examples of Performance-based Funding			
Type	Description	Considerations	Examples
Capitated or Global Payments	Prospective payment to cover a fixed period, based on historical staffing levels, service volume, and desired service capacity.	<ul style="list-style-type: none"> Creates incentive for providers to select a blend of services to meet a person’s specific needs, achieve certain outcomes, and to manage efficient cost structures. Substantial risk if case volume or acuity increases. More complex to implement than fee-for-service. 	Emergency services such as homeless shelters, domestic violence services, and crisis services.
Case Rate or PMPM (per member per month or per case)	Prospective payment to cover the cost of a case; tied to case volume.	<ul style="list-style-type: none"> Same as above except mitigates the risk associated with case volume. More complex to implement than fee-for-service. As enrollment increases, the total number of payments increases, but the payment per case or member remains constant. 	Care management entities, Wraparound, or intensive care coordination services.
Bundled/Episode Payments	Providers receive a pre-determined amount to cover all services associated with a particular condition.	<ul style="list-style-type: none"> Same as above. 	Patient-Centered Opioid Addiction Treatment: Providers receive a bundled payment to cover Initiation of Medication-Assisted Treatment (IMAT) for the first month of services including evaluation, diagnosis, and treatment planning for a patient with an opioid use disorder and the initial month of outpatient MAT. Following this one-time payment, the provider receives a different monthly bundled payment for Maintenance of Medication-Assisted Treatment (MMAT) to cover the monthly costs to provide or coordinate the provision of ongoing outpatient medication,

Table 14. Examples of Performance-based Funding			
Type	Description	Considerations	Examples
			psychological treatment, and social services. ¹⁵³
Outcomes-Based Payments	Contract payment (or partial payment) is made once performance targets are achieved. Incentive payments, where payment is made in addition to base operating costs, are also an option.	<ul style="list-style-type: none"> Creates incentives for providers to achieve certain outcomes. Providers may have to carry costs prior to targets being met. Substantial reporting and tracking demands on the part of providers and managing entities. More complex to implement than fee-for-service or the options above. 	Maine utilizes this model with behavioral health homes whereby 1 percent of their contract payments are at risk associated with timely diabetes screening for certain members.

Aligning payment structures to better support program goals requires careful analysis, planning, and monitoring. Below are examples of how states are applying the options above to behavioral health services.

- ✓ With the goal of reducing inpatient mental health utilization, Allegheny County’s behavioral health MCO implemented a pay-for-performance program for Assertive Community Treatment (ACT) services. ACT providers could earn up to 110 percent of the current fee schedule rate for ACT services by reducing inpatient mental health hospitalization and reducing the average inpatient mental health hospitalization cost per person. In 2014, both ACT providers earned the full 110 percent with a 64 and 28 percent reduction in the average inpatient cost per person per year, respectively.¹⁵⁴
- ✓ In 2016, TennCare launched Tennessee Health Link, a program that incentivizes enhanced care coordination for members with serious behavioral health conditions. Under this program, care teams coordinate behavioral and physical health care for an assigned group of members. Providers can earn outcomes payments based on performance in core quality and efficiency metrics. Providers are evaluated on 15 measures that assess efficiency (such as all-cause hospital readmissions, emergency department visits, mental health inpatient utilization, etc.) and quality (such as psychiatric hospital readmission rates and antidepressant medication management, initiation and engagement of alcohol and drug dependence treatment, body mass index and comprehensive diabetes care, etc.). Outcome payments depend on the extent to which providers meet or exceed state- and MCO-established thresholds for each measure.¹⁵⁵

One challenge in implementing performance- or value-based purchasing models in behavioral health settings is that there are not as many universally recognized outcome measures for behavioral health as there are for physical health services.¹⁵⁶ One way to address this is to focus early on process measures that are associated with positive outcomes and gradually build up to measuring outcomes. This allows time to agree on the measures as well as the data that will be used for reporting the measures.

¹⁵³ American Society for Addiction Medicine. (2018). Patient Centered Opioid Addiction Treatment: Alternative Payment Model. Retrieved from: https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2

¹⁵⁴ <https://www.chcs.org/media/VBP-BH-Brief-061917.pdf>

¹⁵⁵ <https://www.chcs.org/media/VBP-BH-Brief-061917.pdf>

¹⁵⁶ <https://www.chcs.org/media/VBP-BH-Brief-061917.pdf>

Below are some keys to success based on lessons learned in jurisdictions that have implemented performance-based contracting:

- **Obtain a high level of support.** These initiatives require legislative and executive support to be successful. Performance-based contracting can be complex and controversial; high level support from government will encourage negotiation and help maintain momentum during challenging times.
- **Utilize performance-based contracting to improve outcomes and quality.** Focus on the goal of improved outcomes and better quality, rather than cost savings. Payments should cover the cost of care “as is” at first, rather than assuming immediate performance improvement. Up-front investments may be needed to improve the capacity of the system, but cost savings may occur over time as performance improves.
- **Involve a broad range of stakeholders in developing the payment model.** Plan for a long, collaborative planning process that substantially involves any private agencies that will share financial risk and reward.
- **Allow sufficient time for implementation.** The system may need to develop capacity before providers can meet certain measures. Additionally, IT payment and reporting changes may be required, as well as contract revisions, rate calculations, etc. Local and state staff dedicated to this effort will need support with their other responsibilities. Some states have implemented “hold harmless” periods while the new system is being “tested”.
- **Carefully develop the payment model** to factor in issues such as caseload and acuity risk, provider cash flow, and prospective policy changes.
- **Develop capacity for real-time data reports** so that payers and providers have the tools needed to manage the system going forward.
- **Talk to other jurisdictions** that have implemented performance-based contracting, especially neighboring states or states implementing similar models, to better understand how they were successful and their lessons learned.
- **Monitor for unintended consequences.**

DHHS should increase public transparency on the quality of services through provider scorecards and/or public reporting dashboards. Other health care services, public education systems, and child care agencies all have a form of public rating systems resulting in a scorecard, “grade”, or some other measure of transparent quality indicators. Although not widely used in behavioral health at this time, this type of accountability has been proposed¹⁵⁷ and utilized in an inpatient setting.¹⁵⁸

One example of a state that has implemented this model is Arizona. Arizona reports behavioral health outcomes by geographic service areas and the behavioral/physical health managed care organizations that cover those areas. In Table 15 below we provide a sample of their children's behavioral health scorecard for six managed care organizations in Arizona.¹⁵⁹

¹⁵⁷ Santiago, J. M. (1999). Use of the balanced scorecard to improve the quality of behavioral health care. *Psychiatric Services*, 50(12), 1571-1576.

¹⁵⁸ Lin, E., & Durbin, J. (2008). Adapting the balanced scorecard for mental health and addictions: An inpatient example. *Healthcare Policy*, 3(4), e160.

¹⁵⁹ <https://www.azahcccs.gov/AHCCCS/Downloads/Dashboard/scorecard-summary-gsa-child.pdf>

Table 15. Example children's behavioral health scorecard from MCOs in Arizona

OUTCOMES: Has quality of life improved for individuals served by the behavioral health system?

	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	MCO 6
Drug/alcohol use history, now reduced or no use	62.2%	63.6%	58.0%	57.6%	54.8%	55.5%
Are not homeless	99.9%	99.6%	99.8%	99.8%	99.9%	99.7%
Are employed	11.7%	0	0	0	66.7%	14.1%
Attend school	84.5%	86.7%	85.5%	85.5%	81.4%	88.1%
Have no recent criminal justice involvement	94.9%	98.0%	98.0%	98.7%	95.6%	98.2%
Participate in self-help groups	22.5%	2.7%	7.0%	1.4%	1.4%	3.0%

ACCESS: Do individuals and families have access to recovery and resiliency oriented services?

Are satisfied with their access to services	93.0%	90.7%	92.0%	90.9%	83.1%	80.7%
Receive timely services	83.0%	95.0%	96.9%	96.0%	92.8%	89.7%
Live within 15 miles of an outpatient clinic	82.2%	98.6%	93.0%	91.3%	98.0%	99.2%

SERVICE DELIVERY: Are services provided based on the needs of individuals and families?

Participate in their treatment plans	96.0%	93.1%	92.5%	93.2%	93.6%	91.9%
Have a current and complete service plan	88.2%	87.5%	87.5%	82.4%	70.6%	88.2%
Receive services identified in their treatment plan	78.6%	93.3%	85.7%	82.4%	71.4%	100%

Maine is already utilizing a dashboard style of public reporting for BHH providers to indicate the percent of children receiving recommended ADHD treatment according to AAP guidelines. DHHS utilizes MaineCare claims data to determine if children 4-18, assigned to a BHH, with a diagnosis or prescription for ADHD medication, are receiving appropriate clinical services.¹⁶⁰

¹⁶⁰ <https://www.maine.gov/dhhs/oms/vbp/reporting/bhh-adhd.shtml>

18. Establish local Care Review process to support team decision making and best practices.

Responsibility: System of Care
Timeframe: Long-Term

Currently, local systems of care – comprised of providers, educators, juvenile justice, the medical community, advocates, families, and others – are not well coordinated or leveraged to help CFTTs make decisions, identify best practices, or promote local accountability. Throughout this assessment we heard from stakeholders that in some communities different system of care partners are not well-connected nor do they engage in collective community-level problem solving.

One strategy to promote collaboration, support families and children, and strengthen the local system of care is to develop a statewide process to establish and maintain local Care Reviews. For examples of other states, see Care Reviews in North Carolina¹⁶¹ and Family Assessment and Planning Team (FAPT) in Virginia.¹⁶² In a state as large as Maine, these Care Reviews may be county-specific or regionally defined – based on appropriate capacity and in line with populations. A Care Review is a group of individuals who are appointed, elected, or volunteer to serve on a multi-disciplinary team for an established period of time and commit to full participation and regular attendance at meetings. Members of a Care Review can and should be diverse, including:

- A family member or young adult with lived experience in behavioral health services
- Representative service provider(s)
- OCFS Children's Behavioral Health Services staff
- Juvenile justice
- Child welfare
- School social worker or administrator
- Family/pediatric medical professional or social worker
- Public health
- Guardian ad Litem, CASA, or other advocates
- Other community members as identified

These members provide expertise in their respective areas but are not expected to have, nor should they be involved, with the specific treatment of cases that come before the Care Review. Their role is to serve a group of experts and to offer guidance, approval, recommendations, and support to children, families, and treatment teams. Furthermore, each Care Review should have administrative support to facilitate scheduling, report sharing, and documenting next steps. Members are motivated to participate because they want to impact their local system of care and improve services for children. Behavioral health providers may also see Care Review as a mechanism to improve access and coordination for their clients, or they may be required to participate based on contractual obligation.

The Care Review should have an established purpose outlined in its charter and may serve one or more of the following roles, as similar organizations do in other states:

- Consultation regarding complex, unique, or “stuck” cases
- Approval for residential treatment (in state or out-of-state)
- Approval of flex funding or special programs

¹⁶¹ <https://www.alliancebhc.org/wp-content/uploads/Alliance-CareReview-2018.pdf>

¹⁶² https://www.csa.virginia.gov/content/doc/CSA_User_Guide_2018_Update.pdf

- Support transition to adult services
- Venue to organize and analyze around local themes impacting service access, quality, or cost
- Engage in collective troubleshooting to address service gaps or policy barriers
- Provide systematic feedback to central organizers at DHHS for analysis and recommendations

Care Reviews should occur on a regularly scheduled basis (with specific cases scheduled in advance through administrative support), with some flexibility for ad hoc or crisis case reviews as needed. Any member of the CFTT, including the family, can request a Care Review. However, they cannot occur without the identified client (or guardian) present. Care Reviews are not the same as the CFTT or the Case Coordination Unit (CCU), who are responsible for the day-to-day oversight of the treatment plan and provide specific support for children in crisis without a discharge plan. While the Care Review may get to know individual children and families through repeated meetings, their role is that of an advisory capacity and not to offer direct services.

While this recommendation requires strong participation from the system of care and local leadership, the investments in establishing a standardized process will pay off in services that are better coordinated and result in increased innovation, problem-solving, and local accountability for the children of Maine.

19. Expand access to high-quality children’s behavioral health expertise across the state.

Responsibility: System of Care
Timeframe: Long-Term

While access to services is limited across the state, these issues are particularly salient in rural areas of Maine. One strategy to address access issues is to expand capacity for other health care professionals to deliver behavioral health services including assessment, medication management, and treatment services. While many families turn to their primary care physicians for support, these providers may lack the skills and support to effectively treat behavioral health concerns in their practice. It is critical for primary care physicians to have the knowledge, skills, tools (including specific assessment and screening tools), and confidence to identify, assess, and treat behavioral health conditions in children appropriately.

In many states, including Maine, the “hub and spoke” model has been a successful platform to spread expertise from urban hospitals and academic centers (hubs) to rural primary care physicians (spokes). Project ECHO (Extension for Community Healthcare Outcomes)¹⁶³ provides a framework for the hub and spoke model, which has been implemented across the country for many health conditions, including substance abuse and children’s behavioral health (ADHD, Autism, conduct, etc.). In this model, the “hubs” provide didactic presentations through video conferencing to multiple “spokes” in a small group format over one or a series of sessions. Providers may also present de-identified cases for consultation but the model does not provide

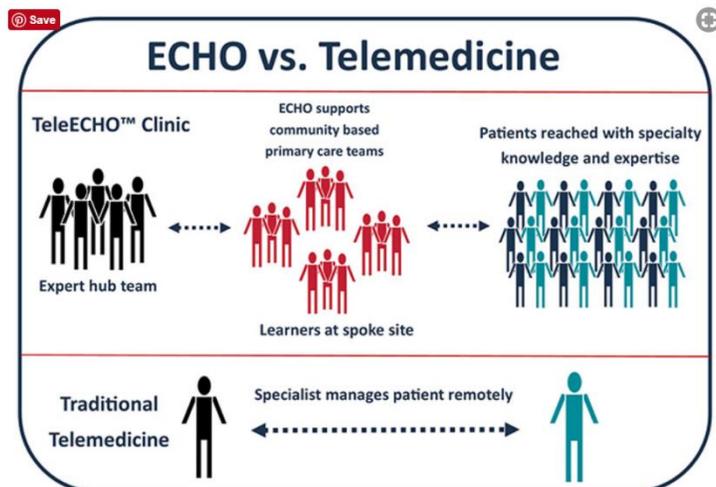


Figure 30. Hub and Spoke (ECHO) versus Telemedicine

¹⁶³ <https://echo.unm.edu/about-echo/model/>

“telehealth” or direct patient services (see Figure 30, right, for a depiction of how “ECHO” differs from “Telemedicine”).¹⁶⁴ The motto of the hub and spoke model is “moving knowledge, not patients,” and the result is increased capacity for primary care physicians or behavioral health providers in rural areas of the state to identify and treat behavioral health conditions and reach more patients than telehealth alone. The hub and spoke model has been in use in Maine to expand access to adult substance use disorder treatment and aims to expand capacity to 900 individuals during fiscal year 2018.¹⁶⁵

The Massachusetts Child Psychiatry Access Program (MCPAP)¹⁶⁶ and New Jersey Pediatric Psychiatry Collaborative¹⁶⁷ are examples of another strategy to expand behavioral health access through enhanced capacity of primary care physicians. In these models, primary care physicians are connected with regional “hubs” through quick telephone access and can receive case-specific consultation from a child psychiatrist, clinical social worker, and/or nurse practitioner – all with expertise in children’s behavioral health issues. This model is supported by the National Network of Child Psychiatry Access Programs¹⁶⁸ and recommended by CMS as a strategy to support children with mental health conditions.¹⁶⁹ These programs are often funded through state general funds with the hope of reducing utilization of more intensive, expensive interventions.

Co-location, or integrated primary care and behavioral health services, are widely used to expand access to behavioral health services and can be effective when carefully implemented and well-supported. DHHS can establish a leadership role in working with Accountable Communities and other interested medical providers to support more integrated services in their practices. DHHS should use staff resources to help these providers identify and address common barriers such as insufficient staff, role confusion, sharing patient information, reimbursement models, and workflow practices. Best practices in integrated care include building a collaborative culture, orientation and training, and a cooperative approach, including a “warm hand-off”.¹⁷⁰

Maine may benefit from additional strategies aimed at integrating physical and behavioral health under one roof in rural areas, similar to a program in Northern Illinois, Florissa, that serves as “one stop shop” for assessment and treatment for all children in a region of state.¹⁷¹ Florissa has been funded by a federal grant from the Office of Rural Health Policy and is supported by health care organizations, the Illinois Department of Human Services, and private donations. The program provides pediatric care, speech, occupational, physical therapy, and behavioral health services, in addition to recreational activities. The program reports that as a result of their multi-disciplinary services, families better understand their child’s strengths and needs and feel more capable to help their child.¹⁷²

¹⁶⁴ <https://www.urmc.rochester.edu/project-echo.aspx>

¹⁶⁵ <https://mainehealth.org/about/health-index-initiative/prescription-drug-abuse-and-addiction/implementing-a-hub-and-spoke-treatment-model-in-our-communities>

¹⁶⁶ <https://www.mcpap.com/>

¹⁶⁷ <http://njaap.org/programs/mental-health/ppc/>

¹⁶⁸ <http://web.jhu.edu/pedmentalhealth/nncpap.html>

¹⁶⁹ CMS SMDL #18-011 “Opportunities to design innovative service delivery systems for adults with serious mental illness or children with a serious emotional disturbance.” November 13, 2018. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

¹⁷⁰ Buche, J., Singer, P. M., Grazier, K., King, E., Maniere, E., & Beck, A. (2017). Primary care and behavioral health workforce integration: Barriers and best practices. *Behavioral Health Workforce Research Center*, 1(1), 1-16. Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA2P3_Team-based-Care-Case-Studies_Full-Report.pdf

¹⁷¹ <https://www.ruralhealthinfo.org/project-examples/805>

¹⁷² http://florissacenter.org/wp-content/uploads/2017/09/2017_Florissa_Brochure.pdf

20. Develop behavioral health urgent care clinics.

Responsibility: System of Care
Timeframe: Long-Term

Similar to urgent care facilities that can triage and treat minor physical ailments, behavioral health urgent care is designed to help individuals in non-life-threatening crisis by providing a calm, trauma-informed environment for assessment, brief intervention, and referral. Behavioral health urgent care is not intended to replace emergency rooms, but to provide another option for individuals to receive specialized psychiatric care in a more appropriate setting. The addition of behavioral health urgent care will not eliminate the need for other crisis and hospital services, but could reduce stays in emergency departments and result in cost-savings for the health care system. This recommendation will be most successful if implemented with other system improvements to increase access to home- and community-based services and will require the participation of other system of care partners including hospitals and crisis providers. In other states, behavioral health urgent care clinics are often connected to major hospital systems or run by large community mental health providers and will probably be most successfully implemented in areas of the state where the population can support the costs of these specialized services.

Behavioral health urgent care is gaining traction in states throughout the country, including North Carolina, California, New York, and Idaho. In North Carolina, individuals access these services when they are in acute distress, require a medication refill, are unable to see their regular behavioral health providers, or need de-escalation before they can be in the community. Clinics are funded through Medicaid and the local managed care organization.¹⁷³ North Carolina is already experiencing positive outcomes; in a Durham clinic, the average visit lasts about two hours, 89 percent of clients assessed are seen by a physician that same day, 72 percent are discharged with a prescription, and 100 percent are referred back to their primary care doctor, existing behavioral health provider, or linked to a new behavioral health provider with a scheduled appointment upon discharge.

In New York and California there are behavioral health urgent care clinics that only serve children (ages 5 to 17).^{174,175,176} In New York one clinic offers the following services to patients: crisis psychotherapy, evidence-based screening and risk assessments, coordination of care, short-term crisis treatment, referral, and linkage to follow-up care. A clinic in California, funded through a philanthropic grant, staffs a psychiatrist, psychologist, clinical social workers, and a case manager. Similar behavioral health urgent care clinics have been funded in Idaho through state general funds that cover start-up costs and initial operations for two years, at which point clinics must incrementally increase self-sufficiency.¹⁷⁷

The design of behavioral health urgent care clinics in Maine should be tailored to meet the state's unique needs and would best serve both children and adults. Hours of operation in behavioral health urgent care vary – from 24/7 to 10am to 7pm, depending on the design and need. If this type of service is developed in Maine it will be critical to ensure that these centers do not become another place for individuals to get “stuck”, but rather a place to receive effective, time-limited services. Behavioral health urgent care providers will also have to be well-versed in the needs of individuals with mental health conditions, substance use disorders, developmental disabilities, and Autism. Established Accountable Communities may also present a useful pathway to pilot behavioral health urgent care in Maine.

¹⁷³ <https://www.alliancebhc.org/general-news-announcements/behavioral-health-urgent-care-clinic-bridges-crisis-care-gap/>

¹⁷⁴ <https://www.kids-care.com/wp-content/uploads/sites/3693/2017/08/PediatricBHUrgentCare.pdf>

¹⁷⁵ <https://pediatrics.northwell.edu/departments-services/pediatric-hospital-medicine/programs-services/pediatric-behavioral-health-urgent-care-center>

¹⁷⁶ <https://www.rchsd.org/programs-services/psychiatry/behavioral-health-urgent-care/>

¹⁷⁷ https://www.idahopress.com/news/local/idaho-senate-unanimously-passes-crisis-center-funding/article_fb70d9f1-da02-50f0-82eb-e162b0c994f8.html

21. Explore the use of Pay for Success to leverage philanthropic investments in evidence-based practices.

Responsibility: System of Care
Timeframe: Long-Term

Human services agencies are increasingly developing public-private partnerships to implement Pay for Success (PFS) programs. In a PFS model (see Figure 31 below), a private philanthropic partner or investor agrees to fund a pilot or start-up program with a strong evidence-base that they believe will demonstrate a good return on investment. A third-party evaluator monitors the implementation and delivery of the program and provides a neutral evaluation of its results. A government entity, such as a social services agency, agrees to back the investment with any savings and fund the program on an ongoing basis if successful; however if the program is unsuccessful the investor loses their investment or fails to make a profit.

Pay for Success has been widely used for social issues including reducing chronic health conditions, preventing criminal recidivism, housing programs, and funding early childhood development programs. The model is most successful when programs are focused on prevention/diversion – diverting participants from more intensive, expensive services to lower cost, more effective programs and services, and require specific outcomes (results not activities). Additionally, PFS should be used with scalable programs that have evidence of strong, replicable outcomes, the program generates savings, and the savings accrue to one government unit.¹⁷⁸

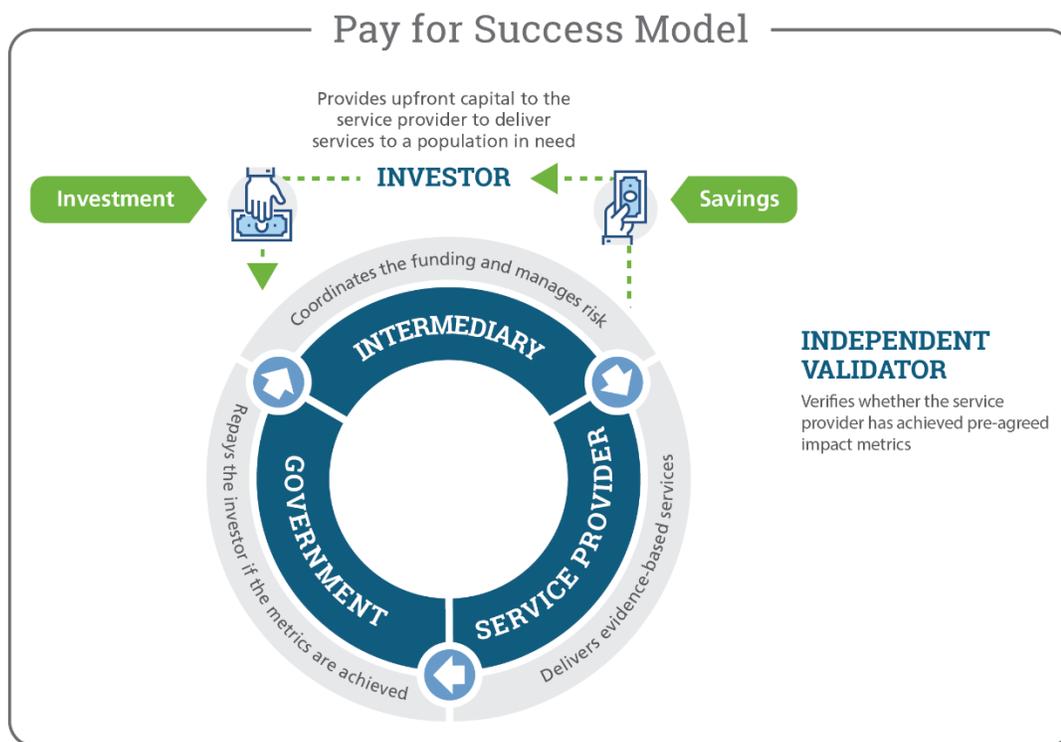


Figure 31. Pay for success model

¹⁷⁸ Weil, K. (ND). The Colorado Future: Rethinking public and private roles. Lecture for the University of Denver. Retrieved from <https://www.mentalhealthamerica.net/sites/default/files/DU%20April%2011%20Policy%20Course%20FINAL.pdf>

Pay for Success presents an opportunity for Maine to test services and programs with a strong evidence-base and see if they can successfully divert children away from more intensive, restrictive, and expensive interventions with minimal financial risk to the government. There are some cautions when considering PFS programs. Even with adequate funding, scaling up services to reach larger populations is difficult, and if programs over-promise on their outcomes and fail to deliver, an entire practice can be discredited. PFS also requires the government to make a commitment to follow-through in a multi-year contract and give programs the opportunity to establish themselves and return results.

In 2015, Maine's state legislature ordered a study of PFS as a funding mechanism for extended learning programs and pre-kindergarten programs.¹⁷⁹ The report, conducted by the Maine Education Policy Research Institute, concluded that PFS (also known as social impact bonds) is a promising opportunity to support public education programs in Maine and initiate innovative approaches in education.¹⁸⁰ While the report focused on educational programs, there are some challenges for rural states to consider including: sample size, capacity of service providers to scale up, staffing and expertise in cost-benefit analysis, and available lenders/investors. The report recommended the following next steps:

1. Create legislation that enables officials to enter pay-for-performance contracts, and secures funding for development and repayment of such contracts.
2. Use rigorous research findings to select a targeted educational service that is an area of need in Maine or a specified region of the state and would result in positive and monetizable results.
3. Engage key private partners to discuss potential areas of service and financing structures.
4. Identify dedicated capacity within government agencies.

22. Strengthen the relationship between juvenile justice and CBHS.

Responsibility: System of Care

Timeframe: Long-Term

As discussed in Finding 5 above, the coordination between juvenile justice and CBHS at the state and individual client level could be strengthened. DHHS and DOC could employ a number of strategies improve communication, coordination, and service delivery for mutual clients. Improved relationships can streamline access to services, reduce inefficiency, and ultimately improve outcomes for children. These strategies may include:

- DOC participation in a Children's Cabinet, Children's Mental Health Oversight Committee, and other groups (see Recommendation 2 above).
- Develop a protocol and best practices for managing cases with juvenile justice and behavioral health involvement.
- Develop a common vision and measurable objectives for DOC and DHHS around mutual youth.
- Collect data on dually-served youth to drive decision-making and inform service array. Examine specific points of interactions such as entry/exit from juvenile justice or behavioral health services.
- Organizational changes to move juvenile justice from DOC to OCFS.

Additionally, DOC can continue to expand their current investments in evidence-based practices like MST and FFT through continued collaboration with OCFS and MaineCare. The state has made great progress towards moving youth from institutional correctional facilities and can continue to explore innovative models for juvenile justice that

¹⁷⁹ https://www.mainelegislature.org/legis/bills/bills_127th/billtexts/HP028501.asp

¹⁸⁰ Stump, E.K. and Johnson, A.F. (2016). An examination of using social impact bonds to fund education in Maine. Retrieved from https://usm.maine.edu/sites/default/files/cepare/Examination_of_Using_Social_Impact_Bonds_to_Fund_Education_in_Maine.pdf

consider the youths' mental health issues, such as *The Missouri Model*.¹⁸¹ Another helpful resource for innovation at the intersection of juvenile justice and mental health services comes from the National Center for Mental Health and Juvenile Justice, which highlights other successful initiatives in Louisiana and Connecticut.¹⁸²

In addition to the ideas above, some states have pulled together multi-disciplinary teams to improve collaboration between behavioral health and juvenile justice systems. In 2015, Florida Governor Rick Scott charged the state's Corrections, Juvenile Justice, Children and Families, Health, and Health Care Administration agencies to conduct a comprehensive review of behavioral health service delivery, including cross-agency coordination and the availability and effectiveness of institutional care compared with community care in three pilot counties. The Department of Corrections and the Department of Juvenile Justice developed inventories of their current investments in adult criminal justice and juvenile justice programs. Using detailed information on costs and evidence of effectiveness, the agencies are identifying areas for improvement in their contracting practices and are working to prioritize program funds going forward. The departments are now collecting data to conduct cost-benefit analyses of their programs to assess and predict the investment value of current and potential program offerings.¹⁸³

23. Conduct further analysis on the coordination between behavioral health services and the educational system.

Responsibility: System of Care
Timeframe: Long-Term

Often children with behavioral health issues are first identified in schools where their symptoms and behaviors present challenges in learning, socializing, and participating in the school community. Schools are the first opportunity for screening and early intervention for these children and families, and when those initial services are insufficient, schools must work with outside providers to refer and coordinate additional treatment options. Children who require more intensive interventions, like day treatment or residential services, require careful coordination between these treatment providers and their home school system. In a recent letter to State Medicaid Directors, CMS encouraged states to consider how to use the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to provide medically necessary services in schools, including mental health screening and counseling.¹⁸⁴ Throughout our assessment we heard from families, providers, and other stakeholders that these relationships could be strengthened and coordination improved. While a full analysis of the coordination between the educational system and behavioral health services was outside the purview of this assessment, DHHS and the larger system of care should conduct further analysis on this coordination.

An in-depth analysis of the educational and behavioral health services systems could potentially explore:

- Communication between DHHS and Department of Education (DOE)
- Opportunities for improved collaboration between schools and providers
- Establishing Memorandums of Understanding or other agreements
- The nature of the funding sources that support the treatment for mutual children
- Specific legal obligations and regulations governing both systems

¹⁸¹ Mendel, R.A. (2010). *The Missouri Model: Reinventing the practice of rehabilitating youthful offenders*. The Annie E. Casey Foundation. Retrieved from <https://www.aecf.org/m/resourcedoc/aecf-MissouriModelFullreport-2010.pdf>

¹⁸² Mental Health and Juvenile Justice Collaborative for Change (2014). *Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System*. Retrieved from <https://www.ncmhjj.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf>

¹⁸³ The Pew MacArthur Results First in Florida (2016). Retrieved from <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/03/the-pew-macarthur-results-first-initiative-in-florida>

¹⁸⁴ CMS SMDL #18-011 "Opportunities to design innovative service delivery systems for adults with serious mental illness or children with a serious emotional disturbance." November 13, 2018. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

- Opportunities to maximize Federal revenue for services
- Pilots or other promising practices in specific areas of the state
- Barriers to co-location or embedded clinical services in schools
- Opportunities for evidence-based practices in school settings
- The funding, oversight, and monitoring of Day Treatment programs
- Strategies to reduce out-of-state placements for children based on educational needs
- Investments in social emotional learning in school curriculums

There are also opportunities for state-level collaboration and coordination between DHHS and the Department of Education as described in Recommendation 2 above. While this analysis requires participation of the full system of care, the initiative should be co-directed by DHHS and DOE to ensure full participation and meaningful outcomes. A toolkit developed by the US Department of Health and Human Services and the US Department of Education may provide useful information to improve school-based services and supports for children in Maine.¹⁸⁵

24. Support initiatives to enhance skills of early childhood and home-based workers to address challenging behaviors in young children.

Responsibility: System of Care

Timeframe: Long-Term

Early identification of developmental and mental health issues and appropriate services can lead to improved outcomes and reduce the use of more intensive and restrictive services. Stakeholders raised concerns that the needs of young children are not adequately addressed by the current children's behavioral health service array, nor were they a focus of this assessment. However, the recent report, *The Voices of Maine's Early Care and Education Teachers: Children with Challenging Behavior in Classrooms and Home-based Child Care*¹⁸⁶, indicates that many early childhood professionals are struggling with challenging infant-toddler mental health concerns and behaviors and presents the following recommendations, which coordinate with other recommendations in this report, for investments in parent-skill training, service coordination, and evidence-based practices.

1. Implement a statewide early childhood consultation program to help teachers and families strengthen supports for children with challenging behavior.
2. Create a partnership with the Technical Assistance Center on Social-Emotional Intervention (TACSEI) in order to expand the state's capacity for professional development.
3. Leverage and coordinate federal, state, and local funding for parent engagement.
4. Develop and implement consistent screening and assessment tools for three-to-five-year old's, using the same process the Developmental Screening Initiative used to implement screening and assessment for zero-to-three-year-old's.
5. Establish the Help Me Grow (HMG) system in Maine. HMG is a systems-level initiative that connects early learning providers, healthcare providers, and child-serving state and local agencies to help families find medical homes and access timely developmental screening, assessment, and services for their young children. Maine Quality Counts for Kids has already completed the planning to bring HMG to Maine.
6. Develop voluntary guidelines for suspension and expulsion that rely on evidenced-based practices for use by early childhood programs.

¹⁸⁵ US DOE and US DHHS (January 2016). Healthy students, promising futures: State and local action steps and practices to improve school-based health. Retrieved from <https://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf>

¹⁸⁶ National Center for Children in Poverty (2018). The Voices of Maine's Early Care and Education Teachers: Children with Challenging Behavior in Classrooms and Home-based Child Care. Retrieved from http://www.nccp.org/publications/pdf/text_1199.pdf

DHHS should leverage existing and new groups (see Recommendation 2) to specifically identify and develop recommendations to improve behavioral health services for young children, particularly where early childhood and behavioral health services intersect. The Maine Children's Growth Council may be a useful organization to partner with to support specific initiatives for young children. Other stakeholders such as the Maine Children's Alliance could also offer a useful perspective on current challenges and innovate strategies to increase services for young children with behavioral health issues.

APPENDIX A: INTERVIEW QUESTIONS

Interview Questions for DHHS, OCFS, and DRM

1.	Tell us about your role and responsibilities as they relate to CBHS How do you support providers/families/children/community?
Services	
2.	Tell us about how families/children access CBHS Tell us about the relationship between CBHS and providers
3.	What is working well in CBHS for Maine? What should be left alone or further supported?
4.	How well does the current service array meet the needs of children and families? a. Are there service gaps? Wait lists? Authorization challenges? b. What barriers to accessing services exist? <ul style="list-style-type: none"> • workforce issues • geographical issues • transportation issues • other?
5.	What can be improved? a. Are there any additional services, programs, or best practices that you think Maine should implement? b. What is on your “wish list” to improve the CBHS?
6.	In the past five years have there been other transformation or change efforts directly impacting CBHS? How is the change typically received? What has worked well in these previous transformations, and what are some of the lessons learned?
7.	Have there been any news stories or controversies concerning CBHS?
8.	Are there any social, political, or economic concerns or sensitivities we should know about?
9.	What are the attitudes about CBHS from community stakeholders? a. Advocacy groups b. Providers c. Families
10.	Did you attend the listening sessions, and if so, what did you learn?
Organizational Structure	
11.	How would describe the CBHS internal organization? What’s working well? What’s not? How does CBHS fit into the larger structure at OCFS and DHHS? How does CBHS interact with other units like Child Welfare?
12.	Have any improvements with CBHS operations been made in the past year? What, if any, recent changes have been implemented to procedures or staffing?
13.	Are you familiar with the reasons for moving children’s behavioral health from adult mental health closer to child welfare? What have been the positives and negatives stemming from that move?
14.	What areas needing improvement have already been identified by OCFS, specifically those that you would like PCG to focus on during the evaluation?
15.	Have there been any reviews, reports, or audits of CBHS? What were the findings?
Funding for CBHS	
16.	How is CBHS funded? a. What role does MaineCare play? b. What are the advantages/challenges of working with KEPRO? c. What other non-MaineCare services are under CBHS? How are these funded?
17.	What is the current payment structure between CBHS and providers for MaineCare and other services? (ex. Fee-for-service, case rate, daily rate) How do providers feel about this structure? About the rates? Has CBHS ever used or considered other payment structures or changing rates?

18.	Is there a plan to move to managed care for Medicaid?
19.	How are the current Medicaid waivers for children working? Do you have plans to apply for any others?
20.	Are you familiar with the Families First Prevention Services Act (FFPSA)? Has the Department started to plan for how Title IV-E could be utilized to fund mental health services to prevent foster care? How will the changes to congregate care impact CBHS?
Conclusion	
21.	<ul style="list-style-type: none"> a. Any questions, concerns, or areas that should be discussed further to support this project? b. Who else do you think we should make sure to speak with? c. As we plan to survey families and other stakeholders online, what's the best way to get the word out? d. As we plan focus groups around the state where/when would you recommend?

Interview Questions for Families

1. Tell me about your family's experience with children's behavioral health services. What services has your child/family accessed? What impact have these services had on your child and family?
2. How did you hear about those services and how did you access them?
3. What were some of the goals you hoped to achieve when your child started services? How close are you to meeting those goals?
4. To what extent are you and your child included in helping to make decisions about services?
5. Tell me about some positive experiences, what has worked well?
6. What challenges have you experienced in accessing or receiving services? What could have been better about your experience?
7. How well have these services supported you in helping you to meet your child's needs?
8. Have you had experience (yet) with helping their child transition from the child to adult mental health system?
9. Does your child or family have needs that haven't been met? Are there service gaps?
10. What changes would you suggest improving services?

Secondary Interview Questions for Stakeholders

1.	Tell us about your role and responsibilities as they relate to CBHS OCFS/DRM suggested we talk to you about your experience with XXXX
Services	
2.	What is working well in CBHS for Maine? What should be left alone or further supported? What are innovative practices or strengths in the system of care? Have there been any successful pilots or special services in recent years?
3.	How well does the current service array meet the needs of children and families? Are there specific challenges related to: workforce geography transportation wait lists authorization for services use of evidence-based practices levels of care available (community based, respite, crisis, residential, EDs, hospitals, etc.) reimbursement/rates working with child welfare staff/cases working with CBHS staff

	other? We have heard some of the challenges in CBHS include xyz... Do you have thoughts about why these challenges exist? What are the root causes of these issues?
4.	What is the relationship like between OCFS CBHS staff and providers? What does monitoring/quality assurance look like? What kind of training or technical assistance is provided?
5.	What can be improved? Are there any additional services, programs, or best practices that you think Maine should implement? What is on your "wish list" to improve the CBHS?
Conclusion	
6.	Any questions, concerns, or areas that should be discussed further to support this project? Who else do you think we should make sure to speak with? As we plan to survey families and other stakeholders online, what's the best way to get the word out? As we plan focus groups around the state where/when would you recommend?

APPENDIX B: SURVEY QUESTIONS

Youth Survey

Maine's Office of Child and Family Services (OCFS) is conducting an assessment of Children's Behavioral Health Services (CBHS) with the assistance of Public Consulting Group (PCG), an independent consulting firm. The goal of this project is to review the behavioral health services provided to children and families including strengths, innovation, challenges, and gaps—and make recommendations to OCFS. PCG would like to hear your perspective on the extent to which these services are meeting the needs of children and families and your ideas on how they can be improved. **Feel free to fill out as much or as little of the survey as you like.**

If you need help to complete this survey, or if you have questions, please contact the PCG Project Manager, Susan Foonsness, at sfoosness@pcgus.com or (919)576-2215.

If you are completing a paper copy of the survey, please mail it to:

Attn: Susan Foonsness
Public Consulting Group
5511 Capital Center Drive
Suite 550
Raleigh, North Carolina 27606

1. Please describe yourself: *(Radio button options)*
 - A young person who gets behavioral health services in Maine (or paid for by Maine)

2. Which county do you live, and receive treatment, in? *(Dropdown options)*
 - Androscoggin
 - Aroostook
 - Cumberland
 - Franklin
 - Hancock
 - Kennebec
 - Knox
 - Lincoln
 - Oxford
 - Penobscot
 - Piscataquis
 - Sagadahoc
 - Somerset
 - Waldo
 - Washington
 - York
 - Don't know
 - I do not receive services in the county that I live in
 - Where do you live? _____
 - Where do you receive services? _____
 - Other (describe): _____

3. Do you live with your family?
 - Yes
 - No

4. What diagnosis, or diagnoses, do you have? (Check all that apply)

- ADD/ADHD
- Adjustment Disorder
- Anxiety
- Autism Spectrum Disorder (ASD)
- Bipolar Disorder
- Brain Injury
- Conduct Disorder
- Obsessive Compulsive Disorder (OCD)
- Depression
- Down Syndrome
- Fetal Alcohol Spectrum Disorder (FASD)
- Mood Disorder
- Oppositional Defiance Disorder (ODD)
- Post-Traumatic Stress Disorder (PTSD)
- Reactive Attachment Disorder (RAD)
- Other (describe): _____
- Don't know
- Don't want to answer
- I do not have a diagnosis

5. What services are you receiving (or have you received)? (Check all that apply)

- Targeted Case Management (Section 13)
 - Mental Health
 - Intellectual Disabilities
 - Don't know
- Crisis Services
 - Mobile Crisis
 - Crisis Stabilization Unit
 - Don't know
- Outpatient Therapy/Counseling and Assessment
 - In the therapist's office
 - In your home
 - In your school
 - In a community setting
- Medication Management
- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (RCS) (Section 28)
- Children's Home and Community Based Treatment Services (HCT) (Section 65)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Assertive Community Treatment (ACT)
- Intensive Temporary Residential Treatment (ITRT)
- Day Treatment
- Emergency Room for Crisis
 - How many times have you gone there? _____
 - For your most recent visit...
 - ❖ How long were you there? _____
 - ❖ Why were you there? _____
 - ❖ Where did you go after you left? _____
- Psychiatric Hospitalization
 - How many times have you gone there? _____
 - For your most recent visit...
 - ❖ How long were you there? _____
 - ❖ Why were you there? _____

- ❖ Where did you go after you left? _____
 - Respite Care
 - Homeless Youth Services
 - Outreach
 - Drop-In
 - Shelter
 - Transitional Living
 - Don't know
 - Juvenile Justice/Corrections Services
 - I have not gotten any services
 - Other (describe): _____
 - Don't know (describe): _____
- 6. How long have you been getting services? _____
- 7. Do you believe your behavioral health needs have gotten worse? *(Radio button options with follow-ups)*
 - Yes
 - Why? *(Unlimited space, open text field)*
 - No
- 8. What are some of the services that have helped you? *(Unlimited space, open text field)*
- 9. What has been hard for you while getting, or trying to get, services? *(Unlimited space, open text field)*
- 10. What could make your services better? *(Unlimited space, open text field)*
- 11. Have you had to wait to start services? *(Radio button options with follow-ups)*
 - Yes
 - How long was the wait?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long did you have to wait? _____
 - Don't know
 - No
 - Don't know
- 12. Were your services ever put on hold? *(Radio button options with follow-ups)*
 - Yes
 - How long did you wait before starting again?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long were your services put on hold? _____
 - Don't know
 - No
 - Don't know
- 13. Have you ever had to get a different type of service because you could not get the service you needed?
(Radio button options with follow-ups)
 - Yes

- Why? *(Unlimited space, open text field)*
 - How long did you have to wait?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long did you have to wait? _____
 - I never got what I needed
 - Don't know
 - No
 - Don't know
14. Have you ever lived outside of Maine to get services? *(Radio button options with follow-ups)*
- Yes
 - Where did you go? _____
 - How long were you there? _____
 - Why were you there? _____
 - No
15. Have you ever been arrested?
- Yes
 - No
16. Do you have an IEP (Individualized Education Plan) for school? *(Radio button options)*
- Yes
 - No
 - Don't know
17. Have you ever been suspended? *(Radio button options)*
- Yes
 - No
18. Have you ever been expelled? *(Radio button options)*
- Yes
 - No
19. Has the school ever made you do a risk assessment because of your behavior or expulsion? *(Radio button options)*
- Yes
 - No
 - Don't know
20. How much do you agree with the statements below?

Statement ¹⁸⁷	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/Not Applicable
I am treated like a partner by service providers and I get to help decide the type of treatments I need.	○	○	○	○	○	

¹⁸⁷ The statements in this survey are adapted from Wichita State University's Center for Community Support and Research's "Principles for the Delivery of Children's Mental Health Services."

Statement ¹⁸⁷	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/Not Applicable
My family members are treated like partners by service providers and they get to help decide the type of treatments I need.	<input type="radio"/>					
The services I get are good enough for me do well in school.	<input type="radio"/>					
The services I get are good enough to help me get along with my family.	<input type="radio"/>					
The services I get help me to stay out of big trouble (such as being sent to juvenile corrections or getting arrested).	<input type="radio"/>					
The services I get help me to plan for my future as an adult.	<input type="radio"/>					
The services I get help me to figure out how I can reach the goals I have set for when I grow up.	<input type="radio"/>					
The services I get help me figure out what I need to do to become a stable and productive adult.	<input type="radio"/>					
The different agencies working with me (for example, DHHS, service providers, juvenile corrections), work well together as a team to make sure that my services go the way they are supposed to.	<input type="radio"/>					
I have access to many different services options.	<input type="radio"/>					
I have access to services options that are good enough to make sure I get the treatment I need.	<input type="radio"/>					
Changes are made to the services I get so that I can get the best results possible.	<input type="radio"/>					
Services are provided in places that work best for my needs and are easy for me to get to.	<input type="radio"/>					
Service providers work with my family to help us get rides so that I am able to get to my services.	<input type="radio"/>					
The residential setting where I live and get services feels like home.	<input type="radio"/>					

Statement ¹⁸⁷	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/Not Applicable
Once I found out I needed services, I was contacted right away and began services soon after.	<input type="radio"/>					
I am encouraged to share my thoughts, opinions, and concerns.	<input type="radio"/>					
I am asked about what I believe needs to be done to reach my goals.	<input type="radio"/>					
Service providers try to do all they can to make sure I do not have to move to different placements.	<input type="radio"/>					
Service providers help me to plan for big changes in my life.	<input type="radio"/>					
Services are provided in a way that respects my culture and way of life.	<input type="radio"/>					
Service providers help my family figure out the best ways to meet my needs.	<input type="radio"/>					
Service providers help me figure out the best ways I can meet my own needs.	<input type="radio"/>					
Service providers want me to reach out and ask my family and friends for help when I need it.	<input type="radio"/>					

21. What is your language? (Check all that apply)

- English
- French/Français
- Spanish/Español
- American Sign Language (ASL)
- Other (describe): _____

22. Are you: (*Radio button options*)

- Male
- Female
- Other
- Don't want to answer

23. Please check all options which best describe your Race/Ethnicity:

- American Indian/Alaska Native
- Asian
- Asian/Pacific Islander
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White/Caucasian
- Hispanic/Latino
- Don't want to answer
- Don't know
- Other (describe): _____

24. How old are you? *(Radio button options with follow up)*

- Younger than 10
 - How old are you? _____
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 18+
 - How old are you? _____

25. Which option best describes your highest level of schooling? *(Radio button options)*

- Currently in elementary school
- Currently in middle school
- Currently in high school
- Dropped out
- I have a high school degree or equivalent (e.g., HiSET)
- I have some college (No degree yet)
- I have a Technical/Vocational degree
- I have an Associate's degree

26. Please feel free to share any other information you would like about your experience with children's behavioral health services: *(Unlimited space, open text field)*

Thank you for your participation!

(Post completion optional question/pop up) Your responses on this survey are confidential. However, if you would like us to contact you to follow-up because there is something specific you would like to talk about then you may share your name and contact information here: *(Unlimited space, open text field)*

Family Survey

Maine's Office of Child and Family Services (OCFS) is conducting an assessment of Children's Behavioral Health Services (CBHS) with the assistance of Public Consulting Group (PCG), an independent consulting firm. The goal of this project is to review the behavioral health services provided to children and families including strengths, innovation, challenges, and gaps—and make recommendations to OCFS. PCG would like to hear your perspective on the extent to which these services are meeting the needs of children and families and your ideas on how they can be improved. **Feel free to fill out as much or as little of the survey as you like.**

If you need help to complete this survey, or if you have questions, please contact the PCG Project Manager, Susan Foonsness, at sfoosness@pcgus.com or (919)576-2215.

If you are completing a paper copy of the survey, please mail it to:

Attn: Susan Foonsness
Public Consulting Group
5511 Capital Center Drive
Suite 550
Raleigh, North Carolina 27606

1. Please describe yourself: *(Radio button options)*
 - A parent/legal guardian of a child who gets behavioral health services in Maine (or paid for by Maine)
 - A family member or natural support of a child who gets behavioral health services in Maine (or paid for by Maine)

2. Which county do you live in? *(Dropdown options)*
 - Androscoggin
 - Aroostook
 - Cumberland
 - Franklin
 - Hancock
 - Kennebec
 - Knox
 - Lincoln
 - Oxford
 - Penobscot
 - Piscataquis
 - Sagadahoc
 - Somerset
 - Waldo
 - Washington
 - York
 - Other (please describe): _____
 - Don't know

3. Are you filling out this survey for more than one child who has received behavioral health services?
 - Yes
 - Number of children: _____
 - *(Message)* When you answer the questions, keep in mind all children as well as your overall experience.
 - No

4. What diagnosis, or diagnoses, does your child have? (Check all that apply)

- ADD/ADHD
- Adjustment Disorder
- Anxiety
- Autism Spectrum Disorder (ASD)
- Bipolar Disorder
- Brain Injury
- Conduct Disorder
- Obsessive Compulsive Disorder (OCD)
- Depression
- Down Syndrome
- Fetal Alcohol Spectrum Disorder (FASD)
- Mood Disorder
- Oppositional Defiance Disorder (ODD)
- Post-Traumatic Stress Disorder (PTSD)
- Reactive Attachment Disorder (RAD)
- Other (describe): _____
- Don't know
- Don't want to answer
- My child doesn't have a diagnosis

5. What is your child's age? _____

6. What services is your child(ren) receiving or what services has your child(ren) received? (Check all that apply)

- Targeted Case Management (Section 13)
 - Mental Health
 - Intellectual Disabilities
 - Don't know
- Crisis Services
 - Mobile Crisis
 - Crisis Stabilization Unit
 - Don't know
- Outpatient Therapy/Counseling and Assessment
 - In the therapist's office
 - In your child's home
 - In your child's school
 - In a community setting
- Medication Management
- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (RCS) (Section 28)
- Children's Home and Community Based Treatment Services (HCT) (Section 65)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Assertive Community Treatment (ACT)
- Intensive Temporary Residential Treatment (ITRT)
- Day Treatment
- Emergency Room for Crisis
 - How many times has your child gone there? _____
 - For your child's most recent visit...
 - ❖ How long was s/he there? _____
 - ❖ Why was s/he there? _____
 - ❖ Where did s/he go after s/he left? _____
- Psychiatric Hospitalization
 - How many times has your child gone there? _____

- For your child's most recent visit...
 - ❖ How long s/he there? _____
 - ❖ Why was s/he there? _____
 - ❖ Where did s/he go after s/he left? _____
 - Respite Care
 - Homeless Youth Services
 - Outreach
 - Drop-In
 - Shelter
 - Transitional Living
 - Don't know
 - Juvenile Justice/Corrections Services
 - My child has not gotten any services
 - Other (describe): _____
 - Don't know (describe): _____
7. How long has your child been getting services? _____
8. Do you believe your child's behavioral health needs have gotten worse? *(Radio button options with follow-ups)*
- Yes
 - Why? *(Unlimited space, open text field)*
 - No
9. What are some of the services that have helped your child? *(Unlimited space, open text field)*
10. What has been hard for your child while getting, or trying to get, services? *(Unlimited space, open text field)*
11. What could make your child's services better? *(Unlimited space, open text field)*
12. Has your child had to wait to start services? *(Radio button options with follow-ups)*
- Yes
 - How long was the wait?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long did your child have to wait? _____
 - Don't know
 - No
 - Don't know
13. Were your child's services ever put on hold? *(Radio button options with follow-ups)*
- Yes
 - How long did your child wait before starting again?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long were your child's services put on hold? _____
 - Don't know
 - No

- Don't know
14. Has your child ever had to get a different type of service because s/he could not get the service s/he needed? *(Radio button options with follow-ups)*
- Yes
 - Why? *(Unlimited space, open text field)*
 - How long did your child have to wait?
 - Less than 30 days
 - 31-60 days
 - 61-120 days
 - 121-180 days
 - More than 180 days
 - ✓ How long did your child have to wait? _____
 - My child never got what s/he needed
 - Don't know
 - No
 - Don't know
15. Has your child ever lived outside of Maine to get services? *(Radio button options with follow-ups)*
- Yes
 - Where did your child go? _____
 - How long was your child there? _____
 - Why was your child there? _____
 - No
 - Don't know
16. Has your child ever been arrested?
- Yes
 - No
17. Does your child have an IEP (Individualized Education Plan) for school? *(Radio button options)*
- Yes
 - No
18. Has your child ever been suspended? *(Radio button options)*
- Yes
 - No
19. Has your child ever been expelled? *(Radio button options)*
- Yes
 - No
20. Has the school ever made your child do a risk assessment because of his/her behavior or expulsion? *(Radio button options)*
- Yes
 - No
21. How much do you agree with the statements below?

Statement ¹⁸⁸	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/Not Applicable
My family members are treated like partners by service providers and we get to help decide the type of treatments my child needs.	<input type="radio"/>					
My child is treated like a partner by service providers and s/he gets to help decide the type of treatments s/he needs.	<input type="radio"/>					
My child's services are good enough for him/her do well in school.	<input type="radio"/>					
My child's services are good enough to help him/her get along with our family.	<input type="radio"/>					
My child's services help my child to stay out of big trouble (such as being sent to juvenile corrections or getting arrested).	<input type="radio"/>					
My child's services not help him/her to plan for the future as an adult.	<input type="radio"/>					
My child's services help him/her to figure out how s/he can reach the goals s/he has set for when s/he grows up.	<input type="radio"/>					
My child's services help him/her figure out what s/he needs to do to become a stable and productive adult.	<input type="radio"/>					
The different agencies working with my child (for example, DHHS, service providers, juvenile corrections), work well together as a team to make sure that my child's services go the way they are supposed to.	<input type="radio"/>					
My child has access to many different services options.	<input type="radio"/>					
My child has access to options that are good enough to make sure my child gets the treatment s/he needs.	<input type="radio"/>					
Changes are made to my child's services so that s/he can get the best results possible.	<input type="radio"/>					

¹⁸⁸ The statements in this survey are adapted from Wichita State University's Center for Community Support and Research's "Principles for the Delivery of Children's Mental Health Services."

Statement ¹⁸⁸	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don’t Know/Not Applicable
My child’s services are provided in places that work best for his/her needs and are easy for him/her to get to.	<input type="radio"/>					
Service providers work with our family to help us get rides so that my child is able to get to his/her services.	<input type="radio"/>					
The residential setting where my child lives and gets services feels like home.	<input type="radio"/>					
Once it was decided that my child needed services, my family was contacted right away and services began soon after.	<input type="radio"/>					
My child is encouraged to share his/her thoughts, opinions, and concerns.	<input type="radio"/>					
My child is asked about what s/he believes needs to be done to reach his/her goals.	<input type="radio"/>					
Service providers try to do all they can to make sure my child does not have to move to different placements.	<input type="radio"/>					
Service providers help my child in planning for big changes in his/her life.	<input type="radio"/>					
Services are provided in a way that respects my child’s culture and way of life.	<input type="radio"/>					
Service providers help my family figure out the best ways to meet my child’s needs.	<input type="radio"/>					
Service providers help my child figure out the best ways to meet his/her own needs.	<input type="radio"/>					
Service providers want my child to reach out and ask family and friends for help when s/he needs it.	<input type="radio"/>					
Service providers use payment systems that are easy to use.	<input type="radio"/>					
My family can afford services for our child.	<input type="radio"/>					
My family can easily work within the behavioral services system to get what we need without any help from others (for example, from attorneys, advocates, or Disability Rights Maine).	<input type="radio"/>					

-
22. What is your language? (Check all that apply)
- English
 - French/Français
 - Spanish/Español
 - American Sign Language (ASL)
 - Other (describe): _____
23. Are you: *(Radio button options)*
- Male
 - Female
 - Other
 - Don't want to answer
24. Please check all options which best describe your Race/Ethnicity:
- American Indian/Alaska Native
 - Asian
 - Asian/Pacific Islander
 - Black/African American
 - Native Hawaiian/Other Pacific Islander
 - White/Caucasian
 - Hispanic/Latino
 - Don't want to answer
 - Don't know
 - Other (describe): _____
25. How old are you? *(Radio button options with follow-up)*
- Younger than 18
 - How old are you? _____
 - 18-24 years old
 - 25-34 years old
 - 35-44 years old
 - 45-54 years old
 - 55+
 - How old are you? _____
26. What is your marital status? *(Radio button options)*
- Single (Never Married)
 - Married (Or in a Domestic Partnership)
 - Widowed
 - Divorced
 - Separated
 - Don't want to answer
27. What is your highest level of education? *(Radio button options)*
- Less than a high school diploma
 - High school degree or equivalent (e.g., HiSET)
 - Some college (No degree received)
 - Technical/Vocational degree
 - Associate's degree
 - Bachelor's degree
 - Master's degree
 - Higher than a Master's degree
28. What is your current employment status? *(Radio button options)*
- Employed full time

- Employed part time
- Unemployed and currently looking for work
- Unemployed and not currently looking for work
- Student
- Retired
- Homemaker
- Unable to Work

29. What is your annual household income? *(Radio button options)*

- Less than \$20,000
- \$20,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- Over \$100,000
- Don't know
- Don't want to answer

30. Please feel free to share any other information you would like about your experience (or your child's experience) with children's behavioral health services: *(Unlimited space, open text field)*

Thank you for your participation!

(Post completion optional question/pop up) Your responses on this survey are confidential. However, if you would like us to contact you to follow-up because there is something specific you would like to talk about then you may share your name and contact information here: *(Unlimited space, open text field)*

DHHS Employee Survey

Maine's Office of Child and Family Services (OCFS) is conducting an assessment of Children's Behavioral Health Services (CBHS) with the assistance of Public Consulting Group (PCG), an independent consulting firm. The goal of this project is to review the behavioral health services provided to children and families including strengths, innovation, challenges, and gaps—and make recommendations to OCFS. PCG would like to hear your perspective on the extent to which these services are meeting the needs of children and families and your ideas on how they can be improved. **Feel free to fill out as much or as little of the survey as you like.**

1. Please describe yourself: *(Radio button options)*
 - A Maine DHHS employee

2. Which of the following best describes your current role? *(Radio button options with follow-up)*
 - CBHS Management
 - CBHS Resource Coordinator
 - CBHS Program Coordinator
 - CBHS Nurse
 - CBHS Clinical Social Worker
 - CBHS Other Position
 - Please list your job title: _____
 - Child Welfare Management
 - Child Welfare Supervisor
 - Child Welfare Social Worker
 - Office of MaineCare Services Employee
 - Please list your job title: _____
 - Office of Aging and Disability Services Employee
 - Please list your job title: _____
 - Other (describe): _____

3. Which OCFS district(s) do you serve? (Check all that apply)
 - Augusta
 - Bangor
 - Biddeford
 - Calais
 - Caribou
 - Ellsworth
 - Farmington
 - Fort Kent
 - Houlton
 - Lewiston
 - Machias
 - Portland
 - Rockland
 - Sanford
 - Skowhegan
 - South Paris
 - OCFS Central Office
 - Other (specify): _____

4. Which option best describes your highest level of education? *(Radio button options with follow-up)*
 - Less than a high school diploma
 - High school degree or equivalent (e.g., GED or HiSET)
 - Some college (No degree received)
 - Technical/Vocational degree
 - Associate's degree
 - What is your degree field? _____

- Bachelor's degree
 - What is your degree field? _____
 - Master's degree
 - What is your degree field? _____
 - Higher than a Master's degree
 - What is your degree field? _____
5. How long have you been in your current position? *(Radio button options)*
- Less than 1 year
 - 1-3 years
 - 4-6 years
 - 7-9 years
 - 10+ years
6. How long have you been working in the children's behavioral health field and/or child welfare? *(Radio button options with follow-up questions)*
- Less than 1 year
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
 - 1-3 years
 - Would you consider yourself satisfied in your current role?
 - Yes
 - No
 - ❖ What improvements would you make to your job if you could?

 - Would you consider your workload to be manageable?
 - Yes
 - No
 - ❖ What, if anything, could be done to improve your workload?

 - 4-6 years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
 - 7-9 years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
 - 10+ years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes

- No (What could be done to improve your workload?): _____
 - Not applicable
7. Have you held another position in the children’s behavioral health field and/or child welfare prior to your current role? *(Radio button options with follow-up)*
- Yes
 - What was your previous position(s)? _____
 - Why did you leave your previous position(s)? _____
 - No
 - Not applicable
8. To what extent do you agree with the following statements regarding your experience with children’s behavioral health services in Maine?

Statement ¹⁸⁹	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Families and children are treated as partners throughout each phase of the process (e.g., assessment, planning, delivery and evaluation) when receiving behavioral health services, and their preferences are taken seriously.	○	○	○	○	○	○
Behavioral health services plans are set up to help children to be successful in school.	○	○	○	○	○	○
Behavioral health services are generally effective in helping children to be successful in school.	○	○	○	○	○	○
Behavioral health services plans carefully consider all options that may help children to live and function well within their families.	○	○	○	○	○	○
Behavioral health services are successful in helping children to live and function well within their families.	○	○	○	○	○	○
Behavioral health services plans outline strategies that help children in avoiding the juvenile justice system.	○	○	○	○	○	○
Behavioral health services are generally able to help children in avoiding the juvenile justice system.	○	○	○	○	○	○
Behavioral health service plans are forward-thinking and aim to ensure children become stable and productive adults.	○	○	○	○	○	○
Behavioral health services set children up to become stable and productive adults.	○	○	○	○	○	○
When children have multiple agencies and systems involved, everyone works collaboratively as a team to ensure that the services plan is implemented properly.	○	○	○	○	○	○

¹⁸⁹ The statements in this survey are derived from Wichita State University’s Center for Community Support and Research’s “Principles for the Delivery of Children’s Mental Health Services.”

Statement ¹⁸⁹	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Children have access to a comprehensive array of behavioral health services, sufficient to ensure they receive the treatment they need.	<input type="radio"/>					
Behavioral health services are continuously evaluated and changed if they are not effective in achieving desired outcomes.	<input type="radio"/>					
Children are provided behavioral health services in the least restrictive settings (e.g., home or community based settings) which are convenient for children and families.	<input type="radio"/>					
Service providers work with families to help them overcome transportation barriers to ensure they can participate in services.	<input type="radio"/>					
When services are provided in a residential setting, the setting is the most integrated and home-like as reasonably possible.	<input type="radio"/>					
Children identified as needing behavioral health services are assessed and served promptly.	<input type="radio"/>					
Behavioral health service plans are built through input from children and families about their strengths and needs, their goals, and the services they think are required.	<input type="radio"/>					
Behavioral health services plans aim to minimize multiple placements.	<input type="radio"/>					
Behavioral health services plans anticipate, and appropriately plan for, transitions in children’s lives (e.g., transitions to new schools, placements and adult services).	<input type="radio"/>					
Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family.	<input type="radio"/>					
Behavioral health services include support and training for families in meeting the child’s behavioral health needs.	<input type="radio"/>					
Behavioral health services include support and training for children in self-management of their own behavioral health needs.	<input type="radio"/>					
Behavioral health service providers help to identify, and appropriately use, natural supports from children and families’ own network of family, friends, neighbors, community and/or religious organizations.	<input type="radio"/>					
Behavioral health services utilize payment processes that are easy for families to navigate.	<input type="radio"/>					
Families are able to afford behavioral health services for their children.	<input type="radio"/>					

Statement ¹⁸⁹	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Families are generally able to access behavioral health services for their children.	<input type="radio"/>					
Families are overall, quite satisfied with the quality of their children's behavioral health services.	<input type="radio"/>					

9. What are some of the best aspects of children's behavioral health services in Maine? *(Unlimited space, open text field)*
10. What are some of the challenges or barriers associated with children's behavioral health services in Maine? *(Unlimited space, open text field)*
11. Please provide any suggestions to improve children's behavioral health services in Maine: *(Unlimited space, open text field)*
12. Please feel free to share any additional information you would like about your experience in working with children's behavioral health services in Maine: *(Unlimited space, open text field)*

Thank you for your participation!

Stakeholder Survey

Maine's Office of Child and Family Services (OCFS) is conducting an assessment of Children's Behavioral Health Services (CBHS) with the assistance of Public Consulting Group (PCG), an independent consulting firm. The goal of this project is to review the behavioral health services provided to children and families including strengths, innovation, challenges, and gaps—and make recommendations to OCFS. PCG would like to hear your perspective on the extent to which these services are meeting the needs of children and families and your ideas on how they can be improved. **Feel free to fill out as much or as little of the survey as you like.**

13. Please describe yourself: *(Radio button options)*
- A behavioral health service provider (including therapy, crisis services, direct support, hospitalization, community based treatment, and/or residential, etc.)
 - Other behavioral health services provider
 - Law enforcement/Corrections *(If selected, answer Questions 2-5, then skip to Question 9)*
 - Advocacy or legal services *(If selected, answer Questions 2-5, then skip to Question 9)*
 - Other (describe): _____ *(If selected, answer Questions 2-5, then skip to Question 9)*
14. What is your job title? _____
15. Which OCFS district(s) do you serve? (Check all that apply)
- Augusta
 - Bangor
 - Biddeford
 - Calais
 - Caribou
 - Ellsworth
 - Farmington
 - Fort Kent
 - Houlton
 - Lewiston
 - Machias
 - Portland
 - Rockland
 - Sanford
 - Skowhegan
 - South Paris
 - OCFS Central Office
 - Other (specify): _____
16. Which option best describes your highest level of education? *(Radio button options with follow-up)*
- Less than a high school diploma
 - High school degree or equivalent (e.g., GED or HiSET)
 - Some college (No degree received)
 - Technical/Vocational degree
 - Associate's degree
 - What is your degree field? _____
 - Bachelor's degree
 - What is your degree field? _____
 - Master's degree
 - What is your degree field? _____
 - Higher than a Master's degree
 - What is your degree field? _____
17. How long have you been in your current position? *(Radio button options)*
- Less than 1 year

- 1-3 years
- 4-6 years
- 7-9 years
- 10+ years

18. How long have you been working in the children's behavioral health field? (*Radio button options with follow-up questions*)

- Less than 1 year
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
- 1-3 years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
- 4-6 years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
- 7-9 years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
- 10+ years
 - Would you consider yourself satisfied in your current role?
 - Yes (Describe the reasons why): _____
 - No (Describe the reasons why): _____
 - Would you consider your workload to be manageable?
 - Yes
 - No (What could be done to improve your workload?): _____
- Not applicable

19. Have you held another position in the children's behavioral health field prior to your current role? (*Radio button options with follow-up*)

- Yes
 - What was your previous position(s)? _____
 - Why did you leave your previous position(s)? _____
- No
- Not applicable

20. What children's behavioral health services do you provide? (Check all that apply)

- Targeted Case Management (Section 13)
 - Mental Health

- Intellectual Disabilities
- Crisis Services
 - Mobile Crisis
 - Crisis Stabilization Unit
 - Both
- Outpatient Therapy/Counseling and Assessment
 - In the therapist's office
 - In the child's home
 - In the child's school
 - In a community setting
- Medication Management
- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (RCS) (Section 28)
 - Basic
 - Specialized
 - Both
- Children's Home and Community Based Treatment Services (HCT) (Section 65)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Assertive Community Treatment (ACT)
- Intensive Temporary Residential Treatment (ITRT)
- Day Treatment
- Emergency Room/Emergency Department care for Mental Health Crisis
- Psychiatric Hospitalization
- Respite Care
- Homeless Youth Services
 - Outreach
 - Drop-In
 - Shelter
 - Transitional Living
- Juvenile Justice/Corrections Services
 - JCCO
 - LCYDC
- Juvenile Criminal Defense Attorney
- Parent Organization
- Other (describe): _____

21. To what extent do you agree with the following statements regarding your experience with children's behavioral health services in Maine?

Statement ¹⁹⁰	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Families and children are treated as partners throughout each phase of the process (e.g., assessment, planning, delivery and evaluation) when receiving behavioral health services, and their preferences are taken seriously.	<input type="radio"/>					
Behavioral health services plans are set up to help children to be successful in school.	<input type="radio"/>					

¹⁹⁰ The statements in this survey are derived from Wichita State University's Center for Community Support and Research's "Principles for the Delivery of Children's Mental Health Services."

Statement ¹⁹⁰	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Behavioral health services are generally effective in helping children to be successful in school.	<input type="radio"/>					
Behavioral health services plans carefully consider all options that may help children to live and function well within their families.	<input type="radio"/>					
Behavioral health services are successful in helping children to live and function well within their families.	<input type="radio"/>					
Behavioral health services plans outline strategies that help children in avoiding the juvenile justice system.	<input type="radio"/>					
Behavioral health services are generally able to help children in avoiding the juvenile justice system.	<input type="radio"/>					
Behavioral health service plans are forward-thinking and aim to ensure children to become stable and productive adults.	<input type="radio"/>					
Behavioral health services set children up to become stable and productive adults.	<input type="radio"/>					
When children have multiple agencies and systems involved, everyone works collaboratively as a team to ensure that the services plan is implemented properly.	<input type="radio"/>					
Children have access to a comprehensive array of behavioral health services, sufficient to ensure they receive the treatment they need.	<input type="radio"/>					
Behavioral health services are continuously evaluated and changed if they are not effective in achieving desired outcomes.	<input type="radio"/>					
Children are provided behavioral health services in the least restrictive settings (e.g., home or community based settings) which are convenient for children and families.	<input type="radio"/>					
Service providers work with families to help them overcome transportation barriers to ensure they can participate in services.	<input type="radio"/>					
When services are provided in a residential setting, the setting is the most integrated and home-like as reasonably possible.	<input type="radio"/>					
Children identified as needing behavioral health services are assessed and served promptly.	<input type="radio"/>					
Behavioral health service plans are built through input from children and families about their strengths and needs, their goals, and the services they think are required.	<input type="radio"/>					
Behavioral health services plans aim to minimize multiple placements.	<input type="radio"/>					

Statement ¹⁹⁰	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Unsure/Not Applicable
Behavioral health services plans anticipate, and appropriately plan for, transitions in children’s lives (e.g., transitions to new schools, placements and adult services).	<input type="radio"/>					
Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family.	<input type="radio"/>					
Behavioral health services include support and training for families in meeting the child’s behavioral health needs.	<input type="radio"/>					
Behavioral health services include support and training for children in self-management of their own behavioral health needs.	<input type="radio"/>					
Behavioral health service providers help to identify, and appropriately use, natural supports from children and families’ own network of family, friends, neighbors, community and/or religious organizations.	<input type="radio"/>					
Behavioral health services utilize payment processes that are easy for families to navigate.	<input type="radio"/>					
Families are able to afford behavioral health services for their children.	<input type="radio"/>					
Families are generally able to access behavioral health services for their children.	<input type="radio"/>					
Families are overall, quite satisfied with the quality of their children’s behavioral health services.	<input type="radio"/>					

22. What are some of the best aspects of children’s behavioral health services in Maine? *(Unlimited space, open text field)*
23. What are some of the challenges or barriers associated with children’s behavioral health services in Maine? *(Unlimited space, open text field)*
24. Please provide any suggestions to improve children’s behavioral health services in Maine: *(Unlimited space, open text field)*
25. Please feel free to share any additional information you would like about your experience in working with children’s behavioral health services in Maine: *(Unlimited space, open text field)*

Thank you for your participation!

APPENDIX C: EMPIRICALLY VALIDATED ASSESSMENT TOOLS

The table below details instruments that are available for free/low cost to providers for clinical use and may be helpful in comprehensive clinical assessments and ongoing monitoring of symptoms and progress.¹⁹¹

Additional resources for primary care physicians available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

Assessment Area	Instrument Name	Age	Link
Anxiety	Children Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997)	6-17	http://icahn.mssm.edu/research/centers/center-of-excellence-for-ocd/rating-scales
	Penn State Worry Questionnaire for Children (PSWQ-C; Chorpita, Tracey, Brown, Collica, & Barlow, 1997)	7-17	https://www.childfirst.ucla.edu/resources/
	Revised Children's Anxiety and Depression Scale Youth and Parent Versions (RCADS/RCADS-P; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000)	6-18	https://www.childfirst.ucla.edu/resources/
	Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997)	6-18	https://www.pediatricbipolar.pitt.edu/resources/instruments
	Spence Children's Anxiety Scale & Spence Preschool Anxiety Scale (SCAS; Spence, 1998; Spence, Rapee, McDonald, & Ingram, 2001)	7-19	http://www.scaswebsite.com
Depression	Center for Epidemiologic Studies Depression Scale for Children (CES-DC; Fendrich, Weissman, & Warner, 1990)	6-23	http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf
	Depression Self Rating Scale for Children (DSRSC; Birlleson, Hudson, Buchanan, & Wolff, 1987)	8-14	http://www.scalesandmeasures.net/files/files/Birlleson%20Self-Rating%20Scale%20for%20Child%20Depressive%20Disorder.pdf
Disruptive Behavior Disorders	Child and Adolescent Disruptive Behavior Inventory-Parent & Teacher Version (CADBI; Burns, Taylor, & Rusby, 2001a; 2001b)	N/A	http://measures.earlyadolescence.org/measures/view/40
Eating Disorders	Child Eating Attitudes Test (ChEAT; Maloney, McGuire, & Daniels, 1988)	8-13	http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/ChEAT.pdf
	Eating Attitudes Test-26 (EAT-26; Garner et al., 1982)	16-18	http://www.eat-26.com
Mania	Parent Report Version of the Young Mania Rating Scale (P-YMRS; Gracious, Holmes, Ruppap, Burke, & Hurt, 1994)	5-17	https://www.tn.gov/behavioral-health/for-providers/best-practices1/february-

¹⁹¹ Beidas, R. S., Stewart, R. E., Walsh, L., Lucas, S., Downey, M. M., Jackson, K., ... & Mandell, D. S. (2015). Free, brief, and validated: standardized instruments for low-resource mental health settings. *Cognitive and Behavioral Practice*, 22(1), 5-19.

Assessment Area	Instrument Name	Age	Link
			2016/best-practices-for-children---adolescents-.html
	Child Mania Rating Scale-Parent Version (CMRS-P; Pavuluri, Henry, Devineni, Carbray, & Birmaher, 2006)	5-17	http://www.dbsalliance.org/pdfs/ChildManiaSurvey.pdf
Overall Mental Health	Brief Problem Checklist (BPC; Chorpita et al., 2010)	7-13	https://www.childfirst.ucla.edu/resources/
	The Ohio Scale-Youth, Parent, and Clinician versions (Ogles, Melendez, David, & Lunnen, 2001)	5-18	ben_ogles@byu.edu
	Pediatric Symptom Checklist and Pediatric Symptom Checklist-Youth Report (PSC & Y-PSC; Jellinek et al. 1988)	4-16, 11-18	http://www.massgeneral.org/psychiatry/services/psc_home.aspx
	Strength and Difficulties Questionnaire (SDQ; Goodman, 1997)	3-16	http://www.sdqinfo.org/a0.html
Trauma	Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001)	8-18	foa@mail.med.upenn.edu
	Pediatric Emotional Distress Scale (PEDS; Saylor, Swenson, Reynolds, & Taylor, 1999)	2-10	conway.saylor@citadel.edu



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