DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

STRATEGIC PLAN

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Introduction

Stakeholder Involvement and Plan Development

Departmental staff members, consumer and provider stakeholders, and public officials initiated the process of planning for the Department's future at a meeting in Waterville on October 27 and 28, 1998. Participants identified key tasks, including assurances to involve stakeholders, to inform people taking part in the planning, and to oversee the planning process itself.

A core team was identified in mid November, 1998, and first met just before Thanksgiving. An ambitious timeline was developed, with the first task the preparation of a uniform message to all stakeholders; this was developed and approved by the end of December. On January 6, 1999, the first stakeholder group, the Statewide Quality Improvement Council, was presented with the opportunity, parameters and timelines for participation. Subsequently, all regional Quality Councils, the two institutional Quality Improvement Councils, the Local Service Network groups, the regional office system, the Mental Health Institutes, and all other interested parties were approached and invited to participate.

Management Information Systems

A key ingredient in the development of a relevant and responsive plan is the identification and implementation of a data management system. To accomplish this, DMHMRSAS has undertaken the formation of a very comprehensive Department- wide information system, that will develop appropriate performance based outcome measures and core data client information systems, and link those to information for financial decisions and needs. It is called the Systems Infrastructure Development Initiative (SIDI).

SIDI is a management information project that will enable the Department's decisions and policy directions to be based upon and supported by timely and complete information. SIDI will also enable the Department to effectively gather output and outcome information from service providers, to utilize this data to shape and direct the community system, and to coalesce behavioral health services provided to discrete populations into a single, complete, accessible system of care. Under development for the past eighteen months, this system is just now coming on line and will be described in specific sections of this plan.

Organizational Challenges

The Department's particular organizational challenges include consent decrees governing services provided to former residents of Pineland Center and to patients of the Augusta Mental Health Institute; the *French v. Concannon* agreement regarding the provision of behavioral health services to Maine's children; and a regional reorientation begun during Productivity Realization Task Force. In addition, the possible "new AMHI" project promises to provide opportunity to examine the long term

roles of the State's psychiatric hospitals and the community system of mental health care.

DMHMRSAS Mission, Vision, Values

To help Departmental staff, the providers with whom we work, and the families and clients we serve, the Department has established mission, vision and values statements, to guide the development of all our activities.

MISSION STATEMENT

The Department's mission is to join with individuals, families and communities to encourage and assist people with developmental disabilities, mental health disorders and substance abuse disorders to achieve good health and meaningful living, through resources that

- build on the strengths and accomplishments of the past
- are local and regional
- encourage widespread participation in policy decisions and planning
- have no barriers in serving all disabilities
- are measured in terms of efficiency, outcomes and impact on quality of life.

VISION STATEMENT

Maine citizens will freely and fully experience the highest quality of life regardless of illness or disability. To achieve this vision we will join with communities and people who receive and deliver services to

- support people to live in and be part of their communities
- promote and support aspirations and growth by building self-confidence, self-esteem and personal responsibility
- promote quality of life by participating in strengthening families and communities
- promote services that merit public confidence, trust and respect
- promote informed choices.

VALUES

In support of our vision, we in the Department value

- **CHOICE**. People have opportunities to make informed choices and get accessible, cost effective, individually tailored supports within their communities.
- **ACCESS.** People have access to jobs, education, healthcare, housing, social, spiritual and recreational opportunities.
- **DIGNITY.** People are treated with dignity and respect, and their rights are safeguarded by all who provide services to them.
- **QUALITY.** People determine the quality of their supports based on the outcomes they experience.
- **PREVENTION AND EARLY INTERVENTION.** Our emphasis on prevention and early intervention will help minimize the effects of illness and disability on people's every day lives.

Administration and Finance Functions

GOAL: To ensure the efficient and effective management of the Department in order to meet its mission, goals, objectives and legislative mandates.

OBJECTIVE: The Department's budget, personnel functions, Regional operations and advocacy services will be managed efficiently and effectively.

Management and Budget

The Department's Central Office oversees the operation of the entire Department, sets policy and direction, articulates the translation from best practice standards to field applications, develops and maintains infrastructure, and develops and allocates resources.

Strategy: The Department shall have supervision, management and control of all programs, institutions, facilities and employees.

Performance Measures:

- **Percentage of contracts completed timely and accurately**
  The Department's ability to successfully execute contracts for services in a timely and organized way will contribute to the abilities of the Regions and providers to access funds to meet client needs, and to identify and project additional resources necessary to meet clients' unmet needs. Contracts sent to Purchases on or before 7/16/99 are considered timely.

  Source of data: Sources and Uses document

  Current data: 24% of 38 Central Office contracts were timely

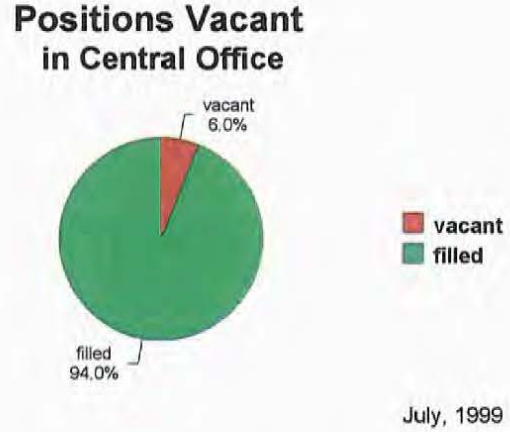
- **Percentage of positions vacant**
  The ability for any agency to attract and retain a skilled labor

force is critical to its ability to carry out its mission. It is even more critical for state agencies, DMHMRSAS in particular, given its mission to care for and support the lives of so many people. Despite competing pay scales and the nature and difficulty of the work, the Department has been successful in recruiting and retaining a consistent and skilled work force, with minimal vacancies. Although the Department will never be able to have zero percent vacancies in an agency this size, the Department tries to maintain a vacancy rate (given the current labor/job markets) of between 5 to 10% depending on the job class. Priority for filling vacant positions is always given to direct care lines.

Human Resources or Personnel functions will be assessed by the number, type and percentage of position vacancies, reflective of the available "inputs" to achieve the Department's mission and goals.

Source of data: vacancy statistics for July 1999

Current data: 6% (4) of 65.5 positions were vacant. Vacancies were all management and support positions.



- **Stage of completion of Systems Infrastructure Development Initiative**

  Paper reporting and numerous separate databases, developed to meet specific needs, have been the norm within the department, including the Mental Retardation Services management Information System (MR MIS); the Case Management Application (CMA), to track the AMHI consent decree class; Children's Services (the French database); and the Office of Substance Abuse Data System (OSADS). However, SIDI is in the process of developing links among these unconnected major databases and the Department budgeting and planning functions, as well as providing a viable method to track compliance with

Data System (OSADS). However, SIDI is in the process of developing links among these unconnected major databases and the Department budgeting and planning functions, as well as providing a viable method to track compliance with contracts and Quality Improvement requirements. The use of the Auditing/Contracting/Licensing Service Center, shared with the Department of Human Services, has placed a barrier to access licensing information.

SIDI is an ambitious, departmental multi-year project to develop a comprehensive data management and retrieval system, an integrated information system which will support fact-based decision making, budgeting, and planning efforts.

Source of data: quarterly reports from Office of Information Services (OIS)/SIDI

Current data: The first phase of OIS/SIDI is substantially completed, with major accomplishments in the following complex processes:

- The Phase One Consolidated Database has been developed and deployed, integrating the CMA database, the MR MIS, the MR waiver database, and Maine Medical Decision Support System (MMDSS), with the French database to be incorporated very shortly. Staff access to this database will increase with its continued development and the development of confidentiality and security guidelines and measures.

  The Consolidated Database has a significant standardized reporting capacity built into it, including information on clients served, services provided, and costs by age, county, gender, etc. This capacity is being augmented by the use of a powerful reporting tool (Oracle's Discoverer). Departmental staff are currently receiving intensive training in the use of this tool.

  A data mapping capacity has been developed, allowing information to be presented geographically. It will show data visually, making the data more clear and immediately useful to a wide range of users. For example, the locations of all community providers or service programs could be shown on maps of Maine or a specific county.

- The Children's Four Goal Project, the workgroup for which includes nine community providers, is piloting the use of individual planning and assessment processes, the tracking of service encounters (both Medicaid and non-Medicaid), and clinical/financial decision-making processes in a managed care context.

- OIS/SIDI is engaged in a major inter- departmental collaborative initiative to explore integration and/or linking of databases and information systems with

the Department of Human Services. This will be a major step forward in the implementation of integrated service systems able to serve Maine citizens seamlessly.

- In another interdepartmental collaborative process, DMHMRSAS and the Department of Labor have been working to provide a joint Help Desk computer technical assistance capacity to DMHMRSAS staff. We are now finalizing draft language for an agreement between the two departments.

- A decentralized team-based information system is in place in regional offices, Central Office, and Department facilities. These teams serve four functions, to provide computer support, application-specific support, computer-related training, and support for report generation. The reporting group team members have begun training to increase their expertise in providing and analyzing increasingly complex reports and data queries.

- **Percentage of information that is timely and complete**

  Linked to the development of a useful, accessible MIS is the need of internal customers for the data to be available in formats and with the degree of accuracy and timeliness necessary to be optimally useful. This measure will assess the status of the Department to equip staff with the tools necessary to do the work.

  Source of data: survey instrument, to be developed

  Current data: none available at this time

Strategy: Each Region shall have supervision, management and control of all Regional programs, institutions, facilities and employees.

The Department has been in the process over the past few years of moving both decision making and service delivery systems as close to the client/provider/family members as possible. This is a fundamental tenet of the Department's mission. Comprehensive regional operations are now available and oversee all the regional services of mental retardation, mental health (excluding the two psychiatric institutions), and children's services. To accomplish this, almost 500 Departmental FTEs (full time equivalents) are assigned to provide a wide range of programmatic services at the community level, in collaboration with several hundred providers.

Each region will be evaluated using the same measures for Finance and Personnel as is Central Office. The contribution of each Region to the overall performance of the Department will be noted, and the Regions will be compared to each other, providing internal bench marking.

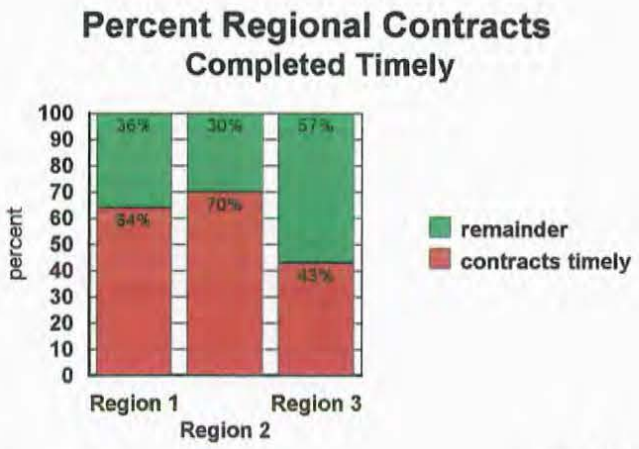
Performance Measures:

- **Percentage of contracts completed timely and accurately**

  The Department's ability to successfully execute contracts for services in a timely and organized way will contribute to the abilities of the Regions and providers to access funds to meet client needs, and to identify and project additional resources necessary to meet clients' unmet needs. Contracts sent to Purchases on or before 7/16/99 are considered timely.

  Source of data: Sources and Uses document

  Current data:



- **Percentage of positions vacant**

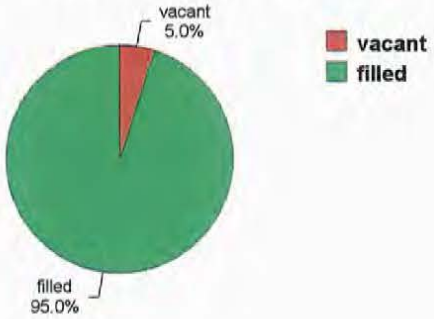
  Within the Department's for FY00

budget, and for the purposes of this plan, only the 38.5 positions specifically budgeted as "Regional Operations" (which are almost exclusively managers) are identified for this performance measure. The reader is asked to keep in mind that almost 500 FTEs also exist within the regions and provide a wide range of Departmental Services. The vacancy rate for those 500 FTEs is consistent with vacancy rates reflected below for the 38.5 lines.

Source of data: vacancy statistics for July, 1999

Current data: 6% of 38.5 positions were vacant

Percent Regional positions vacant
as of July 1, 1999



- **Percentage of timely performance evaluations**

To effectively manage the human resources of the Department, regular and complete performance evaluations establish baseline performance expectations and review progress towards agency goals. For purposes of this indicator, evaluations are considered timely if they are completed in the 30 day period immediately preceding the anniversary date.

Source of data: DMHMRSAS Human Resources

Current data: 50% of FY99 performance evaluations were completed timely

Advocacy

Strategy: The Office of Advocacy will investigate the claims and grievances of clients of the Department; will participate in the investigation of allegations of abuse, mistreatment or neglect of clients; and will advocate on behalf of clients for compliance with all laws, administrative rules and institutional and other policies relating to the rights and dignity of clients.

Advocacy makes a contribution to the performance of the Department, to promote the health, safety and welfare of clients and to assist in moving the system as a whole towards consumer-focused and -directed service delivery.

Performance Measures:

- **Numbers of grievances received**

  Critical to and indicative of the efficiency and effectiveness of advocacy, are the numbers and dispositions of grievances. Currently, there are several methods to lodge a grievance, and currently it is difficult to track the kinds of grievances made, the severity of grievances, or the disposition of grievances. Utilizing the concept of "least contest," it would be desirable for client grievances to be resolved expeditiously, appropriately and at the lowest level of intervention possible. The performance measures seek to demonstrate these elements in the resolution of grievances. The data presented is from Mental Health Services (MHS) and Mental Retardation Services (MRS).

Source of data:	MHS data	MRS data
Current data:	FY99: 12 (Level II/III)	calendar 99: 216

- **Number of allegations of abuse/mistreatment/neglect**

Source of data:	MHS data	MRS data
Current data:	FY99: 2 (Level II/III)	Jan-June 99: 32

- **Dispositions of grievances and allegations received**

Source of data:	MHS data	MRS data
Current data:	FY99: dismissed: 4 ongoing: 8 (Level II/III)	calendar 99: closed: 33

- **Comparison to similar services in other State Departments, other states and state Protection and Advocacy Services**

  A benchmark comparison can be made, by contrasting DMHMRSAS' advocacy services with similar services in other State agencies (such as Consumer Protection Services of the Office of the Attorney General), other states, and with Protection and Advocacy Services operated under Federal authority in each state.

  Source of data: survey instrument, to be developed

  Current data: none available at this time

- **Customer satisfaction survey to determine number or percentage who felt they had been treated respectfully throughout grievance resolution process**

  This measure seeks to demonstrate the degree to which people using the service, including parties making complaints and those against whom grievances are lodged, feel that the process of grievance resolution is fair, impartial and respectfully administered. The performance improvement plan survey should cover all services, including Advocacy.

  Source of data: survey instrument, to be developed

  Current data: none available at this time

Adult Mental Health Services

GOAL: To ensure that the full array of mental health, rehabilitation, residential and other support services are present in Maine communities in order to promote integration and quality of life for adults with long term mental illness.

OBJECTIVE: The maximum possible number of adults with long term mental illness will live independently in their communities, as a result of the availability of a full array of community based mental health treatment, rehabilitation, residential and other support services.

Mental Health Services (MHS) for adults has made great strides towards a community based system of care. Among the accomplishments of the last few years is the development of an increased range of community systems of care, which has resulted in reductions of the censuses of both the Augusta and Bangor Mental Health Institutes; the census at each hospital now stands in the 70-90 range. Additionally, each hospital has participated in the development of plans for further service enhancement within the community, and more creative and active treatment approaches within the hospitals. As an example of the increased community system development that has resulted in reductions of the census figures, community housing sponsored by the Department has increased 250% in the past three years, and now numbers over 1000 units statewide.

The plans for each of the hospitals focus on their taking a more active role in the delivery of community based services, such as day and rehabilitation services, to support people on the way to recovery. At the Augusta Mental Health Institute (AMHI), this work has been an ongoing process, necessitated and spurred by the 1990 AMHI consent decree, and has recently acheived the successful completion of a rigorous Health Care Finance Administration (HCFA) survey. The Department also anticipates the submission of a motion of substantial compliance of the AMHI consent decree within the next 12 months.

At the Bangor Mental Health Institute (BMHI), this shift towards greater integration with community based care has involved a reconfiguration of the hospital and an expansion of the hospital's role in northern and eastern Maine. A series of meetings with stakeholders were held in summer, 1998. These meetings resulted in the development of a plan for adult mental health services in Region III, released in December, 1998. This plan is a working document that serves as the hospital's blueprint for the future.

The development of trauma services brings Maine to the forefront nationally, providing services for people, particularly women, whose sexual, physical and emotional abuse

needs to be regularly considered and recognized as the underlying cause of some mental illnesses. As a result of the importance and prevalence of this issue, the Department has developed trauma safe houses in each region, a Dialectical Based Treatment (DBT) unit at BMHI, and training for hundreds of state and provider staff in DBT and trauma treatment. The Department is also exploring creative ways to fold state-of-the-art trauma treatment approaches into mainstream care systems throughout Maine.

Work Plans

See the Administration and Finance section of this plan for a more extensive discussion of the needs related to data gathering.

Mental Health Services/Mental Health Services Medicaid

Strategy: The Department will provide technical assistance for program development, promote effective coordination with health and human services and develop new resources and revenue streams in order to improve the availability and accessibility of comprehensive community support services to persons with chronic mental illness.

Performance Measures:

- **Percentage or number of services available where and when needed**

  MHS proposes to demonstrate the effective use of resources to enable people to recover from serious mental illness and to lead functional, useful, meaningful lives in their communities, by quantifying and monitoring elements characteristic of a mature and responsive system of service. Chief among these elements is the availability of services where needed, when needed.

  Four key services have been identified that, with the addition of inpatient hospitalization, represent the scope and extent of services provided. These four are crisis services, community support (a collection of services provided to consumers to assist them in the achievement of recovery, the most notable of which is case management), housing support, and vocational services. These four services approximate stages of recovery, in that people who are frequent users of crisis services will often replace crisis services with community support services in order to move towards recovery and stability. Similarly, people with stable and supportive living situations are frequently interested in and capable of meaningful employment. People at all stages of recovery may benefit from periodic hospitalization, and the Department has expanded the choices for inpatient services to include many community hospitals.

  The ability to establish baselines and to demonstrate any trends or improvement in service delivery, is being facilitated by the SIDI project in its development of a comprehensive information system. See the extensive discussion regarding SIDI in the Administration and Finance section.

  Currently, data is gathered in quarterly contract reports from individual agencies providing services, but the information is not necessarily comparable. Within a single Region, the presentation and comparability of data tend to become more similar and more easily analyzed, but comparisons between Regions is often difficult. The data are available, although it is labor intensive to obtain and to compare. With the full operationalization of the SIDI foundation systems, data retrieval and analysis will be much easier.

  Sources of data: FY99 contracts (crisis, housing), MMDSS (community support services), Department of Labor Division of Rehabilitation (vocational services)

Current data:

SERVICES AVAILABLE WHERE NEEDED, WHEN NEEDED

	REGION I	REGION II	REGION III	STATEWIDE
CRISIS* (contacts)	5062	24915	2912	32889
COMMUNITY SUPPORT SERVICES** (people served)	1986	3086	2011	7083
HOUSING*** (people served)	552	549	387	1488
VOCATIONAL SERVICES**** (people served)	730	652	592	1974

FY 99 data. *face-to-face evaluations **includes case management ***Bridging Rental Assistance Program (BRAP), Shelter Plus Care (S+C), General Obligation (GO) bonds, purchasing assistance ****DOL, DVR summary data, interpolated based on regional population estimates

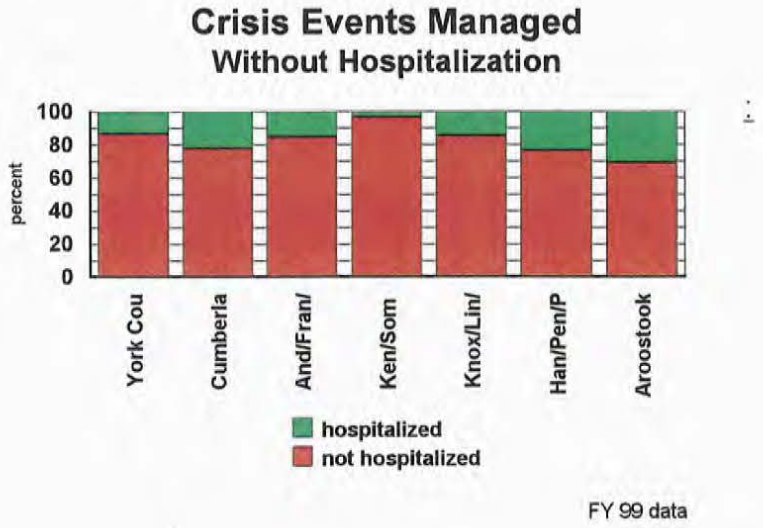
- **Number of crisis events managed at the least restrictive level**

  A subset to the first measure, the tracking of the delivery of crisis services in the least restrictive environment is indicative of easy accessibility and rapid response, permitting the crisis to be managed and brought to resolution with a minimum of escalation.

  As a result of the significant investment by the Department in establishing a statewide crisis system, which includes community hospital emergency beds, regional crisis beds, a network of skilled crisis workers and Assertive Community Treatment (ACT) teams, the rate of crisis events managed without hospitalization is significantly higher.

  The Department's state-wide, single crisis number (1-888-568-1112) links callers from any point in the state to the closest crisis service provider. This system expedites the provision of crisis stabilization services, and does not require consumers of services to know the name or the phone number of the crisis provider covering their area. This, too, has assisted in identifying and responding to crisis events expeditiously.

  Source of data: FY99 contracts



FY 99 data

- **Percentage of clients with positive community connections and participation (such as employment, community or peer support, first use of "generic" services)**

  Achieving community inclusion is not as simple as having a residence in a particular town. When people need help, they often turn first to family, friends and neighbors. People without such support may be more likely to need assistance from government or nonprofit agencies. People who do not experience a sense of inclusion often do not participate in their communities. MHS proposes to track the number or percentage of people served who have made positive community connections that are of a "generic" nature, not specially developed and provided for persons with mental health needs.

  Source of data: Through the implementation of the Quality Assurance plan, a mechanism to gather and track this information is being developed.

  Current data: no data available at this time

- **Percentage of clients with adverse outcomes (such as reports of abuse, incidents, emergency admissions, corrections involvement)**

  Associated with the third measure, this indicator proposes to measure the degree to which support and services were adequate to meet the needs of people.

  The Department's emerging comprehensive information system includes the development of a Critical Events data foundation system, which will include reports of abuse, seclusion and restraint, and other critical incidents. Emergency admissions will also be tracked through the Service Encounter data

reports of abuse, seclusion and restraint, and other critical incidents. Emergency admissions will also be tracked through the Service Encounter data foundation system. It will be possible to correlate these data to gain an understanding of their relationships for planning and service delivery purposes.

Source of data: Through the implementation of the Quality Assurance plan, a mechanism to gather and track this information is being developed.

Current data: no data available at this time

- **Community tenure compared to hospital length of stay**

  With the changing roles and relationships of the State psychiatric hospitals and community hospital psychiatric units, comparison of tenure in the community to the length of hospital stay will provide valuable insight into understanding the full range of system interactions. Persons leaving the hospitals may need re-hospitalization for short periods following the initial discharge. With the passage of time and the development of connections in the community, long-stay patients should be able to resume their lives as community members. Persons admitted to hospitals for shorter stays, in an ideal system, should have their out-of-hospital needs met with some degree of efficiency, and the need for rehospitalization due to system inadequacies should begin to approach zero.

  Community hospital discharge data is collected and maintained by the Maine Health Data Organizations (MHDO) and is not linked to DMHMRSAS information systems. MHDO data is controlled by clearly defined confidentiality statute, and small MHDO staff numbers limit its capacity to design and run such complex queries. With enhanced connections with MHDO, DMHMRSAS will be able to conduct those analyses, as allowed by confidentiality provisions, for its measures involving community hospital data.

  Source of data: The Department is establishing a link through SIDI to access and analyze this data, and it will be folded into the SIDI foundation system.

  Current data: no data available at this time

The Augusta Mental Health Institute

Strategy: The Department will administer the Augusta Mental Health Institute to receive all persons legally sent to the Institute who are in need of special care and treatment, according to commitment laws contained at 34B MRSA §3831.

The Augusta Mental Health Institute (AMHI) is a licensed psychiatric hospital, primarily serving people in Regions I and II. Currently, 103 beds are staffed and available for admissions. Of these, 27 are reserved for male forensics patients; female forensics patients are treated on non-forensics units. Because of principles of sound psychiatric care, community responsiveness and the need for some clients to quickly access safe acute care settings, the hospital does occasionally permit voluntary admissions.

The Bangor Mental Health Institute

Strategy: The Department will administer the Bangor Mental Health Institute to receive all persons legally sent to the institute who are in need of special care and treatment, according to commitment laws contained at 34B MRSA §3831.

The Bangor Mental Health Institute (BMHI) is a licensed psychiatric hospital, primarily serving Region III residents. Currently, 100 beds are staffed and available for admission. BMHI has no dedicated forensics ward or bed; persons on legal hold status are held on regular units. As is the case with AMHI, because of principles of sound psychiatric care, community responsiveness and the need for some clients to quickly access safe acute care settings, the hospital does occasionally permit voluntary admissions.

It is anticipated that the following performance measures will be compared to similar facilities in other states, but certainly against each other.

Performance Measures:

- **Length of community tenure of discharge patients (time since last admission)**

  AMHI and BMHI propose to measure their effectiveness and efficiency in treating people with mental illness, by tracking the community tenure of patients discharged. It is assumed that people who achieve better control over their symptoms and illnesses, have an improved chance to remain stable in the community and are less likely to require frequent hospital admissions or re-admissions after discharge.

  Source of data: AMHI, BMHI medical records

COMMUNITY TENURE OF DISCHARGED PATIENTS

MEAN LENGTH OF TIME SINCE LAST ADMISSION
PATIENTS ADMITTED FY99

AMHI	BMHI
27.5 months	29.5 months

SOURCE: MEDICAL RECORDS DEPARTMENTS, AMHI AND BMHI

- **Number and scope of treatment services offered, facilitated or delivered**

  This is a method to track the nature, scope and volume of services provided on an inpatient basis. There are four essential core institutional services provided within the definition of clinical care: psychiatric/physician care, nursing, social work and psychology.

  Source of data: AMHI, BMHI medical records

SERVICE CONTACTS PROVIDED
FY99

	PHYSICIAN	NURSING	SOCIAL WORK	PSYCHOLOGY
AMHI	101,045	131,167	38,315	10,005
BMHI	97,256	106,624	28,388	7,568

SOURCE: MEDICAL RECORDS DEPARTMENTS, AMHI AND BMHI

- **Efficiency in the use of outpatient services**

  This measures the efficiency of treatment services, particularly the rate of increase in the use of outpatient services. The purpose is to demonstrate the degree to which supports and services are made available to people, intervening in a community setting when appropriate rather than with hospitalization.

  Outpatient services in Regions I and II are contracted through community service providers and agencies. AMHI outpatient clinic serves consumers who are not eligible for entitlements and/or are on waiting lists for community services. The AMHI outpatient clinic is utilized as a safety net for Regions I and II.

  BMHI currently has a significant hospital-based outpatient service that is well integrated and effective in meeting community needs. This outpatient effort includes the Community Link and Support Program (CLASP) and Senior Treatment and Respite Services (STARS), and an extensive medication and dental clinic. This, plus the contracted outpatient services, serves Region III.

This is baseline data, to be utilized for comparison purposes in future.

OUTPATIENT SERVICES CONTACTS
FY99

	Medical Clinic	Dental Clinic
AMHI	185	1,695
BMHI	400	1,332

SOURCE: MEDICAL RECORDS

- **Maintenance of accreditation, licensure and Medicaid eligibility**
  It is important to DMHMRSAS to adhere to national standards of competency and proficiency in the psychiatric hospitals, to ensure the highest standards of care to the people of Maine. The highest independent national standards are those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The approval of the Health Care Finance Administration (HCFA) and the state licensing authority (Department of Human Services, DHS) ensures participation in the Medicaid program and the adherence to statewide standards of practice.

HOSPITALS' LICENSURE AND ACCREDITATION STATUS

	AMHI		BMHI	
	granted	**due**	**granted**	**due**
JCAHO	11/97	11/00	9/97	9/00
HCFA	10/99	10/02	3/98	3/01
DHS	11/99	10/00	5/99	5/02

SOURCE: HOSPITALS

Explanatory Factors: The reorganization of BMHI and the changes in community systems availability are processes that are ongoing and that have been and are being enhanced. The AMHI consent decree and the resources expended to comply are driving forces in the southern part of Maine, which until recently have not been felt as strongly in Region III. The physical plant at AMHI is not conducive to modern inpatient treatment and state-of-the-art forensics treatment services.

Adult Mental Retardation Services

GOAL: To ensure that the full array of habilitative, therapeutic, residential and other support services are present in Maine communities in order to promote integration and quality of life for adults with mental retardation.

OBJECTIVE: Adults with mental retardation will live as independently as possible as a result of the availability of a full array of community based habilitative, therapeutic, residential and other support services.

With the closing of Pineland Center in 1996, Mental Retardation Services (MRS) achieved a major goal of community integration, and now oversees a system that is almost entirely community based. Two small State-run facilities provide specialized services, with their principal focus the support of people who cannot otherwise achieve full integration into their communities.

Mental Retardation Services carries out the Department's plan to maximize opportunities for adults with mental retardation to profit from the variety of options available to all Maine's people. With the exception of the case management and crisis services and the two State operated facilities, all services are provided by private agencies, through grants and service agreements.

MRS has worked to develop programs to comply with the Community Consent Decree. Among the accomplishments is a nationally recognized crisis service, incorporating a proactive approach to avert crisis events rather than merely react.

A persistent problem in MRS has been a two-tiered system of eligibility for services. Pineland class members have benefited from their priority status gained through the *Wuori* decision. Unfortunately, there are many more people who would benefit from the same access to services, who must wait for an opening. Many of these people have been living at home with their families of origin, many without meaningful work and limited involvement in community life.

See the Administration and Finance section of this plan for a more extensive discussion of the needs related to data gathering.

Mental Retardation Services/Mental Retardation Services Medicaid

Strategy: The Department will plan, promote, coordinate and develop a complete and integrated statewide system of mental retardation services to meet the needs of adults with mental retardation.

Performance Measures:

- **Average length of time between the request for services and the receipt of services**

  MRS proposes to demonstrate its effectiveness by monitoring the percentage of all people who receive or are eligible for services, who are waiting for the service, and the length of time that elapses from first request for services and actual service delivery. For purposes of strategic plannning/performance budgeting, MRS proposes to focus on the priority service need areas (residential, programmatic and vocational). It is important for the reader to note that the data below does not reflect instances in which the Department provided services within 30 days. Those instances are considered to be needs that have been met within an acceptable time frame. There are hundreds of clients whose needs are met within 30 days.

  Source of data: MR MIS

Current data:		
	Residential	410 days
	Programmatic	375 days
	Vocational	360 days

- **Number of people on waiting lists for services**

  For purposes of strategic plannning/performance budgeting, MRS proposes to focus on the priority service need areas (residential, programmatic and vocational).

  Source of data: MR MIS

  Current data:

source: MR MIS

- **Number of people who have increased independence due to skill building**
  Personal growth towards independence will be tracked, measured by the amount of specialized, individualized supports required, which should decrease as skills improve.

  Source of data: waiver tracking system, under development

  Current data: none available at this time

- **Customer satisfaction measures, including sense of safety in the community, integration of services, the fulfillment of personal needs or desires, and the availability of choices in everyday life**
  A fundamental concept in human services is the primacy of satisfaction with the services being rendered and the improved quality of life due to the services. A sense of well-being and fulfillment on the part of consumers is the pinnacle of achievement. To this end, MRS proposes to assess the degree of satisfaction with services provided, in a survey process.

  The instrument to collect this data has been under development for some time, and is now completed. Training to staff who will administer the instrument is scheduled for March, 2000; the interviews themselves will be incorporated into the Person Centered Planning process, and will be conducted in conjunction with the preplanning sessions. The data collection system is scheduled to be operational by April, 2000.

  Source of data: Quality of Life Interview Instrument

  Current data: none available at this time

- **Number or percentage of people who are participating in personally fulfilling activities**
  The degree to which people with mental retardation are participating in personally fulfilling activities is one important measure of community inclusion and normalization. Consumers, families and agencies should be working toward ensuring that people have opportunities to experience and choose from the full range of possibilities in life.

  The Quality of Life Interview Instrument, described more fully above, will be the source of information for this performance indicator.

  Source of data: Quality of Life Interview Instrument

  Current data: none available at this time

Explanatory Factors

The Department has the ability to predict with some degree of accuracy the number of people who will need mental retardation services. In contrast to consumers of other services, persons with mental retardation generally require lifelong supports and care. While the degree and type of services needed change over the course of life, almost no person who qualifies for MR services reaches a place where all services can be terminated.

The Department continues to work toward providing supports to all who meet the eligibility requirement for those services. In addition, the department continues to work with other departments to ensure appropriate supports to citizens of Maine, who while not eligible for our services, demonstrate a need for ongoing supports.

Aroostook Residential Center

Strategy: The Department will administer the Aroostook Residential Center to provide training, education, treatment and care to persons with mental retardation.

The Aroostook Residential Center (ARC), located in Presque Isle, provides respite (2 beds) and long term residential care (10 beds) to adults who have been living at home or in small facilities in the community. Behavioral adjustment difficulties, including behavior that is self-injurious or directed towards others, is a frequent reason for admission, as is the need for care while linkage to or development of necessary community services is completed. Persons who have been diagnosed with both mental retardation and mental health issues can receive services at ARC.

People who are admitted to ARC generally enter the facility with a discharge and community transition plan already in place. In order to support the philosophical shift in emphasis from institutional care to community based care and support, ARC's performance indicators should demonstrate the facility's ability to help residents achieve increasingly more rapid reductions in or elimination of specific behaviors, increased skills development, and an increased proportion of successful community living situations following discharge from ARC.

Performance Measures:

- **Number of emergency admissions**

  As a significant part of the Department's safety net in mental retardation services, ARC should be able to respond to the needs of the community and individuals, including a rapid and appropriate response to an emergency need for care.

  Source of data: admission records, FY99

  Current data: 8 persons admitted on an emergency basis

- **Number of persons admitted and discharged**

  Similarly, ARC needs to maintain a system of care that emphasizes individual growth towards as much independence as possible. It is important that people who use ARC's services receive the habilitation and training necessary to leave ARC for a less restrictive community based living situation.

  Source of data: admission and discharge records, FY99

  Current data: 12 admitted (includes 4 emergency and 4 respite)

  9 discharged (includes 4 respite, 5 regular)

- **Number of people discharged whose living situation remained stable 6 months following discharge**

  The stability and appropriateness of the community living situations of the people discharged from ARC six months following discharge demonstrates both the skills of the ARC staff to assess, habilitate and plan appropriate discharges for clients, but also to the strength of the outreach and community system that provides continuing support.

  Source of data: MRS caseworker records, FY99

  Current data: 3 of 5 people discharge (regular discharge) were living successfully in the community 6 months later

- **Number of people who improve independent living and functional behavioral skills**

  Successful community living for people with mental retardation is sometimes hampered by the individual's relative lack of independent living and functional behavioral skills. Through habilitation plans, ARC provides the training necessary for people to acquire these skills. ARC proposes to demonstrate this by measuring number of objectives for improving functional behavior and independent living skills that have been acheived, as described in habilitation plans.

  Source of data: to be developed

  Current data: none available at this time

- **Number of people who demonstrate decreases in aggressive and self-injurious behaviors**

  Behaviors that frequently precipitate admissions include aggression directed towards others or towards property and self-injurious behavior. As with the improved skills in the objective above, ARC provides the training necessary, identified in habilitation plans, for people to reduce aggressive and injurious behaviors.

  Source of data: to be developed

  Current data: none available at this time

Explanatory Factors

Factors which will influence these efforts include the stability of the Aroostook community-based system in general, the availability of specialized services, and the number of people who need ARC's services. The Aroostook community is generally

very welcoming and supportive of its members with intellectual and cognitive impairments; this augurs well for the continued effort to help people be served and stay in their own communities. Economic pressures in Aroostook are two edged, and may exert negative influence against community inclusion, if employment of family caregivers outside the home becomes necessary to ensure the financial survival of the family unit. The same need to work outside the home will increase the pool of people available and willing to support people with mental retardation in their own homes, in community based residences or in the consumers' homes.

Freeport Towne Square

Strategy: The Department will administer the Freeport Towne Square facility to provide training, education, treatment and care to persons with mental retardation.

Freeport Towne Square (FTS) provides both residential care to twelve adults with mental retardation, and the Marty Wuori Workshop, a sheltered workshop setting serving 38 people. The people who live at FTS have called it home for many years.

Performance Measures

- **Number and percentage of current workshop participants transitioning into community based settings of their choice**

  The Department is committed to full community inclusion for people with mental retardation; we number among our successes the decrease in sheltered work settings in favor or "real work, real pay" opportunities in community businesses. It is natural and fitting that the Department's own sheltered workshop participate fully in the de-institutionalization of work for people with mental retardation. The values that will guide the process of developing work sites for the people currently participating in the workshop include wages equal to or greater than that earned at the workshop, work opportunities integrated into the general business community, personal choice in characteristics and location of work, and recognition of and respect for long term peer relationships.

  FTS proposes to measure the success of this enterprise by tracking the number of current workshop participants who have successfully transitioned to community-based worksites, the number of worksites available to people from which to choose, and the number of new worksites developed. The information will be presented in discrete steps, the final step being community job placement.

  Source of data: FTS records

  Current data:

STEPS TOWARD COMMUNITY BASED EMPLOYMENT
OF PEOPLE CURRENTLY AT FTS WORKSHOP

TASK	NUMBER COMPLETING	PERCENT COMPLETING
Employment portfolio completed	19	50
Preplanning meeting held	4	11
Career planning done	0	0
Life Activity planning done	0	0
Job development/job shadowing	0	0
Job placement	0	0

SOURCE: FTS RECORDS, 12/99

- **Number of community work settings developed for people's transitions**

  Source of data: FTS records

  Current data: One site was developed in FY99, with one person successfully transitioning to community employment.

- **Maintenance of accreditation, licensure and Medicaid certification**

  Licensing standards are important criteria that the Department constantly strives for and sees programmatic value in requiring.

  We will continue to maintain licensure as an Intermediate Care Facility for Mentally Retarded Persons (ICF/MR) and certification to receive Medicaid payments

  Source of data: DHS Licensing and Certification

  Current data: full licensure through 3/2000, Medicaid recipient

- **Increases in skills development and decreases in aggressive and self-injurious behaviors**

  To measure the success of the residential program at FTS, an indicator has been proposed to demonstrate the effectiveness of FTS's assessment, care planning and delivery system, by measuring the increased skill development necessary for people to succeed in the community. All habilitation plans to improve independent living skills were reviewed; the data indicated reflects the percent of plans per quarter year where measurable improvement was noted.

  Source of data: FTS client records

  Current data: 30%

Explanatory Factors

The workshop has been a fixture in the mental retardation system and the town of Freeport for many years. Because of the long-standing relationships with contractors providing work to the workshop, the work habits of the people who have attended the workshop, and the natural resistance to change, the transition to community based work may be difficult for some people. The overall economic climate is expected to remain good in the southern Maine area, which will be a positive influence in job development.

Children's Services

GOAL: To ensure that services for children at risk or in need of services, and supportive services for their families, are present in Maine communities in order to promote the children's health and development.

OBJECTIVE: The maximum number of children possible will be able to remain safely at home, due to the delivery of appropriate therapeutic and habilitative services for them and their families in their communities.

Services are provided to children from birth through the 20th year, for mental illness, mental retardation, autism, developmental disabilities, and emotional and behavioral needs. Supportive services provided to families include respite, self help and support groups, family counseling, and after school and summer programs.

Services to children in Maine are the responsibility of four child-serving state agencies: DMHMRSAS, Department of Human Services, Department of Education, and Department of Corrections. DMHMRSAS has been tasked by the Legislature (Public Law Ch 790, formerly LD 1744) to act as lead agency in the development of an integrated children's behavioral health system, under the review of the Children's Oversight Committee. In this role, interagency case resolution committees have been developed in seven locations around the state, to bridge the gaps, through the use of flexible and pooled funding, and to eliminate redundancy in service delivery to children.

As a result of the Governor's Youth Suicide Task Force, a number of initiatives focusing on high-risk adolescents have been implemented, including services to homeless youth and new resources in each Departmental region, such as gatekeeping training in public schools, design and implementation of at-risk screening tools, development of a toll free number and public education materials.

DMHMRSAS Children's Services is currently undergoing an organizational restructuring process to most effectively and efficiently deliver, develop and oversee the provision of services to Maine's children. Some of the initiatives of Children's Services, undertaken to ensure effective service delivery, include

- **MyCare**
  MyCare is a blueprint for the service delivery system, which will allow for managing the behavioral health needs and provision of care across all children's disabilities groups. This model is described in the Children's Medicaid Waiver (Section 1915(b), scheduled to be submitted to HCFA in early 2000.

- **Four Goals Project**
  The DMHMRSAS Children's Services, as part of SIDI, is developing a data management/information tracking system. This tracking system will integrate information pertaining to assessment, individual service plans and financial supports provided to a child.

- **Utilization Review (UR)**
  The primary function of Utilization Review is to assure the most effective and efficient service is delivered to Maine's children and families. This is accomplished through on-site visits and medical record reviews by qualified staff.

- **Case management Standards**
  Case management standards were created to provide a consistent framework for the delivery of core services to children and families.

Work Plans

The Department of Mental Health, Mental Retardation and Substance Abuse Services' enabling acts for children's services is found in two Sections, Chapter 6, subchapter II (34B MRSA 6201.2.C), and Chapter 15. Integration of these two Chapters is a goal over the coming year in order to consolidate all of Children's Services into one Chapter.

See the Administration and Finance section of this plan for a more extensive discussion of the needs related to data gathering.

Children's Services/Children's Medicaid

Strategy: The Department will assure the provision of mental health care, social and habilitative services to children with treatment needs related to mental illness, mental retardation, autism, developmental disabilities, or emotional or behavioral needs; children with disorders of infancy or early childhood; and children at risk of mental impairment, emotional or behavioral disorders or developmental delays, and supportive services to their families.

Performance Measures:

- **Number or percentage of needs that are unmet**

  The needs of children and their families that are unmet is an indicator of the adequacy of the system of care for children in need of services. Core services were identified in collaboration with the Children's Oversight Committee, and include case management, in-home supports, home-based services, acute inpatient services, and residential treatment. While the Department has collected data in all the core services, only case management and in-home supports are reported here, because we are most confident in reporting the data collected on these services.

  Source of data: Agency wait list

  Current data: Service: Case Management
  Source: Case Management Quality Assignment Report
  659 children

  Service: In home Supports
  Source: Children's Services database Round 1 & 2, Service Status Still Wanting Service
  24 children

- **Number of children able to remain in their homes, because appropriate and adequate services were identified and provided**

  Children's Services proposes to demonstrate its successful efforts to develop a comprehensive array of community-based behavioral health services to meet the needs of children and their families, by measuring the number of children who are able to successfully stay in their own homes, because needed services are available and delivered optimally. It is expected that the number of children remaining with their families would increase as the system develops.

  Source of data: Children's Services database Round 1 & 2, Service Status Fully and Partially Served

  Current data: 307 children

- **Average length of stay in out-of-home placements**

  By extension, it is expected that the number of out-of-home placements would decrease as the service delivery system matures. Therefore, DMHMRSAS proposes as a measure the average length of stay in in-state psychiatric hospitals, out of state psychiatric hospitals, and Children's Residential Treatment facilities.

  Source of data: MMDSS

  Current data: Instate psychiatric hospital: 47.5 days
  Out of state psychiatric hospital: 110 days
  Children's Residential Treatment: 212 days

- **Average travel distance to reach services**
- **Number of providers available to provide each service**

  Another pair of measures will demonstrate the distribution of services throughout the state. In an ideal situation, parents and children in populous York and Cumberland Counties would have similar travel distances to non-mobile services as would parents and children in the lightly populated areas Downeast and in Aroostook County. This is a particular problem in Maine, due to the general lack of public transportation and geographic challenges. Similarly, the availability of choices in providers varies from one area of the state to another, related in part to the population density of the area, the proximity to centers of professional education, and similar factors. These two measures seek to demonstrate the progress being made in developing services in all parts of the state to ensure equity in access.

  Source of data:
  mileage: customer survey to be developed
  number of providers: contracts, provider letters of agreement

  Current data:
  mileage: none available
  number of providers:

PROVIDERS OF CHILDREN'S SERVICES

	Region 1	Region 2	Region 3
case management	3	6	3
in home supports	14	27	8
home based services	3	4	2
acute inpatient*	1	1	1
residential treatment	0	6	2

FY 99 SOURCE: CONTRACTS, LETTERS OF AGREEMENT

* The Department does not contract with the hospitals (Spring Harbor, Acadia) to provide services to children. This information is provided to demonstrate the array of services available throughout the state at this time.

Explanatory factors:

As noted throughout the Children's Service plan, there is a significant and dynamic change impacting Maine's system of care for children. Much of this momentum is attributed to the vision set forth in Chapter 790. The law established lead agency responsibility to DMHMRSAS to implement a system of mental health care, in collaboration with other State child-serving agencies. Collaborative strategies to implement the system are documented by Memoranda of Agreement. The children's service system of care will guide the finalization of the MyCare model and structures.

Elizabeth Levinson Center

Strategy: The Department will provide training, education, treatment, and care to all persons received into or receiving services from the Elizabeth Levinson Center.

The Department operates the Elizabeth Levinson Center (ELC), Bangor, a 20 bed facility to serve children with severe or profound mental retardation and multiple medical disabilities. Four beds are reserved for short term respite care of children who are being supported in their family homes or in foster homes. ELC's services are integrated with the Bangor public schools, local health care providers, and other service networks, to meet the educational, health and programmatic needs of the children.

Performance Measures:

- **Number or percentage of parents satisfied with care**

  ELC proposes to measure satisfaction with the services it provides. Data for short term respite care and longer-term residential treatment will be collected and evaluated separately. This system of assessing satisfaction will require some refinement and support to achieve.

  Source of data: survey instrument, to be developed

  Current data: Anecdotal information, in the form of letters from providers and parents, indicate high levels of satisfaction. No formal data is available at this time.

- **Cost of services provided at ELC compared to other, similar facilities**

  A benchmark measure, to assess the fiscal efficiency of service provision, will compare the cost of care at ELC to the cost of similar care at other facilities. For this purpose, facilities that are operated by other governmental entities out of state and private facilities in-state and out of state will be utilized for comparison. This measure will require some oversight and care in execution, to ensure that contrasts are made between similar facilities and/or similar services.

  Source of data: survey to be developed for future use. Current data is limited to ELC only.

  Current data:

DAILY RATES OF FACILITIES

Facility	Medicaid daily rate
ELC	$299.89

SOURCE: MEDICAID DAILY RATES

- **Maintenance of licensure and Medicaid certification**

  It is critical to ensure levels of professional, state of the art care, that ELC continues to be adherent to both state and national certification and licensing standards.

  Source of data: licensing records

  Current data: license issued 6/99, due for review 6/00

- **Percentage of Interdisciplinary Team (IDT) plan objectives met**

  The fourth measure proposed will track the success of the active treatment at ELC, measured by the achievement of IDT objectives. The IDT is a comprehensive plan to describe and direct the habilitation program and the provision of other services to the children at ELC. It is similar to the person centered planning (PCP) process in MRS and the individual service plan (ISP) in MHS.

  Source of data: A data base will be developed for future use. Current data is derived from the review of records of the 15 children at ELC during the period of November, 1998, to November, 1999 (excludes children receiving respite care).

  Current data: progress toward or achievement of IDT objectives for 48% of all objectives

Explanatory Factors: Children's Services currently is in significant transition, charged with taking the lead to grow a comprehensive system of behavioral health care for Maine's children. The degree of system integration will affect the outcomes described above in ways that are, at this time, unpredictable. The rates of growth and maturation of the community system may cause the Department to constantly examine the place of ELC in the array of services, including the possibility for ELC to specialize in very short stay evaluation/assessment/stabilization services, or to a shift in greater or lesser respite care, or to more outpatient and outreach. Because these things are unknown due to larger system unknowns, the entire plan for ELC may require significant adjustment over time.

Office of Substance Abuse

GOAL: To ensure that all Maine people are free from the effects of substance abuse.

OBJECTIVE: Services to reduce substance abuse will be available to Maine's people where needed, when needed, as needed.

The Office of Substance Abuse (OSA) was merged with the Department of Mental Health and Mental Retardation by the 117th Maine Legislature, and formally joined the Department on July 1, 1996. This change has enhanced DMHMRSAS' and OSA's abilities to integrate services to consumers, a significant proportion of whom have substance abuse problems and mental health and/or mental retardation issues.

OSA provides technical assistance and informational materials to treatment and prevention providers, manages the State's response to impaired driving (Driver Education and Evaluation Programs, DEEP), develops and delivers substance abuse services to persons in the correctional system, and oversees the treatment and prevention programs funded by the State and federal resources. OSA does not itself provide any direct services, instead contracting with agencies and individuals for services.

The Office is the primary liaison with other Departments, the Legislature, citizens and service providers on issues pertaining to substance abuse. Additionally, OSA works with other Departments to implement tobacco control, cessation and abstinence programs. Maine has joined with six other states to develop needs assessment and resource allocation methodology based on the measurement of risk and protective factors, to help guide the development and delivery of prevention services for maximal effectiveness.

The OSA data system (OSADS) was started in 1992 and can track treatment clients from admission to discharge. The conversion of the data base from a paper system to electronic filing was begun in 1998, but software problems and personnel changes have hampered the completion of this project.

Work plans: resolution of electronic treatment data transfer to OSADS is targeted for completion in calendar years 1999-2000.

Driver Education and Evaluation Programs

Strategy: The Office of Substance Abuse will administer alcohol and other drug education, evaluation and treatment programs for persons who are required to complete such programs due to an alcohol-related or other drug-related motor vehicle incident.

Performance Measures:

- **Number of people served by each DEEP component**

OSA proposes to demonstrate output, by tallying the number of people enrolled in and completing each DEEP component.

Source of data: Intervention Data System (IDS), Office of Substance Abuse Data System (OSADS)

Current data:

SFY 1998 Completed Cases	
TEEN	745
Adult Assessment	1472
Weekend Program	1578
Treatment	2208
Out of State	747
Military	97

- **Number or percentage of repeat OUI arrests within two years after DEEP intervention**

Source of data: Program Audit and Recidivism Rate Study, Commonwealth Marketing & Development, 1995.

Current data:

Adult Assessment Program	10.0%
Weekend Intervention Program	10.8%
Completion of Treatment Program	22.0%

- **Numbers of repeat OUI arrests for persons not completing DEEP compared to arrests for persons who have completed DEEP**

Source of data: None

Current data: Not currently available. OSA will explore the feasibility of collecting this information.

- **Number of persons who completed DEEP for juvenile offenders who are arrested for OUI as adults**

  Source of data: Program Audit and Recidivism Rate Study, Commonwealth Marketing & Development, 1995.

  Current data:

  TEEN 9.1%

  Effectiveness of the DEEP program will be measured using recidivism rates for juvenile and adult clients, for three separate indicators. OSA began using unique identifiers in July, 1998, which will permit tracking recidivism rates.

- **Percentage of DEEP clients referred for treatment, who complete that treatment**

  Source of data: Not currently available.

  Current data: Exploring the ability to interpolate the data from the Intervention Data System (IDS) and the Treatment Data System (TDS).

- **Client satisfaction with time elapsed from process initiation to entering appropriate DEEP component**

  OSA receives approximately 38,000 calls yearly from DEEP clients, maintains an open caseload of 12, 000, and opens and closes about 6600 cases annually.

  Source of data: Not currently available but will be adding a question to the evaluation form in January, 2000 so data will be available in future.

  Current data: None currently.

Explanatory Factors: Public Safety strategies to increase impaired driver arrests will increase the number of people referred for intake, the number needing services, and the rate of recidivism. Clients typically wait until the license suspension period is nearing the end before enrolling in DEEP, resulting in little control over the extent of the caseload or the length of time a particular client will remain on the open caseload.

Work plans: Legislative action in 1999 allowed OSA flexibility in the program design, which had previously been prescribed in statute. OSA has redesigned the youth

program and will be implementing it in fall, 1999. The adult programs are being redesigned to improve effectiveness and to streamline the application process.

Substance Abuse/Substance Abuse Medicaid

Strategy: OSA will establish and provide for the implementation of a comprehensive and coordinated program of alcohol and drug abuse prevention and treatment.

Performance Measures:

- **Number or percentage of people who complete treatment**
  Treatment completion has a direct and strong relationship with treatment success.

  Source of data: Treatment Data System (TDS), Office of Substance Abuse Data System (OSADS).

  Current data: 42.8%

- **Number of clients in publicly funded programs who are abstinent or who demonstrate a reduction in use at the time of discharge**
  Increases in abstinence and reduction in use are measures of program effectiveness, but also result in savings for health care and improved social productivity and family impact.

  Source of data: Treatment Data System (TDS), Office of Substance Abuse Data System (OSADS).

  Current data: 77%

- **Reduction in arrests during treatment**
  OSA proposes to demonstrate the effectiveness of treatment to improve public safety, by measuring the overall degree of criminality of participants and specifically the prevalence of arrests for substance abuse issues.

  Source of data: Treatment Data System (TDS), Office of Substance Abuse Data System (OSADS).

  Current data: 96%

- **Increased employability at time of discharge**

  OSA proposes to demonstrate improved social productivity by tracking the improvement in employment status of persons who have completed treatment.

  Source of data: Treatment Data System (TDS), Office of Substance Abuse Data System (OSADS).

  Current data: 20%

- **Extent of outreach activities**

  The Office of Substance Abuse will support substance abuse services by developing and managing convenient, accessible, and cost-effective information services that are aligned with the strategic directions of the organization. This strategy will incorporate current technology to organize and present information in a way that maximizes its usefulness to clients.

  Source of data: Information and Resource Center, Office of Substance Abuse.

  Current data:

Items Loaned/Distributed:	FY '98
Books	499
Pamphlets/Handouts/Posters*	57242
Publications	5648
Miscellaneous Items	70
Videos	4206
Total Items Sent	67665

Explanatory Factors: The incidence and severity of substance abuse is closely tied to the health of the economy, with increased occurrence of abuse accompanying economic downturns. Maine's economy is predicted to remain robust for the foreseeable future, but an increase in demand for services during economic circumstances that guarantee no increase in funding will adversely affect OSA's ability to effectively counter the substance abuse problem. Additionally, the availability of illicit drugs in Maine is a variable over which OSA has no control.