STATE OF MAINE
KENNEBEC, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAULS BATES, et al.,

Plaintiffs

v.

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Defendants

COURT MASTER'S PROGRESS
REPORT PURSUANT TO
PARAGRAPH 299

As noted in my last progress report dated February 4, 2021, I entered an order amending the compliance standards for the Consent Decree and Settlement Agreement on January 21, 2021. The amended compliance standards were agreed to by the parties, and since that date the progress reports have taken the form of quarterly Consent Decree Standards Reports issued by the Department's Office of Behavioral Health.

On September 23, 2024, I entered an order pursuant to Paragraph 291 of the Settlement Agreement further amending standards #6(a), #6(b), and #7 for the reasons specified therein. I also recommended that the Department recalculate the data contained in the previously issued quarterly reports and determine and report whether it has achieved compliance with the amended standards for at least four (4) out of six (6) consecutive quarters since 2021. The Department has complied with my suggestion and has provided the recalculated quarterly report. Attached as Exhibit A is a summary chart provided by the Department of all reporting quarters to date indicating that it has achieved substantial compliance with all standards. Accordingly, I recommend that the Department file a notice of substantial compliance with the Court, pursuant

to the original Consent Decree and the Agreement of the Parties, dated January 20, 2021, seeking dissolution of the injunction entered by the Court on August 2, 1990.

At my request the Department has provided the report attached hereto as Exhibit B, outlining system improvements and initiatives currently in place or underway. In my judgment, these efforts are designed to build upon and maintain the improvements achieved in the community mental health system and the State's psychiatric hospitals since the advent of the Consent Decree. The policies, practices and systems put in place by the Department, as described in Exhibit B, reflect enduring improvements to the adult community mental health system, and supported by robust advocacy as currently in place, satisfy the system-based approach to substantial compliance previously articulated by the Law Court (2004 ME 154, ¶¶ 73-81).

Dated: October 24, 2024

Daniel E. Wathen, Court Master

EXHIBIT A

Consent Decree Compliance Standards
Updated Status Report Reflecting Amended Compliance Standards from Sept. 23, 2024

	2021		2022				2023				2024	
Standard	**Jul-Sept**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sept**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sept**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**
1. PNMI Referral Acceptance	100% 25/25	97% 35/36	97% 71/73	98% 61/62	98% 52/53	93% 38/41	97% 36/37	98% 43/44	100% 53/53	93% 50/54	97% 37/38	100% 44/44
2. PNMI Referral Admission	[illegible]	86% 12/14	[illegible]	81% 21/26	[illegible]	83% 20/24	85% 39/46	88% 22/25	80% 35/44	[illegible]	[illegible]	[illegible]
3. BRAP Access	4 Days	3 Days	3 Days	3 Days	3 Days	3 Days	4 Days	4 Days	4 Days	4 Days	[illegible]	[illegible]
4a. Community Integration 7-Day	[illegible]	[illegible]	65% 270/416	71% 252/357	69% 164/239	61% 120/198	63% 130/206	72% 95/132	61% 105/171	70% 97/139	75% 129/173	80% 122/153
4b. Community Integration 30-Day	[illegible]	[illegible]	[illegible]	[illegible]	88% 209/239	85% 168/198	86% 178/206	86% 113/132	[illegible]	86% 120/139	91% 158/173	92% 141/158
5a. Assertive Community Treatment 7-Day	64% 7/11	61% 14/23	69% 27/39	80% 20/25	71% 24/34	68% 13/19	78% 29/37	100% 11/11	71% 10/14	[illegible]	[illegible]	[illegible]
5b. Assertive Community Treatment 30-Day	91% 32/35	90% 10/11	[illegible]	88% 34/39	91% 29/32	[illegible]	92% 34/37	100% 11/11	86% 12/14	[illegible]	[illegible]	[illegible]
6a. Medication Management 14-Day	[illegible]	[illegible]	[illegible]	[illegible]	80% 41/51	82% 36/44	84% 46/55	79% 44/56	84% 52/62	76% 39/51	77% 41/53	85% 39/46
6b. Medication Management 30-Day	[illegible]	[illegible]	[illegible]	[illegible]	96% 49/51	[illegible]	100% 55/55	95% 53/56	95% 569/62	98% 50/51	100% 53/53	98% 45/46
7a. Crisis Response Time Telephone	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	92% 23997/ 26179	96% 27194/ 28459	97% 32674/ 33735	97% 32945/ 34068

Legend
Green-Standard was achieved
Red-Standard was not achieved
Black Outline-Identifies the period where 4/6 quarters achieved compliance. Numerals below the percentages reflect raw data used to compute the percentage for each quarter. For standards 4, 5, and 13, the data excludes individuals who have agreed to be put on a hold-for-service list.

Consent Decree Compliance Standards
Updated Status Report Reflecting Amended Compliance Standards from Sept. 23, 2024

Standard	2021		2022				2023				2024	
	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun
7b. Crisis Response Time Text/Chat	[illegible]	[illegible]	85% 583/683	[illegible]	[illegible]	85% 543/636	[illegible]	[illegible]	88% 428/485	90% 365/406	88% 427/485	90% 442/491
8a. Mobile Crisis Response- Within 2 hours	77% 1532/ 1996	78% 1356/ 1731	88% 1502/ 1704	90% 1347/ 1505	92% 1437/ 1569	86% 1598/ 1848	94% 1216/ 1297	92% 1275/ 1384	91% 1281/ 1410	94% 1635/ 1746	94% 1541/ 1641	94% 1678/ 1789
8b. Mobile Crisis Response- Within 3 hours	[illegible]	[illegible]	91% 1552/ 1704	92% 1387/ 1505	94% 1481/ 1569	89% 1371/ 1538	96% 1243/ 1297	95% 1315/ 1384	92% 1300/ 1410	97% 1686/ 1746	96% 1583/ 1641	97% 1741/ 1789
9. Crisis Resolution Time	84% 1674/ 1993	84% 1452/ 1727	84% 1420/ 1691	83% 1297/ 1563	81% 1234/ 1530	88% 1342/ 1538	88% 1141/ 1299	87% 1198/ 1375	90% 1274/ 1410	91% 1885/ 2078	91% 1491/ 1641	95% 1635/ 1716
10. Crisis Disposition: Involuntary Commitments	2.6% -	2.3% -	2.6% -	1.2% -	2.3% 41/1763	1% 17/1848	1% 13/1304	1% 14/1384	1% 14/1410	1% 24/2040	1% 15/1604	1% 9/1789
11. Crisis Stabilization Units Readmission	12% 35/286	11% 24/219	14% 30/218	13% 38/28	13% 39/306	10% 30/291	13% 43/321	9% 29/314	8% 34/310	11% 28/248	10% 26/265	17% 41/240
12. CSU Inpatient Admission	13% 38/286	7% 16/219	6% 12/218	9% 27/290	9% 26/306	8% 22/291	5% 17/321	9% 27/314	6% 20/310	7% 18/248	8% 20/265	9% 21/240
13a. Behavioral Health Home-7 Days	100% 0/0	100% 0/0	100% 0/0	100% 0/0	100% 0/0	100% 1/1	100% 0/0	100% 0/0	[illegible]	[illegible]	[illegible]	[illegible]
13b. Behavioral Health Home-30 Days	100% 0/0	100% 0/0	100% 0/0	100% 0/0	100% 0/0	100% 1/1	100% 0/0	100% 0/0	[illegible]	[illegible]	[illegible]	[illegible]
14. Referral Rejections	0% -	0% -	0% -	0% -	0% -	0% 7	0% 14	0% 263	3% 27/908	1% 16/1190	<1% 8/1618	<1% 4/1781

Legend
Green-Standard was achieved
Red-Standard was not achieved
Black Outline-Identifies the period where 4/6 quarters achieved compliance. Numerals below the percentages reflect raw data used to compute the percentage for each quarter. For standards 4, 5, and 13, the data excludes individuals who have agreed to be put on a hold-for-service list.

Consent Decree Compliance Standards
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	2021		2022				2023				2024	
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15. Referral Rejections Sanctioned	0% -	0% -	0% -	0% -	0% -	0% -	0% -	0% -	0% -	0% -	0% -	0% -
16a. RPC- Certification	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
16b. RPC- Discharge Within 7 Days	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	75% 15/20	75% 12/16	70% 16/23	75% 18/24	[illegible]	79% 22/28	77% 23/30
16c. RPC- Discharge Within 30 Days	80% 12/15	[illegible]	100% 15/15	84% 16/19	86% 18/21	95% 19/20	88% 14/16	91% 21/23	88% 21/24	[illegible]	[illegible]	100% 30/30
16d. RPC- Discharge Within 45 Days	[illegible]	[illegible]	100% 15/15	95% 18/19	90% 19/21	100% 20/20	[illegible]	100% 23/23	96% 23/24	96% 27/28	96% 27/28	100% 30/30
17. Reporting	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Legend
Green-Standard was achieved
Red-Standard was not achieved
Black Outline-Identifies the period where 4/6 quarters achieved compliance. Numerals below the percentages reflect raw data used to compute the percentage for each quarter. For standards 4, 5, and 13, the data excludes individuals who have agreed to be put on a hold-for-service list.

EXHIBIT
B

Maine's Community Mental Health System of Care
System, Practice & Policy, and Consumer & Advocacy Engagement Improvements
(September 2024)

Since January 2021, the Department of Health and Human Services (DHHS) and its Office of Behavioral Health (OBH) have made a number of systems improvements, have updated practices and policies, and have strengthened partnerships with consumer and advocacy organizations. These efforts to improve the adult mental system are described below. In making these improvements, DHHS has endeavored to create enduring changes that ensure effective management and monitoring of the system, that measure accountability, and that include ongoing quality improvement.

Section 1: Systems Improvements

1. Implementing Certified Community Behavioral Health Clinics in Maine

The Certified Community Behavioral Health Clinic (CCBHC) model is an evidence-based and coordinated model of behavioral health care established by Section 223 of the Protecting Access to Medicare Act of 2014. Since 2022, DHHS has been leading the development of the CCBHC service, reimbursement model, and certification process for qualifying behavioral health organizations in Maine. DHHS has been engaging with stakeholders on a bi-monthly basis to ensure the model is informed by providers, community partners, and individuals with lived experience. DHHS secured a CCBHC Planning Grant in 2023 from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Agency (SAMHSA). And more recently, in June 2024, DHHS was selected by the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) in conjunction with SAMHSA to participate in the CCBHC Medicaid Demonstration Program. With these developments, implementation of the model in Maine is slated for January 1, 2025.

CCBHCs offer a transformational opportunity for the behavioral health care continuum in Maine, offering care coordination, physical health integration, walk-in crisis care, and access to core evidence-based behavioral health outpatient co-occurring care to the individuals in our State. CCBHCs are required to meet the behavioral health needs of their communities regardless of primary diagnosis, insurance status, and place of residence. This work is aligned with the Department's strategic plan to the strengthen our overall behavioral health system.

CCBHC's will offer:

- Coordinated mental health and substance use disorder (SUD) services across lifespan,

regardless of diagnosis, ability to pay or place of residence.

- Person and family centered services driven by the needs and preferences of clients and their families.
- Core CCBHC outpatient services include case management, medication management to include medications for SUD, outpatient mental health and substance use services, and supported employment. Providers can also include Assertive Community Treatment (ACT) as part of their CCBHC model of care.
- Improved quality of care through evidence based and trauma informed services and supports to meet the needs of communities and required quality measurement of the behavioral health services the CCBHC provides.
- Enhanced care coordination for those seeking services and collaboration with our broader healthcare system. Access to care coordination is based on the need for assistance rather than clinical diagnosis and CCBHCs can assist with completing the MaineCare application. Care coordination partnerships must be established between the CCBHC and other behavioral health and social service providers, first responder agencies, hospitals, and correctional facilities that are located within the CCBHC service area.
- An Initial Evaluation must be completed immediately for individuals in crisis, within one day for individuals with urgent needs and within 10 days for those seeking routine behavioral healthcare, as defined by federal SAMHSA criteria for CCBHC certification. Individuals who have a completed an Initial Evaluation can receive CCBHC services and care coordination for up to 60 days, at which time the Comprehensive Assessment must be completed for continued service eligibility.
- CCBHCs offer increased access to peer support services with more consumer choice. CCBHC innovation removes the barrier of having peer support services connected to a specific bundled service model and instead allows stand-alone peer support to be a billable service, broadening access for all individuals served by the CCBHC. Peer Specialists can coordinate and provide access to peer support services, peer advocacy groups, and other peer-run or peer-centered services offered at the CCBHC.

More information on CCBHCs can be found on the DHHS website.

2. Crisis System Reform

Maine has been working on several crisis reform efforts to realize our vision of a strong, robust crisis system that will expand the continuum of care for individuals and families experiencing a behavioral health crisis. National best practice highlights three pillars of the ideal crisis system,

"Someone to Call", "Someone to Respond", and "Somewhere to Go." Maine has invested over $15M in state and federal resources to achieve the ideal crisis system in Maine.

988/Maine Crisis Line

- The 988 Lifeline went live in Maine in July of 2022 after partner engagement with crisis services, 911, EMS, and law enforcement.
- 988 is available to respond 24/7 to calls, chats, and texts from anyone in need of support for themselves or from those concerned about another.
- Planning is underway to increase training for peers staffing the Intentional Peer Support Line and improve and increase collaboration between the Intentional Peer Support Line and the Maine Crisis Line.

Mobile Crisis Expansion

- Statewide crisis system reform is well underway creating team-based crisis response.
- Peer Support Specialists will become an integral part of the mobile crisis team and will receive training to prepare them to respond to individuals of all ages.
- Additional improvements include improved response times, and increased community-based mobile response to ensure individuals are receiving crisis services in the location of their choice.
- Through a contract with a national expert, the Department is developing a standardized crisis training curriculum that will be required of all mobile crisis team members in order to ensure high quality care.

Crisis Receiving Centers

Maine DHHS established the first community-based Crisis Receiving Center in Cumberland County in 2022. The Crisis Receiving Center model in Maine is designed to provided same day, walk-in access to mental health, substance use, crisis stabilization and peer supports services to provide low barrier access to care and divert individuals from law enforcement, emergency departments and hospitalization. In concert with recent legislation (P.L. 2023, ch. 675), Maine will be expanding Crisis Receiving Centers in Aroostook, Kennebec, Penobscot and Androscoggin County.

- Crisis Receiving Centers offer an innovative way to meet the needs of individuals in need of in-the-moment support by offering an alternative to traditional crisis services, emergency departments, or law enforcement involvement.
- Access to care at Crisis Receiving Centers is available 24/7 as a walk-in option.
- Intentional Peer Support Specialists are an integral part of the Crisis Receiving Center team and comprise a significant amount of the staffing pattern.

- In a warm, home-like setting, Crisis Receiving Centers offer integrated mental health and substance use treatment as well as assistance with evaluations and medications.

The Place Matters Project

DHHS is committed to measuring the efficacy of crisis system reforms. OBH has partnered with the Place Matters Project, located within the Justice Policy Program at the University of Southern Maine Catherine Cutler Institute, on a multi-phased Experiential Mapping project. The goal of the project is to convene partners and engage community members with direct experience using the Maine crisis system in a participatory process to gather feedback and develop a trauma and data-informed approach to improving the Maine crisis system. To accomplish this goal:

- Six Peers were identified and trained in Citi Qualitative Interviewing Techniques.
- Community listening sessions were conducted to learn from individuals who had received crisis services within the past 24 months.
- The current phase of the project has peers engaging in qualitative interviews with individuals who have received crisis services within the past 24 months.
- The final phase, will identify mechanisms for measuring the impact of crisis reform efforts from the lived experience perspective.

3. Medication Management Strategic Planning and Stakeholder Engagement

In 2023, to improve timely access to Medication Management services, OBH engaged in stakeholder engagement sessions to learn from the provider community what and how OBH may improve partnership and enhance access to medication management services.

OBH met with 9 behavioral health agencies that collectively serve many of persons who receive medication management services through MaineCare or through OBH grant funded contracts, solicited feedback and developed recommendations based upon this feedback.

- **Consultation**: Providers expressed a desire to be compensated for time spent providing professional consultation. In partnership with DHHS's Office of MaineCare Services (OMS), OBH sent a clarifying communication to providers who deliver medication management services pursuant to Section 65 of the MaineCare Benefits Manual rule, informing them of the mechanism by which they may be compensated for consultation.
- **Access to Assertive Community Treatment**: Providers expressed a need for more ACT services, particularly in rural communities to increase access to medication management at appropriate levels of care. In 2023 OBH released a Request for Application soliciting applications for the development of new ACT teams or expansion of existing ACT teams with priority given to rural communities.

To ensure that individuals discharging from Riverview Psychiatric Center (RPC) and Dorothea Dix Psychiatric Center (DDPC) have continuous medication management, OBH verified that both State hospitals will remain in contact with individuals who have discharged until confirmation is obtained that they have begun services in the community. If there is any delay in accessing medication management in the community, RPC and DDPC will provide ongoing prescriptions.

Additionally, $2.5M was allocated to medication management in the Supplemental Budget enacted in July 2024 to be utilized for employee recruitment and retention efforts. Within the next 60 days, OBH will reconvene medication management stakeholder engagement groups and will develop a strategic plan for how to maximize this funding opportunity to bolster access to medication management for long-term sustainability.

Section 2: Practice and Policy Improvements

The Department recognizes that a goal of the Consent Decree and compliance standards was to establish key tenets, practices and standards of a healthy and robust community mental health system of care, including timely access to care and accountability and monitoring of the system of care. The Department has anchored these tenets in improved practices and procedures in addition to key policy improvements.

1. Practice Improvement – Tracking Referrals and Hold for Service

When Disability Rights Maine (DRM) raised concerns in early 2022 about the referral and hold-for-service processes for core services like Community Integration, the Department and DRM engaged in several months of productive and collaborative conversations. The Department ultimately revamped its internal processes to ensure: (1) that all referrals are captured; (2) that all referrals are tracked to show the provider is either initiating services for eligible individuals, placing the individual on a hold-for-service list (no more "shadow waitlists"), or seeking the Department's approval to reject the referral; and (3) that the Department can adequately oversee and enforce these processes. Since the Department revamped these internal processes, not only has the Department's data collection and data reliability continued to improve, but the Department and DRM have successfully worked together to educate providers and to solve individual access to services issues as they arise on a case-by-case basis.

2. Policy Improvements

The Department has anchored key principles of the Consent Decree into policy and contracts, including incorporating protections for adults with serious and persistent mental illness, which includes "no eject/no reject" and "hold for service" requirements for community mental health

services, into various sections of the MaineCare Benefits Manual rules (10-144 C.M.R. Chapter 101) and the Department's contracts with providers.

Section 3: Consumer and Advocacy Engagement

The Department deeply values the role of advocacy organizations and consumers in ensuring a strong and accountable community mental health system of care. The Department engages in several key initiatives and ongoing activities to accomplish this.

1. Constituent Services

The Department has developed and implemented two pathways for constituents to directly contact the Department: (1) through the general DHHS Constituent Services Coordinator based in the Commissioner's Office, and (2) through a dedicated point of contact at OBH.

First, the DHHS Constituent Services inquiry process allows individuals to submit questions or comments to the Department through phone, email, letter, or an online form and ensures multiple avenues for constituents to obtain assistance that best meet their needs and circumstances. The Form is accessible on the Department's website. The DHHS Constituent Services Coordinator manages the inquiry process and directs inquiries to the appropriate DHHS office based on the constituent's needs.

Second, OBH's dedicated point of contact for constituent inquiries serves as the single point of contact within OBH for Consent Decree inquiries, and allegations of rule violations and grievances pursuant to the Rights of Recipients of Mental Health Services (14-193 C.M.R. Ch. 1). This OBH dedicated point of contact also receives and triages constituent inquiries received directly through telephone to the OBH main line or through OBH's behavioral health rights email address (behavioralhealthrightsobh@maine.gov) created for the Rights of Recipients of Mental Health Services and other general behavioral health inquiries. The email address is posted on the OBH website's home page. Currently, the staff person's name and phone number is listed on OBH's contact page under "Consent Decree" but this will be amended to make clear that it is for all constituent inquiries related to adult mental health services.

Once a constituent inquiry is received at OBH (either directly or from the DHHS Constituent Services Coordinator), the OBH dedicated point of contact reviews and triages the inquiry and directs it to the appropriate OBH program staff, requesting that program staff review the inquiry, provide outreach, address the constituent's issue, and provide an update once available. Inquiries are only closed out once the issue has been resolved or the constituent has

not responded to repeated contact attempts within 10 business days. These inquiries can, however, be resubmitted or reopened if contact is resumed. Each inquiry is tracked for data purposes, and in the first two quarters of 2024, OBH received 284 inquiries, of which 248 came through the Commissioner's Office and 36 were received directly by OBH. Of the 284 inquiries, 63 were triaged directly to the OBH's Community Mental Health team to resolve.

The Department strives to resolve constituent inquiries within 10 business days; however, some inquiries may require additional time due to the complexity of the inquiry and need, or to communication delays from or with the constituent. OBH nonetheless works to resolve these inquiries as quickly as possible under the individual circumstances, and most constituent inquiries received by OBH are typically addressed and closed out within 7 business days or less.

OBH and other DHHS offices also collaborate as necessary on inquiries involving multiple issues or offices and ensure that any misdirected inquiries or referrals are promptly delivered to the office most appropriate to respond. Similarly, for inquiries that are outside of the purview of OBH and DHHS, the Constituent Services Coordinator and OBH staff often work to provide alternative contact information and/or resources to the greatest extent possible in an effort to assist the requestor.

2. Monthly Meetings with DRM & with Consumer Council System of Maine

The Office of Behavioral Health participates in two monthly meetings: one with Disability Rights Maine and the other with the Consumer Council System of Maine (CCSM). These meeting are attended by key leadership from OBH and leadership and advocates of DRM and CCSM. These meetings provide an open and collaborative forum to address and problem solve around system of care issues that DRM and CCSM bring to the attention of OBH. Further CCSM has developed a process in accordance with its statutory authority (34-B M.R.S. § 3611) that provides a mechanism for CCSM to submit "issue statements" to OBH that highlight issues and to which the Department responds.

3. Rights of Recipients Engagement

In 2022, the Legislature adopted a resolve requiring the Department to update the rules governing the rights of adult and children who receive mental health services (Resolves 2021, ch. 132). As part of that initiative, the Department and OBH developed and offered multiple pathways for engagement on the adult Rights of Recipients of Mental Health Services (RRMHS) rule. A survey was distributed during the month of August 2023 which allowed all interested parties to complete an online fillable survey or download and print copies for return through

postal or electronic mail, assuring multiple formats were available. An email inbox (behavioralhealthrightsOBH@maine.gov) was created in conjunction with this engagement to provide an alternative pathway for more general feedback as well as a single point of contact for any questions, concerns, or requests for assistance with the survey or engagement efforts more broadly. In total, OBH received 130 responses to the survey with additional feedback received through the dedicated inbox.

In October and November 2023, OBH hosted two virtual listening sessions on the RRMHS. Workbooks were developed for registrants allowing fillable spaces for each part and section of the rule and was available on our website to allow interested parties unable to attend an opportunity to provide the same feedback. Furthermore, OBH staff collaborated with advocates, hospitals, and programs to ensure that inpatient and residential recipients were afforded an opportunity to attend the listening sessions and express their opinions and lived experience. We assessed our engagement efforts after the first listening session to better inform our approach for the second which resulted in providing more clarity, examples, and additional guiding questions to promote greater discussion and assist those who may have difficulty with the technical language in the rule. In sum, we had nearly 200 registrants for both sessions, noting that some registrants included multiple individuals, such as some hospital and residential groups. OBH similarly held three in-person listening sessions at residential programs in the northern, central, and southern regions of the state in Spring 2024, allowing other programs to Zoom in for participation from their locations. Alongside this ongoing engagement, OBH mailed workbooks with postage-paid, self-addressed return envelopes to every residential program location in the state to ensure recipients who may not have been able to attend prior sessions were afforded every opportunity to provide feedback.

OBH's dedicated inbox, survey, and workbook all remain on the OBH home page to ensure individuals and organizations alike may submit feedback while providing an additional avenue to contact OBH regarding all mental health inquiries and general assistance requests.

4. Consumer Satisfaction Surveys

Annually, the Office of Behavioral Health collects feedback directly from consumers about their satisfaction with the services they received. The collection of consumer feedback is required as part of the required data collection for the federal SAMHSA Mental Health Block Grant, Substance Use Block Grant, and CCBHC reporting. Feedback is captured through a survey instrument that can be completed online or over the phone, and data collection occurs each year in the late summer and early fall. There are three separate surveys used with one focused

on adults who received mental health services, one for adults who received substance use services, and one for children and families who have received behavioral health services.

The Department's contracted vendor assists with the updating of the surveys, mails pre-notification letters, collects responses, and organizes findings for the department. At the end of the annual data collection process the raw data as well as summarized findings are then shared with the department. These data are then used to identify needs, gaps, and areas for improvement.

5. Quality Improvement Council

The Quality Improvement Council serves as Maine's planning and advisory council to support and give voice to persons with lived experience in mental health and recovery, as well as their families. This planning and advisory council meets monthly and is composed of 51% persons with lived experience and/or family members of persons with lived experience, and is a federal requirement placed in statute at 42 U.S.C. § 300x-3 (2022) as part of the funding agreement for the Department's participation in the federal SAMHSA Mental Health Block Grant. The duties of this council are as follows: (1) review plans provided and submit to the State any recommendations; (2) serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.