Janet T. Mills
Governor

Sara Gagné-Holmes
Acting Commissioner

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August 13, 2024

Simonne Maline, Executive Director
Consumer Council System of Maine
219 Capitol St, Suite 7
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Dear Ms. Maline,

Thank you for your issue statement dated June 28, 2024, regarding the lack of Daily Living Support Services (DLSS) and Community Rehabilitation Services (CRS) for those in need of these services in Maine. The primary issues pertain to the lack of DLSS and CRS services, a need for workforce improvement and expansion, and challenges in accessing the services among those with non-traditional housing arrangements.

The first issue raised was a lack of DLSS and CRS for those in need of the services in Maine, and more specifically, a sharp decline in the services' accessibility to assist people in successfully remaining in their homes and to be successful in the community of their choosing. OBH respectfully both agrees and disagrees, acknowledging a need for more providers.

- We have seen a notable increase in the number of grant-funded units, nearly tripling that in the past. Some providers are expanding statewide, such as Assistance Plus moving into the Rumford region while exploring further expansion, and ESM similarly seeking expansion pending staffing growth.
- There are five agencies that have indicated they wish to offer DLSS, all of whom have been approved, though they are newer. This number should hopefully continue to increase in response to recent rate increases implemented in January 2023, increasing the rate from $8.32 to $17.76 every fifteen minutes for DLSS. On August 8, 2024, MaineCare is implementing a cost-of-living adjustment for DLSS which will increase the rate to $18.21 every fifteen minutes, retroactively effective January 1, 2024.
- Providers are able and encouraged to submit information for rate studies, and many do, along with individuals and others who have an opportunity for input during the public comment periods regarding new MaineCare rate schedules.

The second and fourth issues pertained to the lack of providers of these services and others who support the Council's fellow peers, and the need for greater allocation of resources directed toward workforce development in behavioral health services. As the Council advised in their

statement, resources and partnership from Maine citizens and the state as a whole are vital toward achieving more progress toward these goals. The Department continues our focus and attention toward workforce development and strategic planning, resource leveraging and utilization review, and additional collaboration among various entities, organizations, and individuals that could serve to help further those efforts.

- Education requirements for DLSS are minimal and DLSS is one of the lowest barrier workforce positions related to these services. To provide DLSS, an individual is typically only required to hold a high school diploma or GED, and most agencies will provide MHRT training and assist with certification requirements for staff. This is a low-barrier opportunity for more peers to get involved in these services and additionally earn further experience, on-the-job training, and provide more support to fellow peers.
- Though some programs and initiatives may be concluding soon due to ending funding streams, there are still pathways for mental health workers or those interested in becoming one through career centers that may also provide CRMA, MHRT, and other training to further alleviate the costs to those interested.
- New online training for MHRT-1 provisional certifications is in development and should both simplify the process and increase accessibility to the requisite training. This training is anticipated to also better prepare individuals for performing this work, further increasing the probability of not only improved service provision but longer rates of employee retention[1].
- Also of note is the Careers with Purpose[2] campaign which includes behavioral health positions and training encompassing alcohol and drug counseling aides and counselors, direct support professionals, MHRTs, CRMAs, degree courses for various human service and social work fields, and more.
- There has likewise been increased investment in peer training with an emphasis on CIPSS, expanding capacity in every measurable statistic throughout the system of care[3].
- Workforce recruitment and retention are impacted by an array of factors, including cost of living, access to affordable housing (e.g., if relocating, if they have a growing family, etc.), work environments, benefits from employers, and related elements. The State and Department have evaluated and provided various initiatives in the past, including scholarships, loan or tuition forgiveness, tax incentives, bonuses, and more; however, much is outside of the Department's oversight and requires other external engagement and resources. Many industries in and outside of Maine have been and are still experiencing challenges as a result of factors impacting the workforce.

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[1] MHRT-1 numbers have increased year over year between FY 2021-2024 except for a decline in FY 2023 which was recovered in FY 2024, surpassing the 2022 rate. The majority of these were provisional, however, at 3,058 across all four years compared to 1,456 full certifications during the same period.

[2] Career Paths - Careers with Purpose (mainecareerswithpurpose.org)

[3] Between October 2021 and September 2023 continuing education classes increased 20.5%, core training by 80%, IPS core trainers by 250%, Peer Support 101 classes by 30%, co-reflection facilitators by 33%, and co-reflection by 28%.

The third issue was regarding individuals who may have non-traditional housing arrangements and are therefore believed to not qualify for these services.

- The Department's Offices of Behavioral Health and MaineCare services do not believe that the policy requires the services only be delivered in a home; however, there is a common understanding among providers that this is the case. DLSS *could* be delivered in temporary housing or even a shelter, though living situations such as a vehicle or encampments may pose unique challenges and arguably impact the efficacy and applicability of DLSS opposed to other initial services.
    - For example, if an individual receiving services loses their housing, it would still be appropriate for a DLSS provider to assist them during the transition to their next living situation and/or refer them to a higher level of care, such as traditional or targeted case management and HOME, who would hold more expertise in that level of case management and would be better able to assist with their immediate housing and other basic needs. Once their housing was stabilized, DLSS services would then be more appropriate.
- Essentially, non-traditional living situations may ultimately render DLSS less effective depending on the specific circumstances, supporting the suggestion of perhaps working toward DLSS opposed to starting with it, as appropriate[4]. Short-term support could also be provided by a DLSS worker or the above alternatives *in conjunction with* longer-term support planning for case management, including a BRAP application, other housing programs, and related support and assistance. Alternative providers, such as PATH and HOME teams may also be better suited to offer initial homeless, near homeless, or at-risk individuals case management for immediate needs, thereby potentially improving the timing of initial service provision opposed to one (i.e., DLSS) provider holding full responsibility, particularly with the stated increased need for services.
- Of additional note, while HOME services and DLSS are allowed concurrently, HOME and CRS cannot be delivered simultaneously as they are duplicative.

The Council proposed three recommendations to address the aforementioned issues relating to more inclusive definitions of living quarters, clarification on who may access these services, and a wider array of agencies providing a continuum of care that includes DLSS or CRS as integral parts of the program.

- Regarding a more inclusive definition of living quarters and clarification on who may access these services: there is no clear prohibition on where DLSS or CRS can be provided[5]. Rather, as stated above, they may simply be less appropriate in certain living

[4] An example is an individual living in a car: the provider would offer support and services, but that may ultimately look more like maintaining laundry, checking in on self-care, and organizing the cleanliness of the car/temporary living space opposed to the full scope of DLSS.

[5] Qualifications and eligibility requirements are age; mental health symptoms and the impact on daily living skills or independent living; qualifying diagnosis and documentation, or at-risk eligibility which includes homelessness, psychiatric hospitalization, criminal justice involvement, or residential mental healthcare placement; and MaineCare coverage, veteran's insurance, private pay, or grant funding through OBH for those without MaineCare who qualify.

situations where other services are more applicable for immediate needs before transitioning into DLSS or CRS.

- Regarding more agencies providing DLSS and CRS: CRS includes DLSS and has seen a significant rate increase from $79.63 per diem to $114.68 per diem, which has prompted a greater and renewed interest from providers in delivering the CRS model. Community Health and Counseling Services (CHCS), for example, is now delivering the service in non-traditional housing settings in partnership with homeless services and service providers. Additionally, when OBH staff performs site visits for providers, they review applications for services and the array of services that can be or are provided and highlight other services, such as CRS and DLSS. When providers are already offering case management services, the addition or incorporation of DLSS does not impose substantial burdens in terms of staffing or policies, and often compliments the other services. These are conversations OBH staff regularly have with our provider partners, along with housing programs when they want to expand housing services (e.g., PNMIs), and we promote CRS as an important step-down service, with the added benefit of incorporating DLSS. CRS and DLSS are also included as allowable activities within the CCBHC model which should further expand provision of and access to these necessary services over time.

The Council's expected outcome is that no matter what an individual defines as their home, or what area of Maine they live in, they can access DLSS or CRS. The Department acknowledges that, much like many workforce sectors throughout the state and country, there is room for improvement in the workforce. While we continue to explore opportunities, initiatives, and resources to address this, we have worked diligently to mitigate areas of concern in the interim. Examples of this include the Housing First Model that will remove some pressure from DLSS and recognize that many people wish to live in alternative situations while also providing more housing supports; the HOME model, which OBH staff has offered to present more on during one of our regular meetings; and other service expansions. We understand there are concerns that some communities may be underserved and that recent mergers of some agencies may further decrease access; however, the Department has been working to mitigate closures, assure mergers do not limit services in the areas served, and continue to monitor regions most in need for additional resources and opportunities. Though we are in the process of workforce development, others' involvement and assistance is necessary, as suggested by the Council, and the Department remains committed to ensuring appropriate services are available to those who need them to the greatest extent possible.

Sincerely,

Signed by:
Sarah Squirrell
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Sarah Squirrell
Director
Office of Behavioral Health
Maine Department of Health and Human Services