

Maryland

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 4.43.48 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 609980255

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Maryland Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address Spring Grove Hospital Center 55 Wade Avenue, Dix Building

City Catonsville

Zip Code 21228

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Barabra

Last Name Bazron

Agency Name Behavioral Health Administration - Maryland Department of Health

Mailing Address Spring Grove Hospital Center 55 Wade Avenue

City Catonsville

Zip Code 21228

Telephone 410-402-8452

Fax 410-402-8441

Email Address Barbara.Bazron@maryland.gov

State CMHS DUNS Number

Number 135218621

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Maryland Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address Spring Grove Hospital Center - Dix Building 55 Wade Avenue

City Catonsville

Zip Code 21228

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Barbara

Last Name Bazron

Agency Name Behavioral Health Administration-Maryland Department of Health

Mailing Address Spring Grove Hospital Center 55 Wade Avenue/Dix Bldg

City Catonsville

Zip Code 21228

Telephone 410-402-8452

Fax 410-402-8441

Email Address Barbara.Bazron@maryland.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date 9/1/2017 4:42:35 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Cynthia

Last Name Petion

Telephone 410-402-8468

Fax 410-402-8309

Email Address Cynthia.Petion@maryland.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
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Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Barbara J. Bazron, Ph.D.

Signature of CEO or Designee¹: _____

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



LARRY HOGAN
GOVERNOR

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

August 7, 2017

Grants Management Officers
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857

Dear Grant Management Officers:

Several federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. In order to expedite the processing of federal grants, on my behalf, I designate the Secretary of Maryland's Department of Health (MDH), Dennis R. Schrader to make future assurances, sign applications and agreements, and perform any similar act relevant to the Maryland Department of Health.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry Hogan".

Larry Hogan
Governor

Cc: Dennis R. Schrader, Secretary, Maryland Department of Health

STATE HOUSE, ANNAPOLIS, MARYLAND 21401
(410) 974-3901 1-800-811-8336
TTY USERS CALL VIA MD RELAY



MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

MEMORANDUM

TO: Barbara J. Bazron, Ph.D.
Deputy Secretary, Behavioral Health, Maryland Department of Health/
Executive Director, Behavioral Health Administration

FROM: Dennis R. Schrader
Secretary
Maryland Department of Health (MDH) *J. Williams (cos/Acting)*

CC: Cynthia Petion
Acting Director, Systems Management
Behavioral Health Administration

Hilary Phillips
Director, Office of Planning
Behavioral Health Administration

DATE: August 30, 2017

SUBJECT: Delegation of Signatory Authority for the Mental Health Block Grant (MHBG)
and Substance Abuse Block Grant (SABG)

Effective August 4, 2017, pursuant to the Public Health Service Act, Title XIX Block Grants, Part B, Subpart I, Block Grants for Community Mental Health Services and Part B, Subpart II, Block Grants for Substance Abuse Prevention and Treatment, I hereby delegate authority to you as the Deputy Secretary of Behavioral Health/Executive Director of the Behavioral Health Administration to sign funding agreements and certifications, to provide assurances of compliance to the Secretary, Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) and the Substance Abuse Block Grant (SABG). This delegation is subject to an annual renewal so long as the referenced grant remains in effect, or said delegation of authority is otherwise rescinded.

The Community Mental Health Services Block Grant (MHBG) program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions.

Grantees use the funds to provide comprehensive, community –based mental health services to adults with serious mental illnesses (SMI) and to children with serious emotional disturbances (SED) and to monitor progress implementing a comprehensive, community-based mental health system.

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance;
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health, promotion, treatment, and recovery support services.

Maryland's FY 2018 Estimated MHBG Allotment is \$6,756,780.

The MHBG funding supports the following services throughout Maryland:

- Crisis Response Systems/Services
- Implementation of Evidence Based Practices (Assertive Community Treatment (ACT), Supported Employment (SE), and Family PsychoEducation (FPE))
- Early Intervention/First Episode Psychosis
- Systems Evaluation/Research/Outcome Data
- School-Based Mental Health
- Housing Supports
- Public Awareness/Education/Training & Outreach

Maryland's Behavioral Health Administration (BHA) will receive \$34 million in block grant funds to support substance use treatment, prevention and intervention services. SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) administers the Substance Abuse Block Grant funds (SABG).

The SABG supports the following services in Maryland:

- Substance Use Disorder (SUD) treatment across all ASAM levels of care
- Primary Prevention
- Tobacco Use Prevention – SYNAR Amendment
- Women's Services (Pregnant Women and Women with Dependent Children)
- HIV/AIDS Services
- Overdose Prevention
- PDMP (Prescription Drug Monitoring Program)
- Recovery Support Services
- Tuberculosis Services

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Barbara J. Bazron, Ph.D.

Signature of CEO or Designee¹: 

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: Sept 1, 2017

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

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Fiscal Year 2018

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Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Name of Chief Executive Officer (CEO) or Designee: Barbara J. Bazron, Ph.D.

Signature of CEO or Designee¹: 

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: 

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Barbara J. Bazron, Ph.D.

Title

MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

Footnotes:

A large, stylized handwritten signature in blue ink is written across the signature and date fields. The signature is highly cursive and loops around the date field. The date field is empty.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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Signature of CEO or Designee¹: _____

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



LARRY HOGAN
GOVERNOR

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

August 7, 2017

Grants Management Officers
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857

Dear Grant Management Officers:

Several federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. In order to expedite the processing of federal grants, on my behalf, I designate the Secretary of Maryland's Department of Health (MDH), Dennis R. Schrader to make future assurances, sign applications and agreements, and perform any similar act relevant to the Maryland Department of Health.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry Hogan".

Larry Hogan
Governor

Cc: Dennis R. Schrader, Secretary, Maryland Department of Health

STATE HOUSE, ANNAPOLIS, MARYLAND 21401
(410) 974-3901 1-800-811-8336
TTY USERS CALL VIA MD RELAY



MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

MEMORANDUM

TO: Barbara J. Bazron, Ph.D.
Deputy Secretary, Behavioral Health, Maryland Department of Health/
Executive Director, Behavioral Health Administration

FROM: Dennis R. Schrader
Secretary
Maryland Department of Health (MDH) *J. Williams (cos/Acting)*

CC: Cynthia Petion
Acting Director, Systems Management
Behavioral Health Administration

Hilary Phillips
Director, Office of Planning
Behavioral Health Administration

DATE: August 30, 2017

SUBJECT: Delegation of Signatory Authority for the Mental Health Block Grant (MHBG)
and Substance Abuse Block Grant (SABG)

Effective August 4, 2017, pursuant to the Public Health Service Act, Title XIX Block Grants, Part B, Subpart I, Block Grants for Community Mental Health Services and Part B, Subpart II, Block Grants for Substance Abuse Prevention and Treatment, I hereby delegate authority to you as the Deputy Secretary of Behavioral Health/Executive Director of the Behavioral Health Administration to sign funding agreements and certifications, to provide assurances of compliance to the Secretary, Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) and the Substance Abuse Block Grant (SABG). This delegation is subject to an annual renewal so long as the referenced grant remains in effect, or said delegation of authority is otherwise rescinded.

The Community Mental Health Services Block Grant (MHBG) program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions.

Grantees use the funds to provide comprehensive, community –based mental health services to adults with serious mental illnesses (SMI) and to children with serious emotional disturbances (SED) and to monitor progress implementing a comprehensive, community-based mental health system.

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance;
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health, promotion, treatment, and recovery support services.

Maryland’s FY 2018 Estimated MHBG Allotment is \$6,756,780.

The MHBG funding supports the following services throughout Maryland:

- Crisis Response Systems/Services
- Implementation of Evidence Based Practices (Assertive Community Treatment (ACT), Supported Employment (SE), and Family PsychoEducation (FPE))
- Early Intervention/First Episode Psychosis
- Systems Evaluation/Research/Outcome Data
- School-Based Mental Health
- Housing Supports
- Public Awareness/Education/Training & Outreach

Maryland’s Behavioral Health Administration (BHA) will receive \$34 million in block grant funds to support substance use treatment, prevention and intervention services. SAMHSA’s Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) administers the Substance Abuse Block Grant funds (SABG).

The SABG supports the following services in Maryland:

- Substance Use Disorder (SUD) treatment across all ASAM levels of care
- Primary Prevention
- Tobacco Use Prevention – SYNAR Amendment
- Women’s Services (Pregnant Women and Women with Dependent Children)
- HIV/AIDS Services
- Overdose Prevention
- PDMP (Prescription Drug Monitoring Program)
- Recovery Support Services
- Tuberculosis Services

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protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

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The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Barbara J. Bazron, Ph.D.

Signature of CEO or Designee¹: 

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: Sept 1, 2017

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §5794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
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Signature of CEO or Designee¹: 

Title: MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Date Signed: Sept 1, 2017

mm/dd/yyyy

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Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Barbara J. Bazron, Ph.D.

Title

MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

Footnotes:

A large, stylized handwritten signature in blue ink is written across the signature and date fields. The signature is highly cursive and loops around the date field. The date field is empty.

State Information

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To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Barbara J. Bazron, Ph.D.

Title

MDH Deputy Secretary/Executive Director, Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

EXECUTIVE SUMMARY

Maryland Department of Health (MDH)

On July 1, 2017, our State agency officially changed its name to the Maryland Department of Health (MDH), dropping “and Mental Hygiene”, an update that reflects the holistic nature of health services. The Department of Health has four major divisions: Public Health Services, Behavioral Health, Developmental Disabilities and Health Care Financing (Medicaid Program). In addition the department has 20 boards that license and regulate health care professionals; and various commissions that issue grants, and research and make recommendations on issues that affect Maryland’s health care delivery system.

In FY 2015, through the passage of House Bill 1510 during the 2014 legislative session, Maryland’s Mental Hygiene Administration merged with the Alcohol and Drug Abuse Administration to form the Behavioral Health Administration. (BHA). The BHA is responsible for all publically funded specialty mental health and substance related disorder (SRD) services.

Enacted through state legislation, the Maryland DHMH, Medicaid (MA) Office of Health Services and the Behavioral Health Administration (BHA) implemented a new integrated public behavioral health system (PBHS). The MA Office, Behavioral Health Unit and the Behavioral Health Administration oversee and have the authority over the PBHS, which includes policy development, state-wide planning, resource allocation, and continuous quality improvement. The Administrative Services Organization (ASO), Beacon Health Options, assist with the management of the PBHS.

Maryland is providing a combined Behavioral Health Assessment and Plan for the FY 2018-2019 (Mental Health Block Grant and Substance Abuse Block) Applications. This combined application represent information that reflects a new integrated public behavioral health system that support quality, integrated and coordination of care for individuals with mental health and substance related disorders, improve data collection, and promote a recovery oriented system.

This document will highlight much progress made as we continue to move towards an integrated behavioral health system of care. Accomplishments include some of the following:

- Transferred substance use disorder (SUD) ambulatory and residential grant services to fee-for-service structure;
- Expansion of Naloxone training and certification;
- Expansion of Maryland’s Outcome Measurement System to include SUD;
- Adoption of SBIRT as a routine part of primary care and used in emergency departments
- Enhanced implementation of Person-Centered Planning;
- Enhanced outreach and education on Early Intervention including First Episode Psychosis;

- Expansion of Opioid Treatment funded through Cures Act and Maryland's Governor's Initiative; and
- Expansion of Recovery Support Services.

Behavioral Health Assessment and Plan

B. Planning Steps

STEP 1 - ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS:

Overview of the State's Current Behavioral Health System

The Behavioral Health Administration (BHA) is the division of the State of Maryland Department of Health (MDH) that is responsible for overseeing the delivery of public behavioral health services (PBHS). In general, Maryland currently provides or funds public behavioral health services in two ways, directly through its State psychiatric hospital system and by funding its managed fee-for-service system. BHA handles clinical and systemic issues, whereas, Medicaid's Behavioral Health Unit is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan.

BHA and Medicaid worked collaboratively to design integration of mental health and substance use services. In partnership with BHA, Medicaid Office of Health Services contracts with the Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

Maryland provides inpatient psychiatric services directly to its citizens through a network of five psychiatric hospitals, one of which is a forensic facility, and two regional institutes for children and adolescents, or State operated Psychiatric Residential Treatment Facility (PTRF). This is the only area in which Maryland operates services directly. Upon admission, these may be individuals who were or were not eligible for Medical Assistance (MA). Generally, if an individual has MA eligibility, every effort will be made to provide hospital care in a community based inpatient setting, either in the psychiatric sector of an acute general hospital or in a private psychiatric hospital. Some of these individuals will also participate in the fee-for-service system during the same year in which they have a stay in a State facility; others either remain in the facility for the entire year or elect not to access public care when not in the hospital.

The majority of community PBHS services are funded through a managed fee-for-service system. Both services that are eligible for MA reimbursement and services that are not eligible for MA (e.g., residential rehabilitation services, level III SRD services, and some supported employment services) are funded through this mechanism. Further, services are funded both for individuals who are eligible for MA and individuals who are not eligible for MA. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. In FY 2017, this system served over

242,000 people annually through a network of over 3,500 individual, group, agency, and institutional service providers.

Local Behavioral Health Entities

The PBHS is managed in collaboration with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) and the Administrative Services Organization (ASO). The CSAs and the LAAs are entities at the local level that have the authority and responsibility, in collaboration with BHA, to develop and manage a coordinated network of Maryland's public behavioral health services in a defined service area. There are nineteen (19) CSAs covering all 24 jurisdictions and 24 LAAs. These local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. They are the administrative, program, and fiscal authority that are responsible for assessing local service needs and planning the implementation of a comprehensive local mental health delivery system that meets the needs of eligible individuals of all ages. Additionally, CSAs and the LAAs are important points of contact for consumers, families, and providers in the PBHS and develop partnerships with other local, state and federal agencies. They provide numerous public education events and trainings. Additionally, local mental health advisory committees, CSA Boards and local alcohol and drug abuse councils have the opportunity and responsibility to advise the CSAs/LAAs regarding the PBHS and to participate in the development of local mental health plans and budgets.

On January 1, 2017, BHA has been successful in moving grant-funded ambulatory services for substance use disorders (SUD) to a fee-for-service (FFS) structure. The next phase of this process is to move the grant-funded residential SUD services to FFS. We successfully worked with Medicaid to establish and set the rates from the ground up. The rates are based on the actual costs of running these services. The rates are in two bundles: 1) Medicaid Services; and 2) Room and Board. On the providers' side there is now only one billing code which will eliminate double entry coding.

The second wave covering specialty services, includes the 8-507s (requires MDH) to facilitate treatment services for those who have been assessed as needing treatment). Currently there are only three providers managing the 8-507s. In the near future there will be more providers who are licensed to provide these services. Other services include the rate for pregnant women and children, and families involved in the child welfare system, etc. These processes are planned to go into effect in January, 2018.

Recovery Residences

Maryland has legislation that requires DHMH through BHA to approve a credentialing entity to develop and administer a certification process for recovery residences. This will include the development of guidelines and criteria for the oversight of recovery residences. By October, 2017, the credentialing entity must submit to DHMH a list of the recovery residences that have a certificate of compliance. By November 1, 2017, DHMH must publish a list of each credentialing entity and the credentialing entity's contact information on its website; likewise, a credentialing entity must publish a list of recovery residences that hold a certificate of compliance on its website.

Recovery residences are therapeutic, sober living housing for people who are not in treatment. However, in many instances, they are still receiving treatment. BHA is following the National Association of Recovery Residences (NARR) standards to support recovery residences at the state level. Florida is the only other state in the nation with a similar law. BHA representatives travelled to Orlando, Florida to gather information on how the state has set up recovery houses. We want to learn from their experiences and build on their successes as we move forward.

Accreditation

The Department and BHA is moving towards accreditation-based licensure for community behavioral health providers. All behavioral health providers should be scheduled to obtain accreditation by an approved accrediting organization no later than January 1, 2018 in order to be licensed by April 1, 2018 to provide community-based behavioral health services. Providers are encouraged to contact an accrediting entity no later than July 1, 2017 to ensure ability to meet the 1/1/2018 deadline. Technical assistance has been made available to all programs through both the BHA and accrediting bodies to provide support to complete the process.

Legislative Highlights

In response to Maryland's FY 2018 State Budget Analysis language, a report on the feasibility of merging the Core Service Agencies (CSAs) and the Local Addictions Authorities (LAAs) to become the Local Behavioral Health Authorities (LBHAs) and systems managers at the local level is required by the Department. BHA in collaboration with MDH will secure services from a nationally known consultant to look at defining integration, principles for integration, and identifying an integrated process for systems management. The report must also include financial analysis and an assessment of differences in experience in integrated versus separate agencies.

Other legislative highlights include:

- HOPE Act of 2017 - the Maryland General Assembly (MGA) pass the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017. This comprehensive behavioral health measure includes provisions to establish crisis treatment centers (by 6/1/2018), 24/7 crisis hotline to connect callers with appropriate mental health and substance use disorder resources, dissemination of information about opioid use, and require development of a plan for increasing SUD treatment in jails and prisons.
- HOPE Act also require hospitals to have protocols for discharging patients treated for a drug overdose or identified as having a substance use disorder. The protocols may include coordination with peer recovery counselors, connection to community-based treatment, and a prescription for naloxone. A status report of HOPE Act activities is due to the Governor and MGA on or before 9/1/2017.
- This Bill also includes provisions from the Keep the Door Open Act that supports rate increases for community behavioral health (mental health and substance use) providers. BHA is required to submit a rate setting study/report to the Governor and MGA on or before December 1, 2019.

In an effort to address the opioid crisis in the State, a number of policy and legislative initiatives have been implemented, including:

- **Good Samaritan Laws**: Maryland's Good Samaritan law became effective October 1, 2015. This law provides protection from arrest as well as prosecution for specific crimes and expands the charges from which people assisting in an emergency overdose situation are immune with the goal of increasing the availability and access of Naloxone.
- **PDMP**: The Maryland PDMP was fully launched in December 2013. Legislation enacted in 2016 requires mandatory registration of all prescriber as of 7/1/17, and mandatory use by 7/1/18.
- **Naloxone** - The Maryland General Assembly passed a law that went into effect on 10/1/15 that expanded public access to naloxone by allowing training entities to provide naloxone to Marylanders. A statewide standing order was later issued to all pharmacies by the Deputy Secretary of the Maryland Department of Health, and in 2017 a previous statute requiring naloxone prescription recipients to complete training was revised to remove the training requirement. These changes further increase access by allowing pharmacists to dispense naloxone to anyone upon request.

Strengths and Needs

As stated in more detail in the Quality and Data Collection Readiness section, the BHA uses several sources of data to identify unmet service needs and gaps. The primary PBHS data system is currently managed by an Administrative Services Organization (ASO). The ASO data systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. All stored data can be retrieved and reported

either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on a July-June fiscal year. Over 50 standard reports are generated to assist in general planning, policy, and decision making.

Behavioral Health Integration efforts will continue to strengthen through integrating prevention, health disparities, recovery principles evidence based practices, outcomes and cost effectiveness. Efforts are in place to improve data collection and quality measures. New tools will be in place to address the needs of providers to enhance capacity to deliver quality services for individuals across the lifespan as well as to improve care coordination. Through legislation, the BHA convened a Stakeholder Workgroup to make recommendations on issues related to behavioral health, including statutory and regulatory changes to fully integrate mental health and substance use disorder treatment and recovery support. Stakeholder input included review and comments on areas such as draft regulations to require accreditation for providers of behavioral health services.

The Behavioral Health Administration has an increased public health approach that supports and promotes efforts on overdose prevention, suicide prevention and intervention, drug monitoring, tobacco reduction, primary care consultation and problem gambling.

Additionally, each year an extensive plan development process is implemented beginning in January with the submission, to the BHA, of local behavioral health plans and budgets from the CSAs and LAAs. The local behavioral health Plan and Budget guidelines are developed through to guide the development of local plans in identify priorities, strengths, needs and service gaps of the local public behavioral health system as well as a description of stakeholder input. The BHA facilitates an annual plan development meeting in April for stakeholders throughout Maryland. This meeting includes a broad participation of stakeholders including representatives from consumer and family organizations, mental health and substance use advocacy organizations, behavioral health providers, local behavioral health authorities, local mental health advisory committees, and members of the BHA Management Committee. This process enhanced efforts for stakeholders to have input in the identification of the systems strengths and needs.

Some of the strengths identified include but were not limited to:

- Many training opportunities across the state on behavioral health
- Strong peer leadership and peer support community creating lots of support for meeting consumer needs
- Maryland's commitment to Recovery Oriented System of Care (ROSC)
- Changing role of local behavioral health authorities (LAAs/CSAs/LBHAs) in management/as systems managers at the local level

- Applications submitted for CMS/Waivers and piloting a broad range of services in Maryland
- Continuing outcome measures and more detailed and useful measures through the OMS
- Partnership/Coordination between forensics and behavioral health
- Stigma reduction efforts
- Data collection

Some of the needs/gaps identified included:

- Statewide Crisis Services and improved access and quality to hotlines,
- Coherent statewide approach to 24 hour mobile crisis response including:
- Need to address the workforce shortage as it relates to quality clinicians/police/treatment provider burnout; use of salary incentives and grant funded positions
- Need to increase affordable housing services. availability
- Lack of collaboration between Maryland Behavioral Health Advisory Council and local and state councils, not connected
- Local jurisdictions health departments should have increased involvement in setting standards of care for local providers and could partner with locals to develop best practices
- Need to increase education in criminal justice system and behavioral health services in prisons; more coordination needed to prepare individuals for re-entry.
- Need for a model of care for youth/from a youth perspective and increased workforce with a better understanding and training of youth-based disorders
- Look at how other models across the country such as Collaborative Care model, can be used here in Maryland
- Peer/Consumer input needed in the planning process
- Further define and increase peer job description to include areas such as Peer-run respite and hospice

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

STEP 2 – IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM:

The identification and assessment of systems' strengths, needs and existing resources has been implemented through past and current efforts. Each year an extensive plan development process is implemented beginning in January with the submission, to the BHA, of local behavioral health plans and budgets from the CSAs and LAAs. The local behavioral health Plan and Budget guidelines are developed through to guide the development of local plans in identify priorities, strengths, needs and service gaps of the local public behavioral health system as well as a description of stakeholder input.

During the 2016 legislative session, Senate Bill 551 was passed that required the Maryland Behavioral Health Advisory Council (BHAC) to develop a strategic plan to implement 24/7 walk-in crisis services and 24/7 Mobile Crisis Team (MCT) services that can be accessed by each jurisdiction in Maryland. The level of need in Maryland for crisis services has increased, particularly given the increase in individuals seen in emergency departments for behavioral health issues. The Strategic Plan is due to the Maryland General Assembly on December 31, 2017.

The BHAC convene a Steering Committee that guided the process in response to the legislative charge. A survey was conducted online and the community was invited to participate through emails notification and websites. The survey collected over 1000 responses. Responses were captured on questions related to gaps in current crisis system, what do currently exists, services used, etc. Some responses included:

- Lack of consistent follow-up care in some jurisdictions
- Lack of timely 24/7 access to community based crisis services
- Need for improved relationships in the community between behavioral health providers, social services, hospitals and law enforcement.

Additionally, Maryland is responding to the opioid overdose crisis through a multi-faceted approach. In January 2017, Governor Larry Hogan and Lt. Governor Boyd Rutherford announced the administration's 2017 Heroin and Opioid Prevention, Treatment, and Enforcement Initiative, a multi-pronged and sweeping administrative and legislative effort to continue addressing Maryland's ongoing opioid and heroin epidemic. As part of this initiative, Governor Hogan signed an Executive Order amending the 2015 Executive Order to establish the Inter-Agency Heroin and Opioid Coordinating Council, authorizing the council to establish the Opioid Operational Command Center (O OCC). The center will facilitate greater collaboration between state and local public health, human services, education, and public safety entities to reduce the harmful impacts of opioid addiction on Maryland communities. The creation of a statewide Opioid Operational Command Center will assist in breaking down governmental silos and aid in the coordination of federal, state, and local resources, working directly with both local and federal organizations and agencies, as well as 12 state agencies and departments including: the Governor's Office of Crime Control & Prevention; Maryland Health Department;

Maryland Emergency Management Agency; Maryland State Police; Maryland State Department of Education; Department of Human Services, Department of Juvenile Services; Department of Public Safety and Correctional Services; Maryland Institute for Emergency Medical Services Systems; Maryland Higher Education Commission; Maryland Insurance Administration; and the Office of the Attorney General. As a direct result from increased collaboration, the center will collect and collate data – data that will be used to save lives. In addition to \$4 million new funding, three new pieces of legislation are also being proposed: the Distribution of Opioids Resulting in Death Act, the Prescriber Limits Act, and the Overdose Prevention Act.

The Maryland Opioid Rapid Response (M.O.R.R.) initiative, implemented through the Cures Act, is designed to take a strategic and comprehensive approach to increasing access to and enhancing services for individuals with an Opioid Use Disorder (OUD) through targeting high risk regions and populations and reducing gaps in service throughout the Public Behavioral Health System (PBHS) and the state. The goal is to utilize a public health framework of prevention, treatment and recovery services to reduce unmet treatment needs and opioid related deaths. The priorities of the M.O.R.R. Initiative are to:

- Prevent opioid misuse and abuse through enhanced prescriber practices and public awareness;
- Treat opioid dependence by expanding treatment and increasing quality;
- Prevent overdose fatalities through naloxone expansion; and
- Expand recovery supports in the community.

Maryland Opioid Rapid Response Statewide Needs Assessment

Maryland Opioid needs assessment uses multiple information sources to assess and map the current capacity of, and need for opioid treatment in Maryland. This analysis builds on and expands the findings of a recent Opioid Treatment Program (OTP) Needs Assessment Report conducted by the University of Maryland, Baltimore in 2016 and was used to help inform the development of the M.O.R.R. initiative strategic plan and guide State and local planning and system development efforts to increase system capacity where it is most needed.

Analysis and Identification of High-Risk Areas and Populations of Focus

Opioid Use Disorders and opioid related overdose deaths have become a serious public health challenge in Maryland and across the country. Maryland's age adjusted 2015 death rate per 100,000 population involving all drugs (20.9) and involving Opioids (17.7) are well above the national rates of 16.3 and 10.4 respectively. The number of opioid related overdose deaths in Maryland has increased nearly two fold (186%) between 2012 (646) and 2016 (1862). Since 2014, Maryland has seen a substantial uptick in overdose deaths over previous years, as

demonstrated by a 23% increase between 2014 and 2015 and a 70% increase between 2015 and 2016.

In 2016, the opioid related overdose death rate in Maryland was 38 per 100,000 population which is up from 21 per 100,000 in 2015. As shown in Figure 2, opioid overdose death rates vary substantially across Maryland jurisdictions ranging from zero in Garrett County to 125 in Baltimore City. While seven jurisdictions had opioid related death rates higher than the state rate, four jurisdictions (Baltimore City, Allegany County, Washington County, and Wicomico County) had rates over 50 per 100,000 population, indicating areas with higher risk and potential areas to target treatment and prevention efforts. The Baltimore metro area (Baltimore City, and Baltimore, Anne Arundel, Carroll, Harford, and Howard Counties) have had the highest rates historically and over the past few years, rates have been increasing faster than most other areas in the state. Overdose deaths in Western Maryland (Garrett, Allegany, Washington, and Frederick Counties) have increased nearly fourfold over the past six years. In this analysis, two jurisdictions stand out as being at particularly high risk for overdose deaths with rates 2.5 times (Allegany County) and 3.3 times (Baltimore City) higher than the overall state rate. Further analysis of the data shows that in 2016, the gender specific opioid-related death rates for Males, 61.5 per 100,000, was nearly three times the rate for females (21.5). Age specific opioid related death rates were greatest for those individuals 45 to 54 years (64.3) and 25 to 34 years (62.9). There were fewer opioid related deaths to those under 25 years (16.1) and the age specific rate for those over 54 years was 25.4 per 100,000.

The Maryland Department of Health, Behavioral Health Administration (MDH BHA) is developing an overdose predictive risk model. The model is based on data from multiple data sets and designed to identify key risk factors that can be provided to treatment providers, local behavioral health authorities and other stakeholders to assist them in targeting high-risk individuals in the populations they serve and intervening early to prevent overdoses and overdose deaths. The BHA PDMP has new staff and software capacity to conduct cluster analyses based upon overdose incidence, CDS prescriptions filled, dangerous co-prescribing of medications and other relevant factors associated with management of patients receiving opioids.

Maryland's behavioral health delivery system has made significant strides in recent years to become more recovery-focused and person-centered. The Department has instituted regulatory reform, provided financial support for a wide range of enhanced services, invested in the diversification of staffing, and offered broad workforce training in motivational interviewing and trauma-informed care. Maryland's goal has been to align incentives, oversight, payments and staff competencies to enhance the quality, accessibility and coordination of our service system. Despite these advances, gaps remain that inhibit the ability of Marylanders with

behavioral health challenges to access the comprehensive, coordinated quality care that they need.

During the various phases and processes that have led to the development and implementation of behavioral health integration, stakeholders input was invaluable to identifying service needs as well as gaps within the system.

Efforts to Address Workforce Gap

Maryland continues efforts to address the gap and the difficulty in accessing behavioral health services. Factors contributing to this gap include a lack of trained specialists, workforce shortages, particularly in rural settings, and/or provider capacity issues. Through technology rural counties have benefited from telemedicine or telemental health services. Maryland implemented the telemental health policy with the goal of increasing access to health care rural areas such as Garrett, Allegany and Somerset counties.

To address the need for and availability of child behavioral health integration services, the BHA's Office of Child and Adolescent Services has collaborated with University of Maryland School of Medicine, Johns Hopkins School of Public Health, and Salisbury University to implement the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). BHIPP is a free service, available to all pediatric primary care providers in Maryland, which aims to expand the capacity of primary care providers (PCPs) to identify, refer, and/or treat child and adolescent mental health problems. There are currently over 375 providers enrolled in BHIPP statewide. The BHIPP program offers the following services:

1. Telephone consultation for PCPs to receive advice from child and adolescent mental health specialists, including psychiatrists, psychologists, and clinical social workers at the University of Maryland and Johns Hopkins. Mental health topics covered include screening, resource and referral, and diagnosis and treatment;
2. Continuing education opportunities for PCPs and their staff to develop and enhance mental health knowledge and skills;
3. Assistance with local referral and resources to link families to mental health services in their community.
4. In partnership with Salisbury University Department of Social Work, Co-location of graduate level social work students in primary care practices to provide on-site mental health consultation.

Care Coordination

In the current system, while all Maryland jurisdictions have some mental health case management services for adults and children, there is a need to expand and improve integration of formal case management and care coordination for people with both mental illnesses and substance use disorders. Planning efforts are underway to further care coordination to ensure these case management services leverage formal partnerships with medical care and social services resources in Maryland. Beyond traditional 'professional' case

management, peer and family support services will be partners in the expansion of these coordination services. The unique perspective of those with lived experience will be essential not only in furthering care coordination, but also in expanding outreach and engagement services. Maryland has experience in using peers to meet with clients who present in EDs or are admitted to inpatient detox as a result of an overdose. The peers work to engage the clients in SUD treatment, especially opioid replacement therapy, which enhances both initial engagement and ongoing participation in therapy.

In addition to the coordination services mentioned, other efforts implemented to bridge the service gap include:

- Enriched linkages between the correctional behavioral health care system and the community-based system: Maryland currently operates a “data link” program with many local jails and state correctional facilities. Our ASO receives a daily feed of individuals arrested on the previous day from the Department of Public Safety and Correctional Services. The ASO provides a data feed to clinical staff of the local detention center or state correctional facility if the individual is in behavioral health treatment and/or on psychiatric medication. The behavioral health service provider is also notified by the local CSA or LAA, of a client’s arrest when possible and appropriate. This effort will be expanded to include SUD data once the necessary consents are built into the Beacon Health system.
- Improved crisis support services and a more substantial crisis follow-up service: While the mental health block grant supports crisis response and intervention systems two (2) counties and Baltimore City, which has two systems, one for children and adolescents and another for adults, much of the rest of the state has more limited resources. Almost every county has established crisis intervention teams, though they are not necessarily all available 24/7. Additionally, nearly all counties offer short term, state-funded crisis respite beds as both an alternative to, and a step-down from, psychiatric inpatient services. Every county already has access to a 24/7 behavioral health crisis hotline and emergency department psychiatric services. Crisis services continue to be priority as well as intervention, and follow-up stabilization services that utilize peer and family support.
- More robust outreach and engagement of difficult to reach and difficult to engage populations: expansions and enhancements of care coordination will enable Maryland’s service system to more effectively reach out to individuals and families who have either not engaged with the system or are utilizing only emergency room services. By expanding the availability of care coordinators and peers of all ages who can follow-up after hospitalizations, detentions, and out-of-home placements, we will improve connection and engagement with the behavioral health service system. DHMH will also train behavioral health clinicians and care coordinators in techniques known to facilitate client engagement for particularly difficult to reach populations (e.g. young adults) and to encourage ongoing fully engaged participation in treatment and support services.

Maryland recognizes that prevention efforts are a key component of a comprehensive approach for effectively addressing the opioid crisis. MDH BHA has made a significant investment in prevention and has initiated a number of statewide evidence-supported prevention efforts, including:

The Opioid Misuse Prevention Program (OMPP). This program is administered by the MDH BHA Office of Health Promotion and Prevention and utilizes the Strategic Prevention Framework (SPF) process. There are 18 jurisdictions receiving grant funding for the OMPP project. One of the 18 jurisdictions is a regional team made up of five counties known as the Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot). The only jurisdictions in Maryland not participating in the grant program are Charles and Prince George's counties. The funds are provided to strengthen and enhance local overdose prevention plans and to implement evidence-based opioid misuse prevention strategies. The purpose of this program is to reduce opioid misuse, overdoses, and overdose fatalities. Jurisdictions are required to work through the five stages of SAMHSA's Strategic Prevention Framework process (assessment, capacity, planning, implementation, and evaluation) in order to implement their evidence-based strategies.

Substance Abuse Block Grant (SABG) Prevention Set-Aside Program. Maryland provides SABG prevention grant funding to all 24 jurisdictions and four regional college Alcohol Tobacco and Other Drug (ATOD) Prevention Centers. SABG prevention funds are used for primary prevention activities for those who have not been identified as having a substance abuse problem and are used in Maryland to support evidence based prevention programs and best practices. There are currently no evidence-based primary prevention programs that specifically address opioids. Instead, to assist with efforts to prevent eventual opioid misuse, Maryland provides funding to support primary prevention activities that are designed to prevent the misuse of any and all substances. This includes direct service programs that educate youth about the harms and risks of substance use while strengthening their skills in areas such as decision making, goal setting, problem solving, conflict resolution and drug refusal techniques. Direct services are also provided that strengthen family communications and bonding and parents' ability to discuss drug use issues with their children and to model appropriate anti-substance use behaviors. This grant also supports evidence-based strategies designed to change community conditions (retail and social availability of substances, low perceptions of harm and risk of drug misuse, community norms, enforcement of drug laws and policies, etc.) that contribute to and/or foster substance misuse.

Strategic Prevention Framework (SPF) - Rx Grant. The Maryland SPF-Rx initiative has two primary goals: 1) to reduce youth and adult non-medical use of prescription drugs (NMUPD), including opioids, by providing technical assistance and training to local jurisdictions and 2) to strengthen state and local capacity to address overprescribing through the dissemination of state PDMP and State Epidemiological Outcomes Workgroup (SEOW) data to state and local prevention, intervention and treatment authorities, and to providers. Maryland is currently utilizing year one SPF-Rx funding to conduct a required state needs assessment. This assessment will determine high risk populations and geographic areas to target for the state's future NMUPD prevention efforts; the data needs of local communities and their capacity to use data for prevention planning; and the capacity of the state PDMP and SEOW to produce data in formats that state and local authorities can effectively use in their system planning and management, and for service provision within their jurisdiction. In year-2 and beyond, the SPF-RX project will, based on this needs assessment, provide technical assistance and training to local jurisdictions to assist them to provide prescription drug misuse prevention activities and education to schools, communities, parents, prescribers and their patients.

Public Awareness and Education: Recent statewide media campaigns have focused on three subject areas and target the general public. The three areas of focus were 1) Anti – Stigma, 2) Naloxone, and 3) the Good Samaritan Law. These efforts in educating the general public around all three areas of focus were initiated through a series of PSAs that included an NFL football player talking about the stigma associated with SUDs. The PSAs aired on all of the major local stations and in select movie theaters across the state. The "Naloxone Works" campaign highlighted real Marylanders who had saved a life by administering naloxone. Photos and information appeared on transit and billboards throughout the state showing these life-savers in various settings that represented different geographical areas of the state. BHA also worked with state advocates to create an Ambassador program, which entailed family members reaching out to communities in an effort to educate them about the state's Good Samaritan law. In addition, BHA worked closely with Maryland Public Television to develop "Breaking Heroin's Grip, Road to Recovery," an hour long program that featured stories of Marylanders and highlighted Maryland's Crisis Hotline team. BHA also has a heavy presence in social media and hosted three successful Twitter storms that trended throughout the state on the three areas of focus.

Maryland's Commitment to Veterans (MCV)

The Department continues to prioritize efforts to address the behavioral health needs of veterans and their families. Maryland's Commitment to Veterans is a program under BHA that collaborates with the VA Maryland Health Care System, Maryland Department of Veterans Affairs as well as other state agencies and community providers. MCV assists veterans and their families with coordinating behavioral health services for the veteran, including mental health and substance abuse services- either with the VA or BHA. MCV also facilitates and covers transportation costs to behavioral health appointments for veterans and provides information and referrals related to employment, education, housing, and VA benefits. All MCV Regional Resource Coordinators are also Mental Health First Aid instructors. Maryland's Commitment to Veterans (MCV) is linking BHA Peer Support to VA Maryland Health Care Peers. Intent is to have peer training and collaboration among BHA peers in the community and VA peers working inside VA medical center.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness

Maryland's Public Behavioral Health Data Collection/Reporting System

Most of Maryland's major public behavioral health system (PBHS) data is currently collected and managed by an Administrative Services Organization (ASO). In September 2014, ValueOptions Inc., now Beacon Health Options (BHO), was selected to continue their contract as the ASO for the PBHS. Prior to the merger of the administrations for mental health and substance related disorders (MH and SRD), the ASO historically extracted all mental health client level data (MH CLD) for community services reimbursed through the fee-for-service system. The fee-for-service system includes nearly all services that are appropriate to such a payment system, including both Medical Assistance (MA) and state-funded services and includes over 98% of community service funding. The implementation of a combined MH/SRD data system went live January 1, 2015. The ASO collects required data for all SRD services, whether or not it manages or reimburses those services. All required mental health Client Level Data (CLD) and substance related disorders Treatment Episode Data Set (TEDS) data elements are built into Beacon Health Options (BHO). Data will be collected and reported according to grant requirements. Maryland's current reporting system is very robust and comprehensive, but we are seeking ways to encourage discharge reporting, especially in light of the system changes and the TEDS requirements. It is noteworthy, however, that most PBHS services are authorized for six months or less, and that Maryland requires updating of CLD and TEDS information at the start of each concurrent authorization period. The movement to view SRD services as chronic disease conditions, as well as the on-going nature of Medication Assisted Treatment, would be better served by a system of reporting that provides regular updates to data as opposed to one reporting data only at admission and discharge.

The data system collects information on those who receive services in the PBHS. As with mental health services, the majority of community SRD PBHS services are funded through a managed fee-for-service system. With the implementation of the IMD waiver for SRD services on July 1, 2017, Maryland began incorporating residential SRD services into the ASO system, a process that will be complete as of January 1, 2019. In addition to managing MA services, the ASO manages PBHS funded services to uninsured individuals. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. This system serves over 242,000 people (mental health and substance related treatment services) annually through a network of over 3,500 individual, group, agency, and institutional service providers.

The system is driven by a combination of authorizations and claims for behavioral health services. Inherent in the implementation of the PBHS is a series of extremely comprehensive data sets. Data sets on clients' eligibility, service authorization, claims payment, and events, and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the data from the ASO process that providers complete in order to document that an individual meets the criteria to be enrolled as an uninsured individual. Unduplicated counts are facilitated by the ASO assigning a non-changing

unique identifier to every individual who enters the system. Authorizations are generally made on-line and required data elements are updated as part of the request process, whether it be an initial or concurrent request. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files. Expenditures for services funded by this managed fee-for-service system will represent nearly 95% of the PBHS community services budget when all of the SRD residential services are included and it is adjusted for administrative costs. Administrative costs include the cost to operate the BHA, the cost of the ASO, and the cost of local administration. Data that is maintained on the consumers using these services are extracted from enrollment, claims, authorization, and Outcomes Measurement System (OMS) data systems.

The Behavioral Health Administration (BHA) appreciates the importance of functional assessment in mental health treatment and started using the Daily Living Activities instrument (DLA-20) as the uniform assessment instrument for adults receiving MH treatment limited to psychiatric and residential rehabilitation and mobile treatment services. In Maryland, the instrument will be used for care planning and identifying support needs, but will not be used in determining eligibility for services. The DLA-20 for the public behavioral health system became operational in February 2017. Work is almost complete in creating a DLA-20 DataMart with secure access to management as well as the jurisdictional authorities and the providers of these specific services. The DLA-20 DataMart will display data by demographic, DLA-20 items and outcome information relative to an episode of care. The DataMart will allow the providers search and display data at the client level which will help the clinician get a snapshot of the progress in treatment. The DataMart with data based on the most recent service request (point in time displays) will be available in August 2017. Change over time analysis will be available later in the year as concurrent authorizations are not yet available to track this.

The OMS for the public behavioral health system has been operational since September 2006. Under the newly established Behavioral Health Administration (BHA), the OMS was expanded beginning January 1, 2015 to include recipients of Level 1 outpatient Substance-Related Disorder (SRD) services, and on October 1, 2016-Opioid Treatment Programs (OTP). The OMS is a very rich source of outcome data that can be viewed using OMS DataMart at http://maryland.beaconhealthoptions.com/services/OMS_Welcome.html

In addition to support behavioral health services access, utilization review, and care coordination tasks, the ASO is contracted to collect and display Outcomes Measurement System (OMS) data on most outpatient services. The PBHS OMS data are displayed on a publically accessible DataMart by demographic, clinical service, and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PBHS data system, through a series of interrelated databases and software routines, can report over 200 elements for both inpatient and outpatient care, including the National Outcome Measures (NOMS). Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals;
- services utilized by level of care and service;

- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal year reports. Currently, over 60 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Currently, access to the PBHS data is monitored by the ASO/BHA. Based on content and appropriateness, these are available to BHA administrators, to administrators of local systems known as Core Service Agencies (CSA), to providers, and in near future to Local Addiction Authorities (LAA). Requests for access must be submitted to the BHA along with signed and approved data user agreements. There are set licenses for administrative executive level staff, Local Addictions Authorities (LAA), as well as for Core Service Agencies (CSA)-county specific behavioral health entities who, in collaboration with BHA, develop and manage a coordinated network of Maryland public behavioral health services. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC) where a parallel data repository is maintained. The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts. SEC staff aid in the reporting capabilities of the BHA. In addition to the processed data, BHA personnel have access to all of the person/claims level data from the ASO data warehouse.

Automated access to the PBHS ASO data reporting platform is disabled after 45 days of inactivity. Password reset protocol is implemented every 90 days. Staff utilizing the PBHS data reporting platform are trained either by the ASO or BHA MIS staff. A user guide is provided, and policies are outlined in the data use agreement. Periodically, information regarding HIPAA policies and Protected Health Information (PHI) are distributed to all licensees.

Mental Health service authorization information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this module has enhanced service quality and provided a rich resource to enhance data analysis efforts.

An unanticipated problem resulting from PBHS implementation contributes to an undercount of persons served. The ASO Management Information System (MIS) does not capture data for individuals who receive services covered by Medicare, unless they receive a service not part of the Medicare benefit but covered by Medicaid. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data.

BHA is currently receiving grants through SAMHSA/Eagle Technologies to help support Behavioral Health Services Information System (BHSIS) related activities. The required Basic and Developmental Tables will be submitted in December 2017 along with a Client Level Data

(CLD) file that will contain client specific data for all served in the PBHS and State Psychiatric facilities in FY 2016. The BHA will continue to submit quarterly TEDS required files. A few tables required are NOMs- based data tables. All tables will be submitted this year, including developmental tables. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS), all of which are within the ASO system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Perception of Care Survey for some of the National Outcome Measures (NOMs).

For individuals who are receiving non-emergency services through other treatment modalities or from private practitioners or groups which are not required to participate in the OMS, authorization of service is also required. As previously indicated, most authorization data are collected through the web based BHO ProviderConnect® system. Data collected through the authorization process include employment, housing, detailed racial and ethnicity information, as well as information on diagnoses, symptoms, co-occurring substance abuse conditions, and other issues.

Data from state-operated inpatient facilities are obtained from a Hospital Management Information System (HMIS) implemented in 1986. The HMIS system tracks all admissions and discharges in and out of the state facilities. There are various modules that capture basic demographic and diagnosis data, as well as federally mandated National Outcome Measures (NOMs). Access to HMIS is granted at the facility level, as well as limited access by BHA. HMIS is monitored and maintained by DHMH-Office of Information Technology (OIT). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS), NOMs and CLD reporting. While this system does not use the same consumer identifiers as the ASO data system, there are elements common to both which BHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. Data is used at the Executive, facility, and CSA level to track facility usage, forensic population, and length of stay. Data is designed to be used to complete ad hoc requests.

In addition to the ASO, BHA contracts with the Systems Evaluation Center (SEC), a component of the Behavioral Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Psychiatric Services Research to assist with evaluation and data infrastructure activities. As BHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 2002. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. In this coming year the SEC will continue to collaborate with BHA and

key stakeholders to identify areas of interest related to the PBHS that could be analyzed using multiple databases. These databases include claims, authorization, consumer perception of care survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

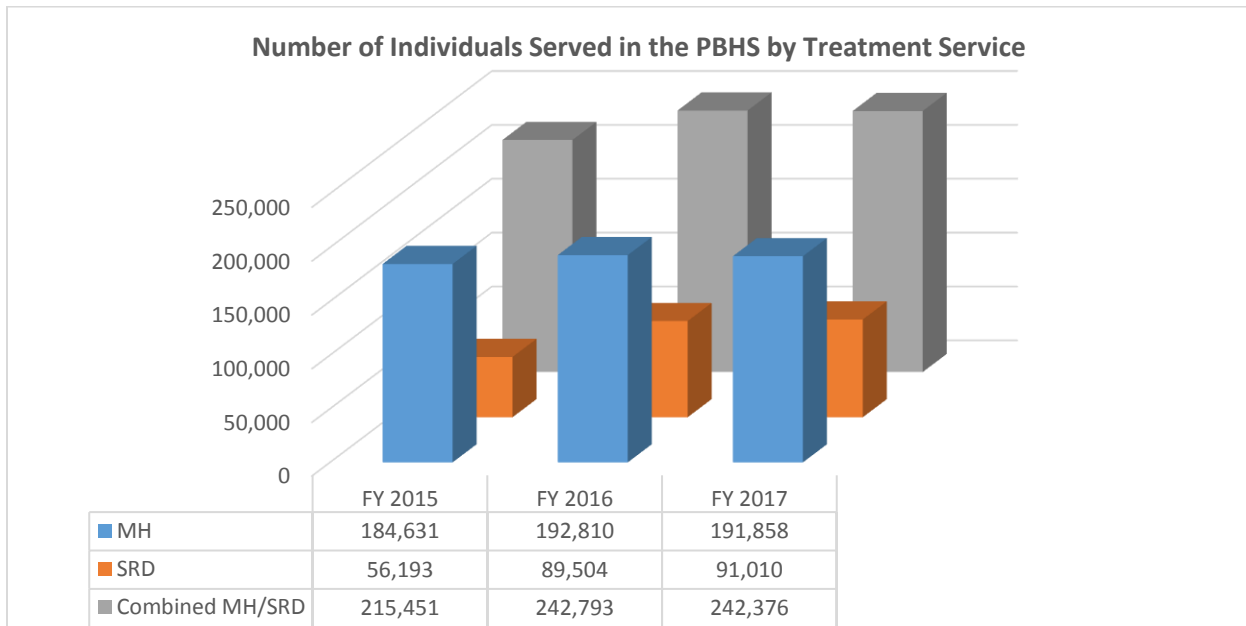
The Administrative Services Organization's Management Information System (ASO MIS) was utilized to produce most of the data. Data for FY 2016 are based on claims paid through May 31, 2017. Since claims can be submitted up to twelve months following the date of service, the data for FY 2016 may be incomplete, although cash flow considerations require most providers bill within a few days of providing a service. Specific diagnoses were used to define SMI. An individual was categorized as Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted

Maryland's BHA also receives information from the Office of the Chief Medical Examiner (OCME) and the Vital Statistics Administration (VSA) on unintentional deaths in Maryland that involve a drug and/or overdose. Maryland's rich data resources have allowed for the identification of individuals who were in treatment in the PBHS prior to their deaths and data have been analyzed to alert providers to characteristics that may identify individuals at risk of overdose death.

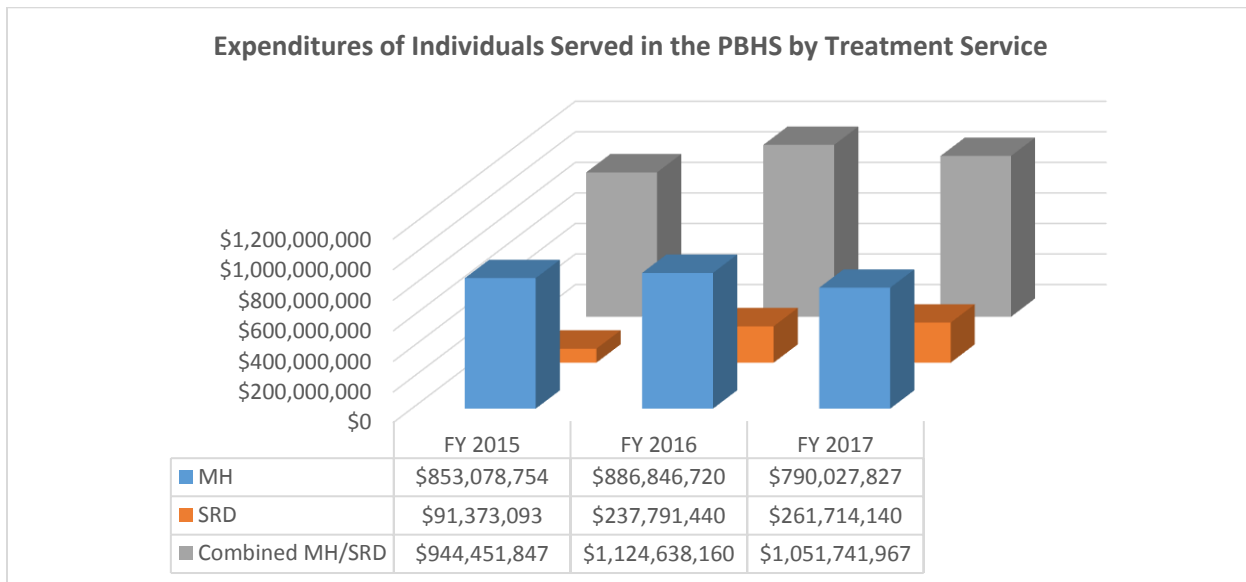
Public Behavioral Health System (PBHS) Service Utilization and Expenditures Coverage

The current Maryland Public Behavioral Health System serves over 242,000 people (mental health and substance related treatment services) annually through a network of over 3,500 individual, group, agency, and institutional service providers. The PBHS services both Medicaid recipients and the uninsured population.

The combined PBHS service expenditures were over \$1.1 billion in FY 2016. 90% of claims were paid through Medicaid funds.



Totals are unduplicated among service categories. FY 2015 SRD services represents 6 months of data as implementation of the merged data collection system began on January 1, 2015.



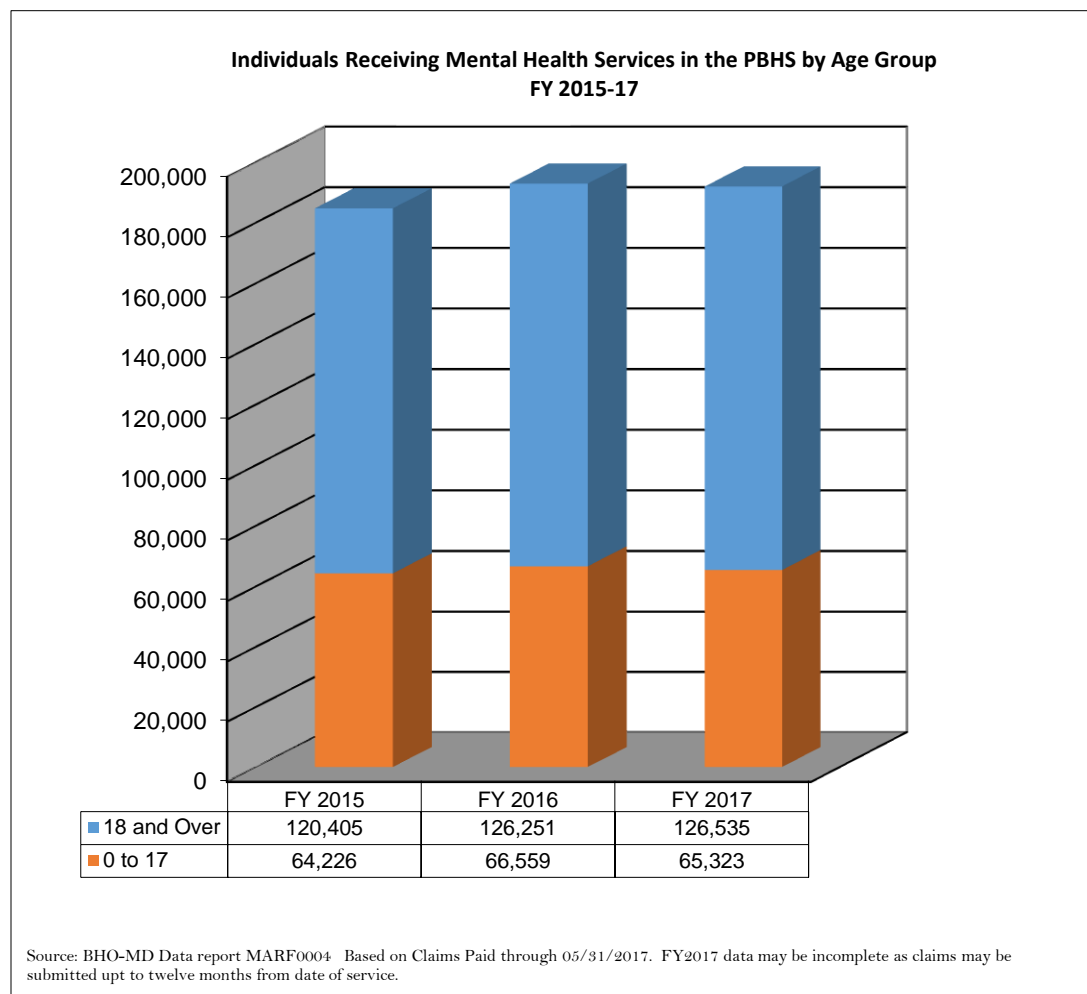
Access to services is critical for any behavioral health system. In recent years and as an ongoing strategy in the FY 2018 State Plan, BHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PBHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

Many of these increases result from the implementation of the Affordable Care Act, which provided funding allowing states to cover more people with Medicaid. The expansion of Medicaid, especially the extension of Medicaid to childless adults and the parents of children in Maryland’s Children’s Health Program (MCHP), improved access to health care and services. It is estimated that an additional 250,000 Marylanders were eligible for Medicaid and 13-15 percent of that population used PBHS services within the coming fiscal years.

	Average Maryland Medicaid Eligible	Total MA Recipients Receiving MH Services	Penetration Rate
FY 2013	1,066,815	143,496	13.5%
FY 2014	1,181,231	156,545	13.3%
FY 2015	1,310,720	176,751	13.5%
FY 2016	1,278,854	184,443	14.4%
FY 2017	1,365,342	183,995	13.5%

Public Behavioral Health System (PBHS) Mental Health Service Utilization and Expenditures

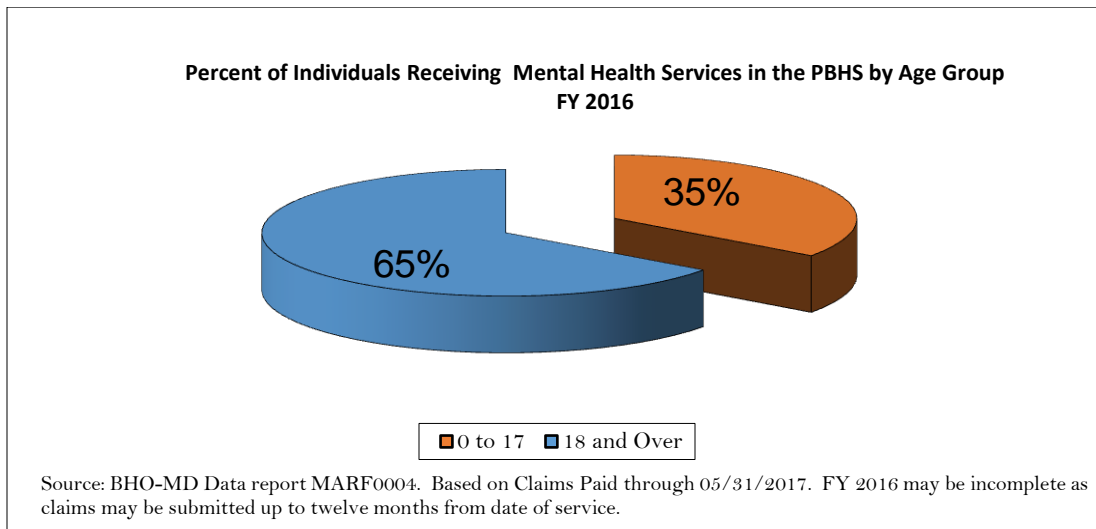
The total number of individuals served in the fee-for-service PBHS for mental health services has increased from 184,631 in FY 2015 to 191,858 in FY 2017, a 4 percent increase. Tables on the following pages provide data on consumers served by age group in FY 2015, 2016 and 2017. FY 2016 data shows 192,810 individuals had claims submitted for mental health services through the fee-for-service system. Of the total, 126,251 are adults, and 66,559 are children. This total has increased by 4% during the same time period from FY 2015. In FY16, 10,802 uninsured individuals utilized PBHS services who meet specific eligibility criteria. This is a slight increase from FY15 (n=10,520), although current data for FY17 is showing a significant decrease of almost 40% in the number of uninsured served.



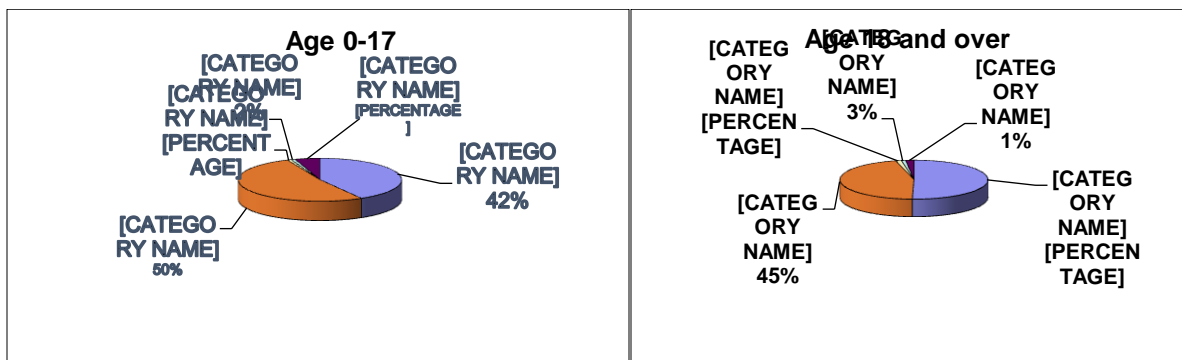
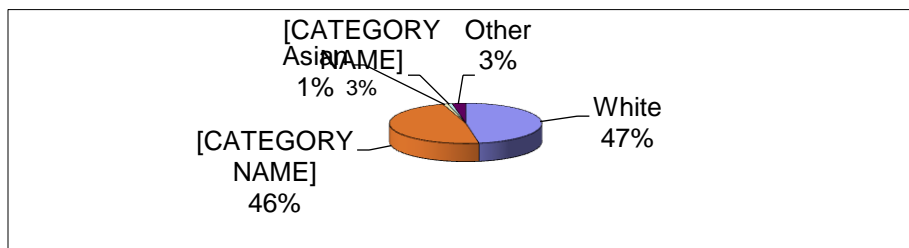
Demographics of Consumers Receiving Mental Health PBHS Services

The number of children and adolescents, aged 0-17, accessing mental health services grew 2% while adults 18 and older experienced a 5% growth, increasing the numbers served by 4 percent over the same time period between FY 2015-2017.

Currently, 65 percent of the individuals served in mental health services are adults and 35 percent are children.



The racial distribution of the PBHS population receiving mental health services is 46% Black/African American, 47 % White, 1% Asian, 3% other and 3 % unknown.



Source: FY 2016 URS Table 2A

Note: Other includes: American Indian, Native Hawaiian, Pacific Islander and those individuals with more than one race. Data includes through also served in state psychiatric facilities.

POPULATIONS – CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by 5,200. This average loss is approximately 1,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 3%, each year (36,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

Behavioral Health Administration
Prevalence Estimates for Serious Emotional Disorder (SED) by County
Child and Adolescent
Population

County	Under 18 Population	Low Prevalence	High Prevalence
		6%	12%
Allegany	15,408	924	1,849
Anne Arundel	139,581	8,375	16,750
Baltimore County	201,827	12,110	24,219
Calvert	23,772	1,426	2,853
Caroline	8,393	504	1,007
Carroll	41,360	2,482	4,963
Cecil	26,112	1,567	3,133
Charles	42,221	2,533	5,067
Dorchester	7,480	449	898
Frederick	64,578	3,875	7,749
Garrett	6,331	380	760
Harford	62,719	3,763	7,526
Howard	83,884	5,033	10,066
Kent	4,129	248	495
Montgomery	266,060	15,964	31,927
Prince George's	231,927	13,916	27,831
Queen Anne's	11,777	707	1,413
St. Mary's	30,539	1,832	3,665
Somerset	5,699	342	684
Talbot	7,601	456	912
Washington	36,373	2,182	4,365
Wicomico	27,502	1,650	3,300
Worcester	9,967	598	1,196
Baltimore City	148,239	8,894	17,789
Statewide Total	1,503,479	90,209	180,417

Source: Maryland Vital Statistics Annual Report. July 2015.

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
 - Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.

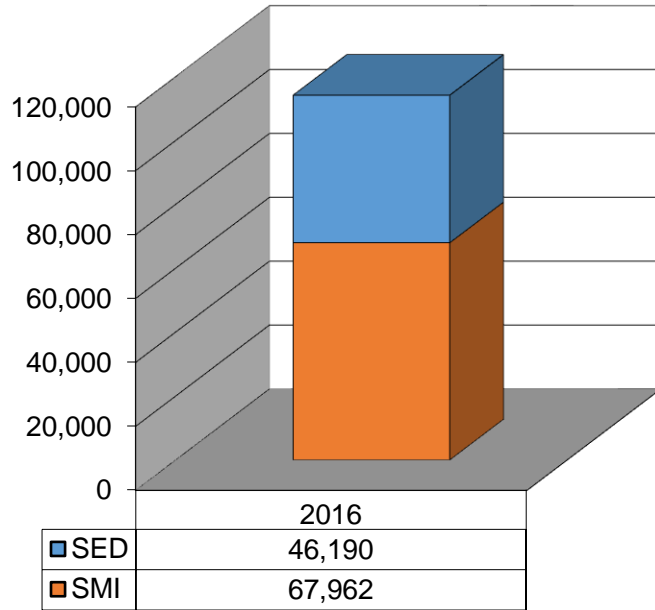
- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
 - Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Behavioral Health Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

Behavioral Health Administration
Prevalence Estimates for Serious Mental Illness (SMI) by County
Adult Population

County	Over 18 Population	Prevalence 5.4%
Allegany	57,120	3,210
Anne Arundel	424,614	23,428
Baltimore County	629,301	34,922
Calvert	66,763	3,728
Caroline	24,186	1,342
Carroll	126,267	7,045
Cecil	76,270	4,243
Charles	113,897	6,307
Dorchester	24,904	1,388
Frederick	180,744	10,026
Garrett	23,129	1,290
Harford	187,571	10,445
Howard	229,530	12,659
Kent	15,658	874
Montgomery	774,056	42,686
Prince George's	677,608	37,557
Queen Anne's	37,127	2,005
St. Mary's	80,874	4,479
Somerset	20,069	1,134
Talbot	29,911	1,658
Washington	113,212	6,304
Wicomico	74,868	4,199
Worcester	41,573	2,298
Baltimore City	473,610	26,347
Statewide Total	4,502,862	249,628

Source: Maryland Vital Statistics Annual Report. July 2015.

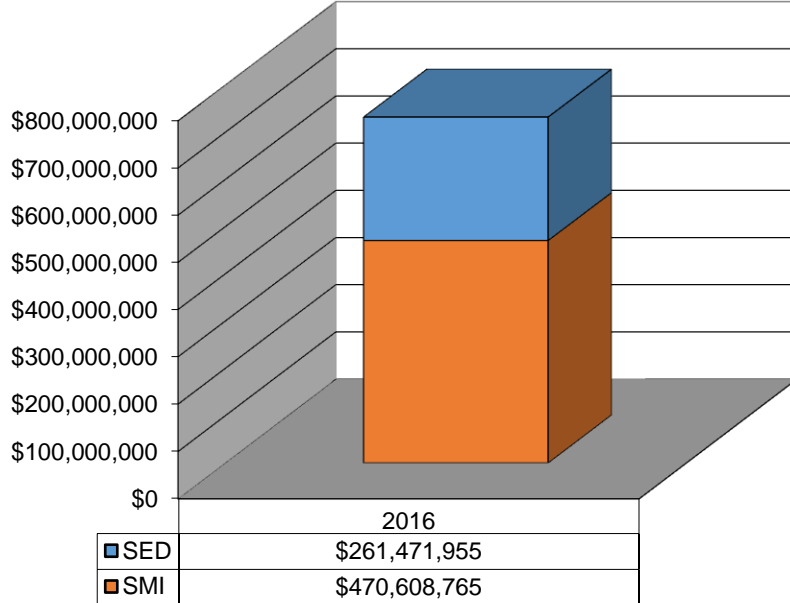
Total SMI/SED Consumers Served in the PBHS in FY 2016



Source: BHO-MD Data Report MARS+161 Based on Claims Paid through 5/31/2017. FY 2016 Data may be incomplete as claims may be submitted up to twelve months from date of service.

In FY 2016, 69% of individuals under age 18 served in the PBHS had a SED utilizing 29% of all service expenditures. 54% of all adults served had a SMI and utilized 53% of all service expenditures.

Total PBHS Expenditures for SMI/SED Consumers Served in FY 2016



Source: BHO-MD Data Repository Based on Claims Paid through 05/31/2017. FY 2016 Data is incomplete as claims may be submitted up to twelve months from date of service.

Specific diagnoses were used to define SED/SMI. An individual was categorized as having a Serious Emotional Disorder (SED) or Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted.

In FY 2016, 31% of individuals receiving mental health treatment services in the PBHS were dually diagnosed. These individuals have a primary mental health diagnosis, as well as a secondary diagnosis of substance abuse. This population accounted for 45% of all mental health claim expenditures.

	Total Count Receiving		
	MH Services	Number Dually Dx Served	% of Total Served Are Dually Dx
2015	184,631	52,435	28.4%
2016	192,810	59,036	30.6%
2017	191,858	53,787	28.0%

	Total MH Expenditures		Dually Dx % of Total MH Expenditures
	Total MH Expenditures	Dually Dx Expenditures	
2015	\$853,078,754	\$375,640,130	44.0%
2016	\$886,846,720	\$397,803,988	44.9%
2017	\$790,027,827	\$293,900,950	37.2%

Maryland's *Commitment to Veterans* initiatives drive the import of tracking those with Veteran status accessing the PBHS.

	Total Veterans Receiving MH Services	MH Expenditures of Veterans	Total Veterans Receiving SRD Services	SRD Expenditures of Veterans
2015	490	\$3,256,569	1,849	\$3,884,169.00
2016	470	\$3,173,384	2,773	\$9,834,928.00
2017	430	\$2,390,397	2,929	\$11,074,551.00

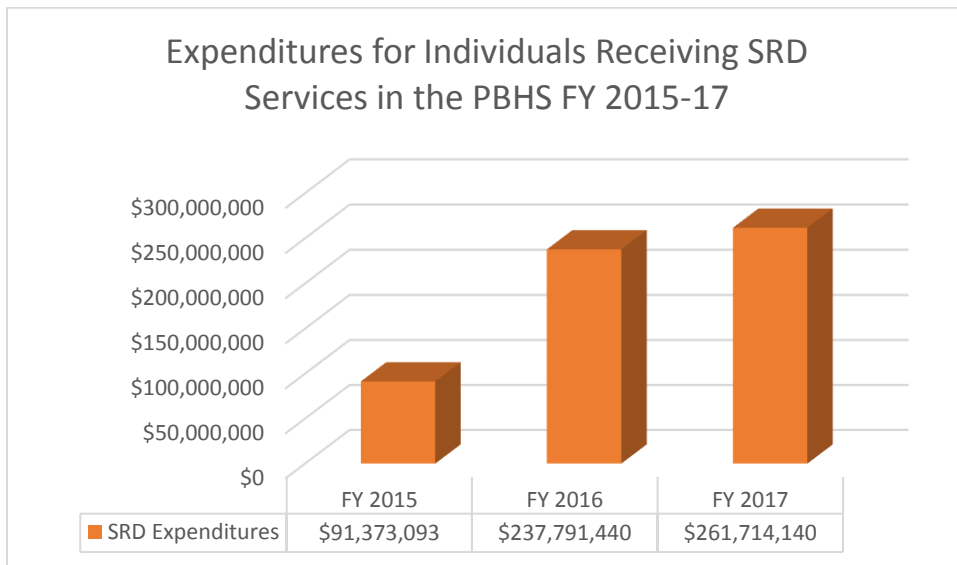
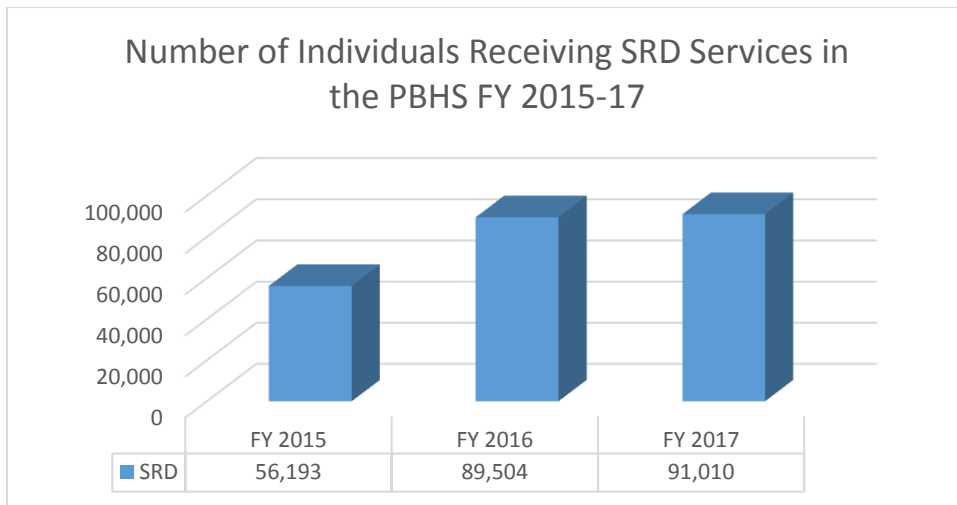
Utilizing the Maryland Outcomes Measurement System (OMS) data, the number of individuals receiving outpatient behavioral health services and response to outcomes and performance measurements.

Fiscal Year 2016

	Outpatient SRD Adolescents		Outpatient MH Adolescents	
	Number Answered Question	Percent Responded "Yes"	Number Answered Question	Percent Responded "Yes"
Have you been homeless in the past 6 months?	766	2.0%	35,916	2.6%
Do you smoke cigarettes?	950	29.9%	24,666	4.3%
Do you attend school when in session?	951	83.9%	40,573	93.0%
In the past 6 months, have you been arrested?	950	31.9%	24,666	3.4%
Are you currently employed, or have been in the past 6 months?	634	20.8%	11,257	14.3%
	Outpatient SRD Adults		Outpatient MH Adults	
	Number Answered Question	Percent Responded "Yes"	Number Answered Question	Percent Responded "Yes"
Have you been homeless in the past 6 months?	8,501	13.6%	50,258	12.1%
Do you smoke cigarettes?	11,964	68.6%	62,184	41.0%
In the past 6 months, have you been arrested?	11,964	22.3%	62,184	5.5%
Are you currently employed, or have been in the past 6 months?	11,964	45.2%	62,184	33.1%

Public Behavioral Health System (PBHS) Substance Related Disorder Service Utilization and Expenditures

The implementation of a combined MH/SRD data system went live January 1, 2015. The ASO system has the ability to collect required data for all SRD services, whether or not it manages or reimburses those services. FY 2016 represents the first complete fiscal year of substance use data in the merged Public Behavioral Health System. In FY16, over 89,500 individuals received substance related treatment services in the PBHS. To date, FY17 data reports a 2% increase in the number served. This number is expected to grow in FY18 and subsequent years as residential treatment services are transferred from grant funded to fee-for-service. 47% of those served in the PBHS for substance use received a Level 1 or Outpatient service and 37% received service from an Opioid Treatment program. 96% of those served through SRD treatment services are adults.

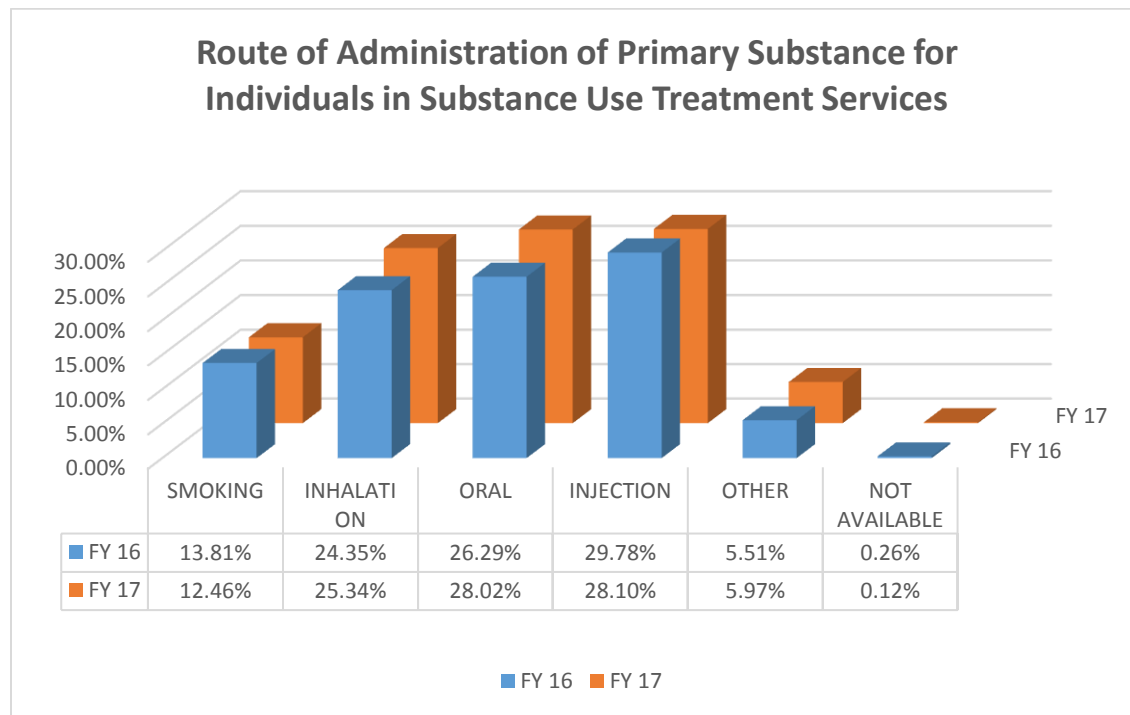


FY 2015 SRD services represents 6 months of data as implementation of the merged data collection system began on January 1, 2015.

In FY16, over 67,500 individuals were admitted to substance-related disorder treatment programs. The primary substance at admission was heroin comprising 48% of all admissions, followed by alcohol 17%, opioids 13%, and marijuana 11%. Final FY 17 is predicted that the number of admissions reporting heroin as the primary substance used at admission will be over 50%-a 13% increase in the number of individuals using heroin from the prior fiscal year.

It is important to note that the difference in the total number served receiving SRD treatment services in FY 2016 (89,504) and the 67,500 referenced above in the same time period were those admitted to treatment services, while the 89,504 includes those that received SRD support services, i.e., labs.

Route of administration for those receiving SRD treatment services has remained stable over the past two fiscal years.



Individuals authorized to receive Substance Related Disorder Treatment through the Maryland PBHS, the number and rate using heroin or other opiates in FY 2015-2017.

	FY 2015		FY 2016		FY 2017	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Heroin	23,158	385.56	32,679	544.08	37,175	61,893.00
Other opiates	5,975	99.48	8,947	148.96	10,589	176.30

Total Opiates	29,133 485.04	41,626 693.03	47,764 795.23
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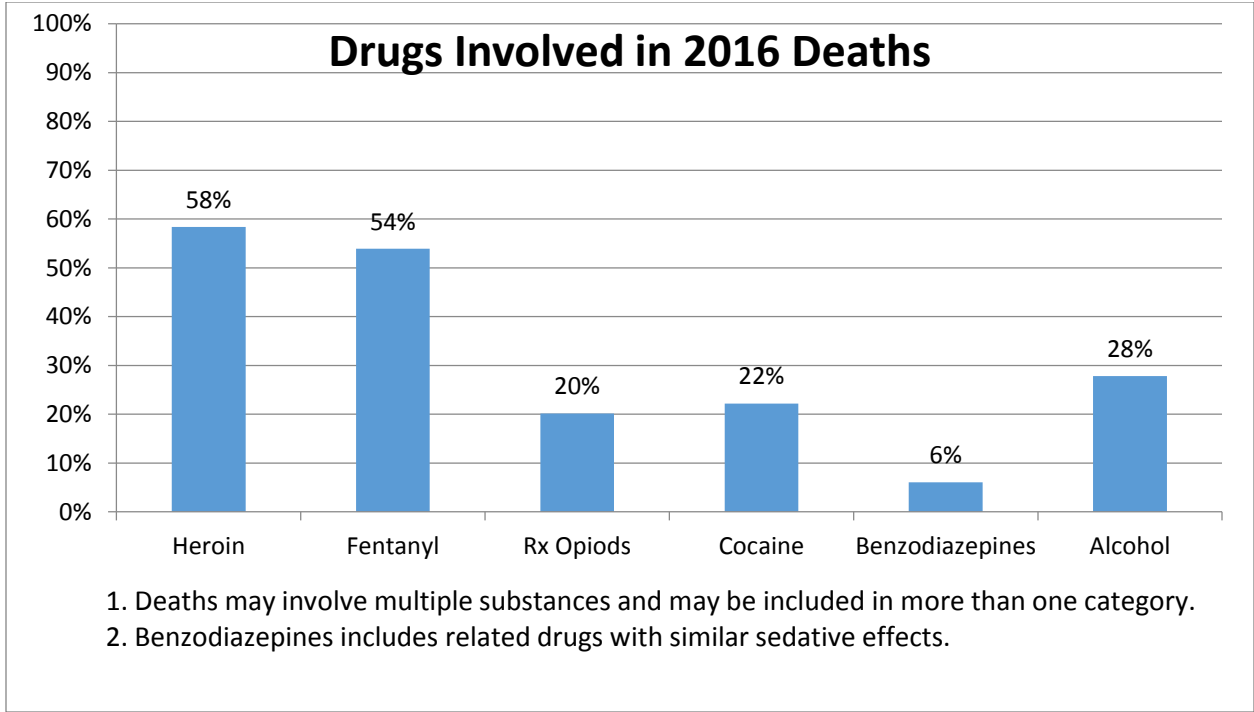
In recent years, Maryland has experienced a dramatic increase in the number of accidental overdose deaths. In March 2017, Maryland Governor Larry Hogan declared “a state of emergency for opioid crisis.” The signed State of Emergency executive order provided an additional \$50 million in funding to support coordination of care among state agencies in prevention and treatment services.

Total Maryland Deaths with Drug Overdose

- 2012: 799
- 2013: 858 (7.4% increase)
- 2014: 1,041 (21.3% increase)
- 2015: 1,259 (20.9% increase)
- 2016: 2,089 (66.0% increase)

(Excludes deaths identified as suicides or homicides)

25% of 2016 overdose decedents received a SRD treatment or support in the PBHS during the previous year. 25% of this group experienced a fatal overdose within 7 days of their last date of SRD service, and 45% within 30 days. 22% of 2016 overdose decedents received a MH treatment or support in the PBHS during the previous year. 25% of this group experienced a fatal overdose within 7 days of their last date of MH service, 49% within 30 days. This data combined with the OMS data are being used to identify those individuals most likely to experience a fatal drug overdose. It suggests that those whose life experience include homelessness and arrest and who have dual diagnoses of SRD and MH may be at greatest risk, and deserve special clinical attention.



Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Customers - Enhance Communication Tools, Processes and Access
 Priority Type: SAP, SAT, MHS
 Population(s): SMI, SED, PP

Goal of the priority area:

1. Develop and implement bi-directional communication tools and processes, as well as marketing materials.

Objective:

1. Obtain bi-directional feedback from internal and external customers.

Strategies to attain the objective:

1. Expand the outreach and education efforts of the Anti-Stigma Project (ASP), in collaboration with On Our Own of Maryland (OOOMD), Core Service Agencies (CSAs), LBHAs, and other stakeholders, to address the issue of stigma within the behavioral health system and the broader community.
 2. Expand distribution channel for all Promotion and Prevention materials to reach internal and external partners and stakeholders.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Number of workshops on stigma, barriers, and practices in mental health held over 12 months
 Baseline Measurement: Minimum of 50, 2 hour presentations/workshops, minimum of 900 participants
 First-year target/outcome measurement: Number of workshops; number of participants
 Second-year target/outcome measurement: Number of workshops; number of participants

Data Source:

On Our Own of Maryland, Anti-Stigma Project

Description of Data:

Consumer operated program to address the issue of stigma within the public behavioral health system. Data is collected and evaluated on presentations provided, length of presentations, topics discussed, people attending (consumers, family members, behavioral health professionals).

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
 Indicator: Number of people reached by public awareness and prevention initiatives
 Baseline Measurement: n/a
 First-year target/outcome measurement: Number of people reached
 Second-year target/outcome measurement: Number of people reached

Data Source:

Social Marketing Campaigns, Stigma Reduction Initiatives, Harm Reduction Outreach, Public Opinion Surveys

Description of Data:

Surveys, print distribution, PSAs, social media

Data issues/caveats that affect outcome measures::

none

Priority #: 2
Priority Area: Internal Business Processes
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP

Goal of the priority area:

1. Develop and implement a recovery-oriented, integrated system of care with clearly articulated quality and outcome standards.

Objective:

1. Accreditation: To uphold practice standards throughout the service delivery system
2. Fee-for-Service Movement: To communicate information, regulations, and processes regarding the transfer of grants to fee for service.
3. Maintain and expand capacity to provide sufficient substance use, mental health and addictive disorder services to address the needs of individuals in care and their families.

Strategies to attain the objective:

1. Collaborate and provide active consultation with accreditation organizations, and provide technical/fiscal assistance to providers to support implementation of the accreditation initiative.
2. Maintain an infrastructure within schools across the state that supports students with mental health, substance-related, and/or co-occurring disorders to receive Medicaid reimbursable school-based assessment and counseling services.
3. Facilitate expansion of peer workforce via promotion and delivery of peer training.
4. Build capacity to promote awareness of resources for tobacco prevention and smoking cessation training to behavioral health care professionals and consumers.
5. Perform fidelity assessment and evaluation of Assertive Community Treatment (ACT), Supported Employment (SE), and Family Psychoeducation (FPE) programs
6. Maintain/Expand residential service providers for pregnant/postpartum women and women with children.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of behavioral health provider sites accredited
Baseline Measurement: None- new measure
First-year target/outcome measurement: Number of behavioral health provider sites accredited
Second-year target/outcome measurement: Number of behavioral health provider sites accredited

Data Source:

BHA's Division of Quality Assurance

Description of Data:

Number of providers with accreditation-based licensure requirement

Data issues/caveats that affect outcome measures::

Accreditation requirements not met

Indicator #: 2
Indicator: Number of students who received school-based assessment and counseling services
Baseline Measurement: new measure

First-year target/outcome measurement: Number of students who received school -based assessment

Second-year target/outcome measurement: Number of students who received school -based assessment

Data Source:

ASO Billing

Description of Data:

Number of students who received school-based assessment and counseling services

Data issues/caveats that affect outcome measures::

n/a

Indicator #: 3

Indicator: Number of Certified Peer Recovery Specialists

Baseline Measurement: Number of Peer Support Specialists trained

First-year target/outcome measurement: Number of Peers trained to become Certified Peer Recovery Specialists

Second-year target/outcome measurement: Number of Peers trained to become Certified Peer Recovery Specialists

Data Source:

Database system to collect peer training data

Description of Data:

number of trained

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Number of new SUD residential providers to serve women and children

Baseline Measurement: Number of SUD residential providers

First-year target/outcome measurement: Number of new SUD residential providers to serve women and children

Second-year target/outcome measurement: Number of new SUD residential providers to serve women and children

Data Source:

ASO billing

Description of Data:

Number of pregnant women with children admitted

Data issues/caveats that affect outcome measures::

none

Priority #: 3

Priority Area: Learning and Innovation

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PP

Goal of the priority area:

Develop and implement tele-health and E-health applications to support service delivery.

Objective:

Electronic Service Delivery and Consultation Technology

Strategies to attain the objective:

Expand tele-health support through B-HIPP for Primary Care and other grant programs to support rural areas to address the shortage of Child Psychiatrists in their regions.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of BHIPP consultations provided through tele-health services

Baseline Measurement: Number of BHIPP consultations calls provided

First-year target/outcome measurement: Number of providers using BHIPP consultations via tele-health

Second-year target/outcome measurement: Number of providers using BHIPP consultations via tele-health

Data Source:

REDCap, secure web based database

Description of Data:

Number of consultation calls is the number of times a Pediatric Primary Care Provider has called for the toll free consultation line. This does not include training and office visits. To track the contacts, REDCap is utilized. the Team tracks each contact in the internal database, included are consultations and enrollment.

Data issues/caveats that affect outcome measures::

none

Priority #: 4

Priority Area: Overdose Prevention

Priority Type: SAP

Population(s):

Goal of the priority area:

Maintain and expand capacity to provide sufficient substance use, mental health and addictive disorder services to address the needs of individuals in care and their families. This includes prevention, intervention, treatment and recovery services and supports.

Objective:

In collaboration with local addiction authorities address naloxone training gaps by incorporating novel training and distribution models such as street -based outreach and prioritizing peer-delivered training.

Strategies to attain the objective:

Increase overdose education and naloxone distribution throughout the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained in overdose response through Overdose Response Program

Baseline Measurement: Number trained in overdose education and naloxone use

First-year target/outcome measurement: Number of individuals trained in overdose response

Second-year target/outcome measurement: Number of individuals trained in overdose response

Data Source:

Overdose Response Program (ORP) Administrative Tracking System

Description of Data:

Overdose Response Program (ORP) Administrative Tracking System: Maintained by BHA and contains data on the number of naloxone distribution sites, trainings conducted, persons trained, and naloxone doses administered statewide.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$49,971,060		\$0	\$10,741,260	\$244,578,188	\$10,513,608	\$3,965,238
a. Pregnant Women and Women with Dependent Children**	\$570,410		\$0	\$10,741,260	\$12,000,000	\$0	\$0
b. All Other	\$49,400,650		\$0	\$0	\$232,578,188	\$10,513,608	\$3,965,238
2. Primary Prevention	\$13,561,892		\$0	\$0	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$22,000	\$0	\$0
4. Early Intervention Services for HIV	\$3,407,998		\$0	\$0	\$2,600,000	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$3,517,422		\$0	\$0	\$5,813,950	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$70,458,372	\$0	\$0	\$10,741,260	\$253,014,138	\$10,513,608	\$3,965,238

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$116,198,311	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$0	\$0	\$0	\$64,648,528	\$0	\$0
8. Mental Health Primary*		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$1,351,356	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$603,717	\$0	\$0	\$0	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$1,955,073	\$0	\$0	\$180,846,839	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	0	1553
Women with Dependent Children	0	15277
Individuals with a co-occurring M/SUD	0	55528
Persons who inject drugs	0	22679
Persons experiencing homelessness	0	5838

Please provide an explanation for any data cells for which the stats does not have a data source.

See Attached.

Footnotes:

PLANNING TABLES

Table 3 SABG Persons in need/receipt of SUD treatment

Fiscal Year 2016

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women		1,553
Women with Dependent Children		15,277
Individuals with a co-occurring MH/SUD		55,528
Persons who inject drugs		22,679
Persons experiencing homelessness		5,838

Please provide an explanation for any data cells for which stats does not have data source

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Footnotes:

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Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$23,810,499
2 . Primary Substance Abuse Prevention	\$6,803,000
3 . Tuberculosis Services	\$0
4 . Early Intervention Services for HIV*	\$1,700,750
5 . Administration (SSA Level Only)	\$1,700,750
6. Total	\$34,014,999

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy		IOM Target	FY 2018
		SA Block Grant Award	
Information Dissemination	Universal		\$1,360,600
	Selective		
	Indicated		
	Unspecified		
	Total		\$1,360,600
Education	Universal		\$408,180
	Selective		\$238,105
	Indicated		\$34,015
	Unspecified		
	Total		\$680,300
Alternatives	Universal		\$476,210
	Selective		\$183,681
	Indicated		\$20,409
	Unspecified		
	Total		\$680,300
Problem Identification and Referral	Universal		\$34,015
	Selective		
	Indicated		
	Unspecified		
	Total		\$34,015

Community-Based Process	Universal	\$613,971
	Selective	\$32,314
	Indicated	
	Unspecified	
	Total	\$646,285
Environmental	Universal	\$3,401,500
	Selective	
	Indicated	
	Unspecified	
	Total	\$3,401,500
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$6,803,000
Total SABG Award*		\$34,014,999
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	\$0
Total SABG Award*	\$34,014,999
Planned Primary Prevention Percentage	0.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	b
Military Families	e
LGBT	e
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	e
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems		\$389,994		
2. Infrastructure Support		\$389,586	\$474,950	
3. Partnerships, community outreach, and needs assessment				
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement				
6. Research and Evaluation				
7. Training and Education		\$145,282		
8. Total	\$0	\$924,862	\$474,950	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:1027123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52777

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. *Health Affairs*. 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, *JAMA Psychiatry*. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, *JAMA Psychiatry*. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. *JAMA Psychiatry*. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. *Annals of Emergency Medicine*. 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Maryland Department of Health (MDH) Behavioral Health Integration Activities

Vision and Mission:

"The Behavioral Health Administration's vision is improved health, wellness and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care. This vision is support through BHA's mission to develop an integrated process for planning, policy and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions. The BHA will, through publicly funded services and supports, promote recovery, resiliency, health and wellness for individuals who have or are at risk for emotional, substance related, addictive, and/or psychiatric disorders to improve their ability to function effectively in their communities".

Maryland continues to implement ongoing efforts to integrate services for mental health and substance use disorders. The Maryland Department of Health (MDH) formerly, the Department of Health and Mental Hygiene (DHMH) serves as the State Mental Health Authority, the Single State Agency (SSA) for Substance Use Services, and the State Medicaid Agency. MDH has four divisions—two of which have significant roles in the administration of Maryland's public behavioral health system: the Behavioral Health Administration (BHA) and the Medicaid Agency.

BHA is responsible for all publicly funded specialty mental health and substance use disorder (SUD) services. BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes the public health and safety of patients, participants, families, and communities in all jurisdictions throughout Maryland.

MDH's Maryland Medicaid program, which serves more than 1.3 million Marylanders. In fiscal year (FY) 2015, funding for Medicaid services for behavioral health was moved from BHA to Medicaid, which created a specialized unit for behavioral health services that works in close partnership with BHA to administer behavioral health services for individuals funded by Medicaid. BHA

handles clinical and system issues, whereas Medicaid is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan. BHA and Medicaid worked closely together to design integration of mental health and substance use services. In partnership with BHA, the Department/Medicaid contracts with Beacon Health Options, formerly, ValueOptions, Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

Maryland's behavioral health integration efforts also included the movement of its outpatient substance use disorder (SUD) services into a fee-for-service managed care system that has resulted in increases in access both within and across jurisdictions. On June 30, 2016, the MDH submitted a Section 1115 waiver renewal application for the Health Choice program, Maryland's statewide mandatory Medicaid managed care program that was implemented in 1997. As the state works with its partners in the provider and payer communities to transform the health care system, the renewal application included an initiative for the implementation of the Institute for Mental Diseases (IMD) waiver for SUD residential treatment. Effective, July 1, 2017, Medicaid expanded coverage benefits to include adults who meet medical necessity (ASAM) criteria for residential ASAM levels of care.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Maryland's goal in integrating services is to build on the existing strengths of the public behavioral health system and programs. BHA in partnership with Maryland Medicaid agency and the ASO share a commitment to continuous quality improvement that involves ongoing review of our regulations, process and procedures.

Additionally, Maryland's Department of Health's Behavioral Health Administration is moving towards accreditation-based licensure for community providers. In accordance with COMAR, 10.63.02, all behavioral health providers will need to obtain accreditation by an approved accrediting organization by January 1, 2018 in order to be licensed by April 1, 2018 to provide community based behavioral services. MDH's Medicaid's Behavioral Health Unit and Behavioral Health Administration collaborate on developing and evaluating policies, drafting regulations and overall administration of behavioral health services to participants. These include establishing provider rates and setting the benefit design standards, setting medical necessity standards, utilization review and prior authorization criteria and establishing and managing other data and reporting standards. Maryland promotes a strategic and comprehensive approach to increasing access to and enhancing services for individuals with an Opioid Use Disorder (OUD) through reducing gaps throughout our public behavioral health system (PBHS) and our state. Our goal is through utilizing a public health framework of prevention, treatment and recovery services to reduce unmet treatment needs and opioid related deaths. Our priorities are to:

- prevent opioid misuse and abuse through enhanced prescriber practices and public awareness;
- treat opioid dependence by expanding treatment and increasing quality;
- prevent overdose fatalities through naloxone expansion; and
- expand recovery supports in the community.

Providers play a key role and are responsible for working with participants to provide quality services that meet the participants' goals and needs as well as maintaining a high standard of medically necessary, efficient and cost-effective care that addresses each participants' individual needs. Other responsibilities include, but are not limited to, delivering the principles of recovery and resiliency in treatment, promoting innovation and evidence-based and best practices, honoring participants rights to dignity and choice and complying with local, state, and federal laws and regulations, as well as Medicaid/PBHS rules

BHA, through the MHBG, partners with the University of Maryland's Evidence Based Practice Center, to provide training and consultation for the Substance Abuse Specialists and Team Leaders on current and future Assertive Community Treatment (ACT) teams to enhance the DDC of those teams, in collaboration with the ACT Consultant/Trainer. Intensive onsite training and consultation, as pre-approved by BHA, is provided for agencies requesting assistance in implementing practice change which promotes agency-wide Dual Diagnosis Capability (DDC) including provision of training on empirically supported tools to help agencies self-assess their DDC. This includes TA to develop plans for any DDC gaps identified, and to implement and monitor fidelity using empirically supported tools. Ongoing training for behavioral health providers is facilitated on the use of scientifically validated screening and assessment instruments, in support of state regulations requiring this screening and assessment for COD. In conjunction with this activity, a series of cross-training sessions are delivered with mental health and substance abuse professionals, addressing integrated treatment principles and practices.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? j n Yes j n No

and Medicaid? j n Yes j n No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Medicaid Eligibility

Beginning in January, 2014, under the ACA, Medicaid eligibility expanded for adults under the age of 65. The income eligibility threshold for parents increased from 116 % of the federal poverty level (FPL) to 138% of the FPL. More than 240,000 individuals have gained coverage as a result of the expansion, including 95,889 who transitioned from the state's Primary Adult Care (PAC)

into the full-benefit Medicaid Healthchoice program as expansion adults. As a result of the ACA, Maryland's uninsured rate dropped to six percent, having fallen from 11 percent in 2013. As of May 2016, Maryland's Medicaid (MA) enrollment was 1,276,968 enrollees.

According to Maryland's Health Benefit Exchange 2016 Annual Report, 162,652 Marylanders enrolled in private Qualified Health Plans, a 33% increase from the previous year. Of the total enrollments, 51,195 were new customers, and 111,457 were returning enrollees. Marylanders have enrolled in health insurance through Maryland's state based insurance marketplace, Maryland Health Connection.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? j n Yes j n No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education j n Yes j n No

b) Health risks such as

i) heart disease j n Yes j n No

ii) hypertension j n Yes j n No

viii) high cholesterol j n Yes j n No

ix) diabetes j n Yes j n No

c) Recovery supports j n Yes j n No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? j n Yes j n No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? j n Yes j n No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Maryland is committed to ensure participants receive continuous, quality and coordinated care through a seamless integrated system that provides opportunity to access and individuals' rights to receive services they need regardless of what door they enter. BHA in collaboration with State agency partners and stakeholders continue to implement efforts to promote wellness, education, awareness and improved health and safety. Maryland's advocacy community has also championed efforts around parity provisions. The Mental Health Association of Maryland's (MHAMD), Maryland Parity Project continues to educate behavioral health consumers and providers on their rights under the Federal 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act. According to the Mental Health Association of Maryland 2014/2015 Annual Report, through presentations, more than 10,000 individuals were reached, and 17,000 pieces of literature was distributed, and to date the project has assisted over 210 consumers and providers with insurance questions, appeals and complaints.

10. Does the state have any activities related to this section that you would like to highlight?

Models of Primary Care and Behavioral Health Integration:

Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP)

Maryland continues efforts to address the gap between the need for and availability of child behavioral health services. Factors contributing to this gap include a lack of trained specialists, workforce shortages, particularly in rural settings, and/or provider capacity issues. The BHA's Office of Child and Adolescent Services has collaborated with University of Maryland School of Medicine, Johns Hopkins School of Public Health, and Salisbury University to implement the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). BHIPP is a free service, available to all pediatric primary care providers in Maryland, which aims to expand the capacity of primary care providers (PCPs) to identify, refer, and/or treat child and adolescent mental health problems. There are currently over 375 providers enrolled in BHIPP statewide. The BHIPP program offers the following services:

1. Telephone consultation for PCPs to receive advice from child and adolescent mental health specialists, including psychiatrists, psychologists, and clinical social workers at the University of Maryland and Johns Hopkins. Mental health topics covered include screening, resource and referral, and diagnosis and treatment;

2. Continuing education opportunities for PCPs and their staff to develop and enhance mental health knowledge and skills;

3. Assistance with local referral and resources to link families to mental health services in their community.

4. In partnership with Salisbury University Department of Social Work, Co-location of graduate level social work students in primary care practices to provide on-site mental health consultation.

Maryland will expand this model to include the youth and adults with substance use disorders served in primary care settings.

Warm line consultation would be made available to primary care practitioners on issues related to substance use and abuse, including a focus on supporting buprenorphine prescribers in their primary care practice. This service would be available statewide. The purpose is to strengthen the link between somatic and behavioral health and to increase the number of providers who are willing to prescribe buprenorphine.

opportunity to build a person-centered system of care that achieves improved outcomes for recipients of state Medicaid programs. Health Homes aim to further integration of behavioral and somatic care through improved coordination. Medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person. The program targets populations with behavioral health needs who are at risk for additional chronic conditions, offering them enhanced care management services from providers with whom they regularly receive care.

The BHA continues to collaborate with Maryland Medicaid on the implementation of a Chronic Health Home SPA. Maryland's implementation model enable health homes to act as a locus of coordination for individuals with a serious and persistent mental illness (SPMI) or serious emotional disorder (SED), in combination with meeting medical necessity criteria for Psychiatric Rehabilitation Programs (PRP) or Mobile Treatment (MT) services, or an opioid substance use disorder (SUD) that is being treated with methadone, and at risk for an additional chronic condition due to current alcohol, tobacco, or substance use. Health Home services also include: comprehensive care management, health promotion, comprehensive transitional care, individual and family support and referral to community and social support. Provider training and stakeholder education activities are ongoing. In addition to ongoing training and guidance from the Department, several forms of health information technology aid Health Homes in serving their participants, at zero to minimal cost to the providers. This includes real-time hospital encounter alerts and pharmacy use data from the Chesapeake Regional Information System for our Patients (CRISP), as well as an eMedicaid online portal that acts as an enrollment, reporting, and tracking mechanism. As of September 2016, Maryland has 83 Health Home sites, with 5372 active participants in third quarter reporting of 2016.

Maryland's behavioral integration accomplishments include: transferred SUD ambulatory to fee-for service structure, expansion of naloxone training, SBIRT services using Peer Coach model in hospitals, and implementation of public awareness campaigns through various media platforms: bill boards, bus ads, and social media.

Please indicate areas of technical assistance needed related to this section

Footnotes:

Mental Health Association of Maryland, 2014/2015 Annual Report

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard? Yes No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?

Highlights

The Administration works collaboratively with the Maryland Health Department Office of Minority Health and Health Disparities through efforts such as the Maryland Health Disparities Collaborative, and the Cultural and Linguistic Competency Workgroup. The Workgroup addressed issues of health disparities in health care access, behavioral health, utilization, and quality and outcomes.

Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234) was implemented in April 2012 in response to persistent health disparities. The law established a \$4 million pilot project to reduce health disparities in the state, improve health outcomes such as infant mortality, obesity and cancer and lower health costs and hospital admissions.

Core aspects of the law include:

- Create Health Enterprise Zones (HEZs) where health outreach will be targeted, with grants for community non-profits and government agencies along with tax breaks for health care providers who come to practice there
- Establish a standardized way to collect data on race and ethnicity in health care and ensure carriers are working to track and reduce disparities
- Require hospitals to launch community health initiatives and report on their success.
- Establishes a process to set criteria for health care providers on cultural competency and health literacy training and continuing education

The funding for this initiative was placed in the budget of the Maryland Community Health Resources Commission (CHRC) consistent with their charge to direct resources to communities where poor health persists despite ongoing services provided by public and private sectors. In January 2013, the MDH designated Maryland's first five HEZs: Anne Arundel County, Dorchester and Caroline Counties, Dorchester Health Department, Prince Georges County, St Mary's County and Baltimore City. The HEZs covered areas such as efforts to reduce diabetes-related and smoking illnesses, obesity, cardiovascular disease, promotion of school-based wellness programs, crisis response teams, access to primary and behavioral health services, and increases in community resources. Additionally, through the MDH's Office of Minority Health and Health Disparities, technical assistance and guidance were provided to HEZ Coordinating Organizations and partners. The BHA also participated in activities coordinated by the Maryland Health Disparities Collaborative, which was established in 2008 and is comprised of more than 200 state health experts, health care organizations, academics and health advocates. The Collaborative was fully engaged in assisting the Department with the implementation of the Maryland Health Improvement and Disparities Reduction Act of 2012. The Collaborative established five work groups (Awareness, Leadership, and Capacity Building, Health and Health Systems, Cultural and Linguistic Competency and Research and Evaluation) to address the core aspects of the Act and develop recommendations.

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, ($V = Q ? C$)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? j n Yes j n No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- a) Leadership support, including investment of human and financial resources.
- b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- c) Use of financial and non-financial incentives for providers or consumers.
- d) Provider involvement in planning value-based purchasing.
- e) Use of accurate and reliable measures of quality in payment arrangements.
- f) Quality measures focus on consumer outcomes rather than care processes.
- g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- h) The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The Evidence-Based Practice Center (EBPC) is one of three centers in the Behavioral Health Systems Improvement Collaborative (BHSIC), located within the Division of Psychiatric Services Research in the Department of Psychiatry, School of Medicine at the University of Maryland, Baltimore. The EBP Center, through the MHBG, provides multi-faceted training, consultation and/or booster training on three specific evidence-based practices under the oversight of the BHA Clinical Services Unit:

- Supported Employment (SE)
- Assertive Community Treatment (ACT)
- Family Psychoeducation (FPE)

The EBP Center provides:

- Training, consultation and technical assistance on co-occurring disorders to providers, programs and counties/jurisdictions in order to achieve dual diagnosis capability at the provider/program level, and promote integrated treatment for mental health and substance use disorders at the system level (oversight by Clinical Services Unit)
- Training, consultation and technical assistance on PCCP principles and practices in order to assure that these principles are being promoted and integrated into service delivery at the provider/ program level (oversight by Clinical Services Unit)
- Training, consultation and technical assistance on a BHA-identified empirically supported transition-age youth (TAY) practice to BHA-supported programs serving this population, and to the two programs selected for participation in the recently awarded Maryland Healthy Transitions (MD-HT) Grant, to meet the requirements of that Grant (oversight by BHA Child and Adolescent Unit)

Currently, the EBPS provide with ESMI include Family Psychoeducation (FPE) and Supported Employment, and Supported Education.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Psychiatry, University of Maryland School of Medicine received a \$1.2 million contract through the Governor's Supplemental budget to establish the Maryland Early Intervention Program (EIP), which is designed to support clinical and research programs focused on the treatment of people who are at increased risk for developing psychosis or in the early stages of a psychotic disorder. Robert W. Buchanan, M.D. is the Director of the Maryland EIP and P.I. for the contract. In FY 2015, the budget for the Maryland EIP was transferred to the State of Maryland Behavioral Health Administration (BHA) budget. The State of Maryland Legislature approved the budget request for the Maryland EIP (\$1.224 million), which should allow for recurring dollars, and we continue to develop and expand our program of clinical and research services.

The Maryland EIP is a specialized program with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with psychotic disorders. The Maryland EIP is comprised of three components: 1) Outreach and Education Services; 2) Clinical Services; and 3) Training and Implementation Support. Research is integrated into each of these components and focuses on the development of objective methods for early detection and prediction of disease emergence, progress or recovery; and intervention development to enhance efficacy and effectiveness.

The purpose of the Maryland EIP is to reduce chronicity and increase the likelihood that a person with early signs of psychosis will be able to manage their illness, move successfully through the appropriate developmental stages of growth, and establish a life of their choosing. The Maryland EIP takes a broad public health perspective, in which we directly address the issues of aggression, violence, and substance use that are associated with criminal acts and constitute a risk to public safety; and associated problems, such as metabolic risks and other co-occurring medical conditions. The Maryland EIP is built on the foundation of the University of Maryland School of Medicine (UMSOM) Maryland Psychiatric Research Center (MPRC) and the Department of Psychiatry Divisions of Child and Adolescent Psychiatry, Community Psychiatry, Psychology, and Psychiatric Services Research; and the University of Maryland Baltimore County Department of Psychology, all of which have extensive experience in providing unique services to the citizens of Maryland. All EIP activities are guided by a multi-disciplinary Advisory Council, including youth, family and consumer advocacy membership.

Our ultimate goal is to work with BHA to develop a comprehensive, state-wide program, through a combination of primary clinical sites, satellite sites, consultation services, and tele-psychiatry to provide state of the art clinical services for all citizens of the State of Maryland, who are at risk to develop or who have developed a mental illness with psychotic symptoms.

I. Outreach and Education

A. Background. Lack of knowledge about mental health problems and treatments, as well as concerns about stigma related to mental illness, are factors that can increase the threshold for treatment-seeking and prolong the duration of untreated psychosis. Therefore, one strategy for reducing untreated illness is to increase awareness of the signs and symptoms of psychosis and reduce stigma and other barriers to obtaining access to clinical appropriate clinical services. At the same time, it is important to balance issues of false-positives. Over-sensitivity to signs of psychosis among the community could lead to undue stigma and treatment for individuals wrongly thought to be at risk for psychosis. The emphasis of outreach and educational efforts will be on teaching providers how to identify signs of clinical high risk and early psychosis, familiarizing them with relevant evidence-based practices (EBPs), and providing them with ample ways to refer individuals for further consultation and treatment. These efforts will span settings and providers who serve the range of age groups that can be impacted by clinical high risk and early psychosis, including but not limited to intermediate and secondary schools (middle school and high school), higher education (community college, university/college), advocacy groups, and behavioral and medical treatment settings. Maryland EIP faculty and staff will work to incorporate best practices by consulting with leaders in the field. There are two main foci for this arm of the project: 1) training around early psychosis/risk for psychosis and the importance of early identification; and 2) outreach about available Maryland EIP clinical services.

B. Outreach and Education Programs. Using state-of-the-art evidence-based practices and technology, we will reach out to diverse audiences to build on pre-existing connections in the community, as well as expand efforts to form new collaborations, which will enhance our outreach and education activities, and ultimately increase appropriate referrals. Educational content will include review of early symptoms and impact of psychosis, the importance of early identification and intervention, differentiation of psychosis risk versus first episode psychosis, services available through the Maryland EIP, and how to make a referral or request a consultation. Depending on the audience, presentations will go more into clinical practice, including screening, assessment, direct intervention, and strategies on engagement.

1. Community partners:

- a. Behavioral Health Providers: Maryland EIP faculty and staff provide outreach and education to community behavioral health providers through broad and interdisciplinary clinical, research, and training networks, including those who address substance use and co-occurring disorders (Mountain Manor, EPOCH Counseling Services, Harbel Prevention and Recovery Center).
- b. Schools: Led by the Center for School Mental Health, outreach and education focuses on collaborating with intermediate and secondary schools (middle and high school), higher education (community college, university/college), Maryland State Department of Education, and Maryland Association of Community Colleges.
- c. Health Care Providers: in collaboration with Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP), Maryland EIP faculty and staff provide outreach and education to health care providers of adolescent and transition age youth, which include day hospitals, inpatient/outpatient settings, emergency departments, primary care, and family medicine.
- d. Family and Youth Advocacy Groups: With guidance from MD Coalition, NAMI, MD-HT, On Our Own, and Taking Flight, the EIP faculty and staff provide outreach and education directly to youth and families while promoting patient-centered, family-oriented,

and recovery focused care, with emphasis on shared decision making.

2. Outreach and Education about Clinical High Risk and Early Psychosis to Behavioral Health Settings: Broad-based outreach and education efforts will continue to target behavioral health treatment providers' knowledge and skill development related to early psychosis, including symptoms, assessment and evidence-based treatment. The goal of these activities will be to provide a general background on clinical high risk and early psychosis so that behavioral health providers, including those who address substance use and co-occurring disorders, will have an understanding and necessary skill set needed to identify these clinical domains.

These activities will also include information on ways to receive consultation on suspected cases of psychosis/risk, as well as how and where to make referrals for young people who have transitioned from clinical high risk to early or first episode psychosis. All activities are individualized to specific behavioral health settings based on their treatment population. For example, outreach will be tailored to providers at settings such as adolescent clubhouses for substance use and residential treatment centers to meet client specific needs. Taking into account the training needs and populations served, Maryland EIP faculty and staff work with providers to integrate knowledge and strategies into the specific care they are providing.

3. Outreach and Education about Clinical High Risk and Early Psychosis to School/Colleges and Health Care Providers: Similar to activities described above for Behavioral Health Settings, activities for schools/colleges and health care providers will be led by Maryland EIP faculty and staff, who will continue to provide tailored education on issues related to clinical high risk and early psychosis. For example, those targeting school/colleges might focus on identification tips for educators and work with administrators and the Maryland State Department of Education Student, Family, and School Support Team to attain more expansive outreach and education dissemination. Education activities developed for health care settings might include the infusion of self-report screening checklists in the waiting rooms and education on improving and de-stigmatizing the emergency department and hospital experience.

4. Outreach and Education about Clinical High Risk and Early Psychosis to Federal Transition Age Youth Centers: Broad-based outreach and education efforts will further align with the goals of advisory council partners, who serve transition age youth (e.g. Maryland Healthy Transitions, On Our Own, Taking Flight), to ensure that the youth voice is heard and contributes to the enhancement of Maryland EIP activities. Through these collaborations, utilizing pre-existing curricula, and working together to create new material, we hope to maintain and expand our reach to new regions and foster the development of other sustainable programs for transition age youth. These activities, for example, will provide in-person education to transition age youth and their providers on topics, such as stigma reduction, young adult leadership and advocacy; materials created for transition age youth and their providers will be designed to create a tangible level of understanding of what early psychosis is and when to seek help. Additional information will be provided on consultation and referral processes. The Peer Specialist will be a primary resource for setting up and attending these activities.

5. Outreach and Education Related to Tele-psychiatry Technology and Other Web Technology: Outreach and education efforts will explore how distance technology can be used to enhance education and consultation to areas with difficult access to Maryland EIP clinics and services. Maryland EIP faculty and staff will further promote first episode clinical and consultation tele-psychiatry services, including frequency and availability of these services, through wide-scale dissemination during presentations, at conferences, on social media and other media outlets. Use of this technology may also include face-to-face interaction for psychoeducation and referral purposes. Free multi-media, multidisciplinary online web-trainings, housed on the www.mdbehavioralhealth.com platform, will continue to be disseminated at all presentations, as well as conference and community events. Reach of outreach and education will continue to expand via social media/Facebook, online monthly newsletters, postings on partner websites, and material in national databases of first-episode and psychosis risk clinics. Information will be regularly updated, will work to increase awareness and promote education, and will inform audiences of new services available through the Maryland EIP, new literature regarding the topic of early identification and intervention, relevant media on topics such as decreasing stigma in individuals with psychosis, and current events, policy, and conferences related to early psychosis.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Plans for the additional funding for the 10% set-aside initiative include efforts to further promote recovery support services such as person-centered planning, peer support specialists, as well as a combined model of evidence-based supported employment and supported education. These support services enable individuals to choose, obtain, maintain or advance within a community-integrated work and education environment consistent with their interests and preferences.

Peer recovery support services are delivered based on a clearly defined set of principles and outcomes. The knowledge, skills, and abilities of the core competency curriculum for certification of Peer Recovery Specialists have been established through the initial BRSS TACS Policy Academy which was convened in 2013 to support education, planning, and implementation of recovery supports including peer health reform education efforts and projects to promote best and emerging practices in peer services

The OnTrack team started training and providing services to one young person in December 2014. They are currently providing services to 17 young adult clients and families. Four of these young people have obtained employment, one has graduated from high school, and two are currently enrolled in college while working with the team. The Supported Employment and Education Specialist (SEES) is actively working with twelve (12) young people, nine (9) of whom are pursuing competitive employment, while six (6) are pursuing college graduation. This team has also reached out to agencies, schools, and service providers in counties in

Southern Maryland (Montgomery, Prince George's, Anne Arundel) and to some nearby in counties to the north (Frederick, Howard) to educate them generally about CSC for early psychosis and specifically about how to make a referral to their team. These types of outreach have resulted in referrals as well as in enhancing awareness about services for young people with early psychosis and their families.

The Hopkins EPIC/MEIP team started training and providing services in April 2015. They are currently providing services to twenty (20) young adult clients and families. The SEES was employed in May and is currently providing services to seventeen (17) young people. Nine of these young people are in high school, and two (2) are in college, three (3) of which have returned to school due to the SEES' support. Seven (7) young people are also pursuing competitive employment with the SEES. This team has also connected with potential referral sources that reach north of Baltimore City, with several consumers and families traveling from Baltimore, Harford, Carroll, as well as Wicomico Counties to work with them. Here again, this broad outreach not only yields referrals to this particular team but also educates academic and mental health service providers about the early psychosis and the need for early and intensive care for some youth and their families.

Additional funding would further training and implementation support, particularly around developing tools for fidelity review and outcomes measurements/evaluations.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Enhancing New Peer Support Services: Peer Specialists have an important role in countering stigma associated with mental illness and sharing their stories of recovery and hope. The individuals hired to provide peer support services for Maryland EIP clinics and Coordinated Specialty Care (CSC) will serve in many different capacities within the clinics directly, but also to enhance outreach, encourage help-seeking, and help identify potential sources for referrals. Other roles of the Peer Specialists may be to set up or attend meetings and presentations, participate in the development of newsletters, social media, and other informational materials, and help build collaborative relationships between and among community agencies and services. For example, the Peer Specialist may accompany or collaborate with other outreach team members to present to behavioral or medical health providers, advocacy groups, and/or educational staff (administrators at a local high school) to inform them about the program components, how the Maryland EIP is different from traditional treatment, and how the program works with young people.

Outreach and Education to Support Early Intervention Teams: The Maryland EIP faculty and staff will work with CSCs to assist in marketing for their clinics and teams, as well as help promote new teams and members as they are established. Further outreach will be provided related to general marketing resources.

Evaluation of Outreach and Education Activities: Outreach and education efforts will include development of materials in tailored formats and associated evaluation efforts to examine activities, materials, and formats in an effort to improve the reach, applicability, and dissemination of information across the state. Evaluation will consider impact on service outcomes and productivity, including acquired knowledge and perceived behavioral expectation. The Maryland EIP centralized contact line will collect information on referral source to determine rate of referral from outreach and education efforts.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Evaluation will consider impact on service outcomes and productivity, including acquired knowledge and perceived behavioral expectation. The Maryland EIP centralized contact line will collect information on referral source to determine rate of referral from outreach and education efforts. Based on evaluation data on service outcomes, productivity, and referrals, will target locations for outreach with low referral rates for further outreach and education. In an effort to ensure fidelity implementation of the First Episode Psychosis (FEP) Coordinated Specialty Care program model, BHA has established an ongoing training and consultative relationship with Donald Addington, MD, Professor of Psychiatry, University of Calgary and co-developer of an internationally-recognized fidelity assessment scale for First Episode Psychosis. Dr. Addington provided direct technical assistance and consultation for BHA Clinical Services and University of Maryland School of Medicine staff involved in program development, implementation, training, and fidelity assessment and evaluation of Maryland's FEP programs. This consultation included the administration of a mock fidelity review with one of the FEP programs. Developing competency with the FEP assessment scale will enhance Maryland's ongoing ability to evaluate its implementation efforts to prevent any unintended departure from established evidence-base practices.

10. Please list the diagnostic categories identified for your state's ESMI programs.

1) Serve annually a minimum, unduplicated count of twenty-five (25) to thirty (30) youth and young adults, ages 15-30, with a diagnosis of a schizophrenia spectrum disorder, diagnosed in accordance with DSM-5 criteria, for whom the current episode of psychosis is within two years of the first onset of psychotic symptoms. The EIP serves male and female individuals of any ethnicity, between the ages of 12-35, who present with clinical high risk symptoms that may be predictive of future psychosis, who have early signs of psychosis, or are in the initial stages of psychoses, including DSM 5 Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Bipolar Disorder with Psychotic Features, Major Depressive Disorder with Psychotic Features, and Other Specified Schizophrenia Spectrum and Other Psychotic Disorder.

2) Utilize a Critical Time Intervention (CTI) approach which sets an expectation for a two year length of stay, as evidenced by a step-down to a lower level of care, as clinically indicated, within two years of program enrollment, and the development of an individualized, graduated plan to facilitate the eventual transition to an outpatient level of care.

Does the state have any activities related to this section that you would like to highlight?

The OnTrack Maryland Program finished the second quarter in FY2017, with 27 enrollees, exceeding the maximum enrollment of 25 individuals through the end of December, 2016. There were three individuals discharged during this quarter for inactivity and moving out of the state, and three new referrals came in and enrolled during that time. Referrals from this quarter came from FSI's Outpatient Mental Health Clinic, inpatient and partial hospital units, private or group practice outpatient psychiatrists and

therapists, and self/family. The Team Leader met with all three of the newly referred/enrolled individuals with their family members, either in a "Meet and Greet" meeting, or in a transfer meeting from the OMHC.

There was a total of seven referrals made officially, including the three enrolled. One referral from Adventist Behavioral Health inpatient unit was redirected to other MEIP teams, since the individual lives in Ellicot City and would be outside of the geographical restrictions for OnTrack. Two of the other referrals, who were not ultimately enrolled, had parents who spoke with the Team Leader at length, however eventually decided that they did not want to come to a Coordinated Specialty Care team at this time.

The Team Leader continues to outreach to any referrals made within 1-2 business days upon receipt of the referral, utilizing the referral form/phone screen in order to assess appropriateness, answer questions, and start the initial engagement process with the person making the referral. Since many of the people making referrals are concerned family members, the Team Leader provides psychoeducation telephonically, and makes recommendations based on the young person/family's needs. This quarter, (after appropriateness and interest is confirmed) the Team Leader continued to offer the "Meet and Greet" as it has been highly successful in not only enrollment rate, but providing a more accurate needs assessment, as the program is operating over capacity. This quarter there was a 60% enrollment rate after the "Meet and Greet."

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
4. Describe the person-centered planning process in your state.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

5. Person Centered Planning

3. Describe how the state engages consumers and their caregivers in making health care decisions and enhance communication.

Person centered planning (PCP) or person centered care (PCC) is designed to enable individuals to direct their own plan for services and supports and is aligned with BHA's emphasis on a recovery-oriented system of care. The Plan of care is intended to create a personalized, highly individualized approach that reflects the services and supports important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences and that are oriented toward recovery and resilience.

Participants and family members are the central members of the team responsible for planning and developing a person-centered plan. They are provided the option to direct and manage the planning process. The plan is directed by the individual and people important to the individual are included in the process to achieve the desired outcomes. Providers make available the necessary information and support to ensure that the individual directs the process to the maximum extent possible. During the PCP meeting, participants can utilize a variety of person-centered planning methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy. The family, friends, neighbors, professionals, and others important to the person can be invited to the meeting based on the person's preferences.

Community Coordinators work with individuals to organize their meetings and develop their plans. The coordinator either has a relationship with the individual, or establishes a relationship with the individual prior to the meeting. They may be the individual (with support if desired), a family member, the support coordinator or professional affiliated with another agency / organization. They contact the participant to obtain the person's preferences for the best time and location of the meeting. Meetings are held at participants' homes, jobs, community sites, day programs, or wherever he or she feels most comfortable reviewing and discussing his/her plan.

As part of the process of developing the Person-Centered Plan, the Coordinator works with the individual to gather information regarding the participant's goals, needs, preferences, health status, risk factors, etc. Together they review formal health, developmental, communication, and behavioral assessments conducted and this information is shared with the individual and his/her representatives about available services during initial meetings, quarterly monitoring activities, and annual plan meetings. The individual is encouraged to consider what is important to them to ensure services reflect their personal preferences and strengths and needs (clinical and support), so that their desired outcomes are achieved. Providers assist individuals in identifying individual goals related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others. This allows the individual opportunities to seek employment and work in competitive integrated settings, the opportunity to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid.

Individuals and providers work together to identify risk factors and plans to minimize them. They are also assisted in cultivating strategies for solving disagreement and are given choices regarding services and supports they would like to receive and from whom. The person's Coordinator is charged with assisting the participant in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. They provide assistance, as necessary, to help the individual connect with this array of services and supports and ensure their coordination. The coordinator assists the individual with integrating the delivery of supports and in scheduling visits with providers or, providing a listing of providers. Participants are encouraged to learn about multiple providers and meet and interview staff regarding services prior to selecting their provider agency. Person centered planning discovers what is important to the individual and what is important for the individual; and balances these viewpoints. Roles and responsibilities for services and supports are outlined in the Person-Centered Plan.

The Coordinator will monitor the implementation of the plan by maintaining contact with the individual on an ongoing basis through telephone, e-mail, and face-to-face contacts to ensure that the participant's health and safety needs continue to be met. The plan is updated at least annually, at which time the Coordinator will determine the need for any service changes to take place and they also make sure that services are delivered in the manner described in the Person-Centered Plan, and that the participant's goals, needs, preferences, etc. are being addressed and met. The plan should change as often as the person's life changes to reflect the on-going needs of the individual.

4. Describe the person-centered planning process in your state.

In Maryland, Person centered planning is included in state policy. Providers develop jointly with the individual a person-centered service plan. In developing this plan the individual is able to choose individuals who can offer support so that the individual may gain skills for participation in discussion and meetings related to creating their service plan. It is a process that enhances community connections and natural supports and encourages the involvement of the individual/family with the community.

Providers ensure that support is offered to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. The process should be done in a timely fashion and occur at times/locations of convenience to the individual. In fact, the setting is chosen by the individual and is integrated in, and supports full access to the greater community. In addition, the plan should use plain language, reflect the cultural considerations of the individual, reflect the individual's strengths and preferences and include individually identified goals and desired outcomes. The plan should offer choices to the individual regarding the services and supports the individual receives and from whom reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need.

Process

1. A PCP meeting is scheduled to develop the individual plan
 - Participants and family members are the central members of the team responsible for planning and developing a person-centered plan.
 - The Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS) are conducted.
 - The SIS measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires.
 - The HRST assesses the participant's health and safety needs. Areas of assessment and planning may include but are not limited to: community safety, health/medical, sexuality/relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, etc.
 - Information gathered from the participant, his/her family, friends, and any other individuals invited to participate regarding the participant's goals, needs, preferences, health status, risk factors, etc.
 - Information is shared during initial meetings, quarterly monitoring activities, and annual plan meetings to continue to assist in identifying appropriate services and supports and to offer support in accessing these services.
2. The plan is implemented. The coordinator:
 - Ensures that the participant's health and safety needs continue to be met,
 - Determines the need for service changes to take place, and
 - Makes sure that services are delivered in the manner described in plan, and that the participant's goals, needs, preferences, etc. are being addressed and met.
3. The plan is monitored.
 - annual periodic reviews and updates to assess the appropriateness and adequacy of the services as participant needs change

HIGHLIGHTS

The Clinical Services Division of the Behavioral Health Administration (BHA) continues to promote and actively support consumer recovery, personal growth, independent living, and improved quality of life through the development of person centered planning. Dissemination of Person Centered Care Planning principles and practices (PCCP) continues through regional training sessions to community behavioral health providers on the core practitioner competencies and values. The current FY 2018 Behavioral Health Plan speaks to continuing to provide community-based, person centered, recovery oriented services and supports.

PCCP Training supported by the BHA began as early as 2007, prior to the call for systems transformation from the federal and state levels. PCCP training was featured during annual conferences and continued as one of a number of discrete BHA-sponsored Recovery and EBP trainings and initiatives to occur over the last several years. It has become one of the bedrock philosophies of all EBP implementation efforts throughout Maryland.

These initiatives were identified as a priority in the FY 2010 State Mental Health Plan with the goal of the full integration at the state level, and to move from concept to practice by being fully embraced and adopted at the provider and practitioner level. The plan prioritized work to bring providers and practitioners at every level into the process of transforming adult mental health services and supports toward a recovery-oriented service delivery system. In a transformed, recovery-oriented system, roles and relationships among providers, consumers, and families are shifting and services are evolving to be more person-centered and individually driven.

There continues to be considerable and growing literature about the importance of recovery values and practice in the mental health service delivery system. There is also a clear consensus about how person-centered treatment and rehabilitation plans are critical to making recovery a reality for adults with serious mental illness. Yet current practice often falls considerably short of this vision. Translating these principles and values into actual person-centered services and outcomes continues to be a challenge in many treatment and rehabilitation settings.

Addressing consumer concerns in describing goals and objectives, as well as the services and supports needed to enhance resiliency and achieve recovery, is essential. This assures that services are individualized, person-centered and are driven by individual choice and preference. However, providers are challenged with formulating plans that are meaningful and relevant, while meeting the COMAR administrative and regulatory obligations all the while supporting the documentation of medical necessity required for billable services in the Public Behavioral Health System (PBHS).

A. Training

In FY 2013 in keeping with BHA's systemic efforts to transform the PMHS to a recovery-oriented system, wherein consumers of behavioral health services take greater control over their treatment and life decisions, the then Office of Adult Services expanded its Person Centered Planning (PCP) Initiative by means of a two-pronged approach. Diane Grieder, national person centered planning (PCP) trainer and MHA consultant, continued her core competency training of designated master trainers. These trainers were charged with assisting selected provider agencies, with whom they have existing training and consultative relationships, to promote the adoption and implementation of person-centered planning within their respective specialty domains (aging, co-occurring mental illness and substance use disorders, traumatic brain injury (TBI), co-occurring mental illness and intellectual disability, assertive community treatment (ACT), and supported employment(SE)) as the cornerstone of treatment and rehabilitation planning. As a complement to training of the supported employment master trainers, a more focused, targeted training was offered to the Evidence-based Practice Supported Employment supervisors on the implementation and adaptation of person-centered planning principles and practices within the context of the delivery of a non-clinical service. In the exchange for the receipt of intensive training, consultation and technical assistance from a nationally recognized expert, the pilot site agreed to train other pilot sites in subsequent years.

Diane Grieder continued her core competency training of designated master trainers in FY 2014 and 2015. Again these master trainers were charged with assisting selected provider agencies in promoting the adoption and implementation of person-centered planning within their respective specialty domains. Ms. Grieder was key note speaker at BHA's 2017 Conference that included discussions on Maryland's system and workshops on Person-Centered Case Planning: An Emphasis on Engagement and Cultural Humility and Screening and Accommodating for a History of Traumatic Brain Injury (TBI): A

Critical Component of Building a Person Centered Plan. In FY 2016 PCCP Trainers conducted 38 trainings and in FY 2017, 27 trainings were conducted.

Maryland Collaboration for Homeless Enhancement Services (MD- CHES) will begin its third year in October 2017. The grant has served over 259 individuals and housed 154 individuals (as of June 2017). The staff in the grant have and continue to be trained by the Project Directors, both of whom have also been identified as trainers of Person-Centered Care Planning (PCCP) principles and practices and who have promoted the adoption and implementation of person-centered planning within their respective specialty domains.

In FY 2018, Maryland will continue reinforcement of core competency training of designated trainers who will continue to provide intensive training, and technical assistance to existing provider agencies with whom they have existing training and consultative relationships to promote the adoption and implementation of person-centered planning within their respective specialty domains. ACT providers will continue to be assessed using both the Dartmouth Community Treatment (DACT) and Tool for Measurement of Assertive Community Treatment (TMACT) fidelity assessment tools with the goal of moving solely to the use of the TMACT tool, in which Person-Centered Planning is specifically evaluated at the program level.

B. Assessment Tools

Also in FY 2017,'s the DLA-20, a tool used for the assessment of individuals who are accessing home and community based services, was chosen to be utilized as part of the Balancing Incentive Program. This tool is being used to assess needs and level of function with the outcome of the development of a plan of care and is the standardized assessment required within all of the state's Mobile Treatment Services, Assertive Community Treatment teams and Residential and Psychosocial Rehabilitation Programs with an estimated staff of 2,000. The tool can also be used to develop a plan of care and/ or identify support needs of individuals being served in the community. The DLA-20 measures how often or how well the individual independently performs or manages each of the identified 20 activities of daily living within the last thirty days and the information is collected every 6 months by the University of Maryland. The EBP Center staff who conduct PCCP training are also recruited and credentialed to be able to complete DLA-20 trainings and will continue to provide trainings and consultations on the use of the DLA-20 to develop a person center care plan.

C. Accreditation

Lastly, by January 1, 2018 all Maryland programs will be required to be accredited in order to be licensed to provide community-based behavioral health services. As such, these programs must show evidence of person centered practice plans in their applications for licensure in order to obtain this accreditation.

D. Regulations/Policy

Present Code of Maryland Regulations (COMAR)

- 10.21.17- Community Mental Health Programs -Definitions and Administrative Requirements -.07 Program Model require community mental health programs to develop

program model that promotes recovery and resiliency.

- 10.21.20- Outpatient Mental Health Centers .04 Program Model: A Outpatient Mental Health Center (OMHC) shall provide services that are age and culturally appropriate and focused on recovery and resiliency.
- 10.63-.02 Community Based Behavioral Health Programs and Services .03 B): A program with an accreditation -based licenses shall comply with the requirements and meet the standards of the accreditation organization by which it is accredited. For example CARF standards require Person Centered Care Planning.

BHA policies and Beacon Options EBP Service Descriptions:

Assertive Community Treatment:

- In order to be eligible for the EBP rate a provider has to meet the minimum score on the Dartmouth ACT Fidelity Standards which include persistent caring attempts to engage clients in treatment n to foster a trusting relationship between the individual and the ACT Team. Also, Maryland is piloting a newer fidelity tool The Tool for Measurement of Assertive Community Treatment (TMACT) which includes an Item Person -Centered Planning and Practices.
- Beacon Health EBP Practice Service descriptions for Assertive Community Treatment and Supported Employment emphasize that in order to receive the differential rate providers must adherence to principles and essential program elements which include individuals support and treatment and mutually agreed upon goals.

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? Yes No
2. Are there any concretely planned initiatives in our state specific to self-direction? Yes No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? Yes No

Does the state have any activities related to this section that you would like to highlight?

The BHA Office of Local Planning and Management completed quarterly monitoring exercises that occurred during the first, second, and fourth quarters, conducted through conference calls, for all 19 CSAs in compliance with the MOU for FY 2016. (The third quarter monitoring process consisted of the BHA review of local behavioral health authorities Program Plans, Annual Reports, and Budgets.)

BHA follows an extensive procurement process in accordance with the Human Services Agreement Manual (HSAM). In the 1st quarter BHA reviewed submissions from the 24 local jurisdictions on the timeliness of sub-vendor contract execution, type of contract, audit requirements, and sub-vendor contracts for congruency with BHA and CSA/LAA contract conditions of award. In the 2nd quarter Local Planning and Management staff reviewed submissions from the local jurisdictions on expenditure and outcome measures against the state fiscal year budget for State General Funds and Federal Block Grant funds. Local authorities are also required to respond to items contained in a Questionnaire such as: status on Crisis Response and Crisis Intervention activities, Public and Consumer Education, contract monitoring, and potential conditions of award changes for next fiscal year. In the 4th quarter BHA liaison staff review a sample of State General Fund and Federal Mental Health Block Grant Fund awards to sub-vendors. The review looked for compliance on policy and procedures for internal control authorizing payments, CSA sub-vendor site visits and monitoring of BHA conditions of award, CSA review of sub-vendor required financial audits, and appropriate use of Consumer Support funds. Local authorities are also required to respond to items contained in a Questionnaire such as access and review of high cost user data. Follow up items from the first and second quarters were reviewed. This included both verbal feedback through scheduled conference calls and documentation of findings for each local authority. A follow up

letter is distributed with copies available for review in BHA's Office of Local Planning and Management.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - Data on consequences of substance using behaviors
 - Substance-using behaviors
 - Intervening variables (including risk and protective factors)
 - Others (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

Archival indicators (Please list)

Hospital data (HSCRC); Impaired driving data (MAARS); and Vital statistics data (NVSS).

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

State developed surveys - Maryland Public Opinion Survey on Opioids (MPOS) and Maryland Young Adult Survey on Alcohol (MYASA)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Our SEOW and State Advisory Council conducted a statewide substance misuse prevention needs assessment. The purpose of the needs assessment was to provide data-driven recommendations to the BHA Prevention Office regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding. Then in order for local jurisdictions to receive SABG funding from BHA, they must conduct local needs assessment activities to determine the substances/substance misuse issues they will be addressing with SABG funds, the target populations for their efforts, the intervening variables and contributing factors they will be addressing, their goals, objectives and evidence-based strategies.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

To assist local jurisdictions in their needs assessment and strategic planning, BHA and its contractual technical assistance providers (UMD School of Pharmacy) provide ongoing, intensive training, and technical assistance to our local jurisdictions in quantitative and qualitative data collection, data analysis, and specifically using data to plan their evidence-based prevention activities. The team provides state and jurisdiction level data and descriptive, "how to" workbooks and tool kits to guide their needs assessment and planning.

Please indicate areas of technical assistance needed related to this section

No need for T/A.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

The Maryland Association of Prevention Professionals and Advocates oversees Maryland's prevention certification process in collaboration with the International Certification and Reciprocity Consortium. BHA is also establishing a Prevention Workforce Development Work Group to review and update prevention core competencies needed to successfully implement the Strategic Prevention Framework model in the planning, development, implementation, and evaluation of their funded prevention activities.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

BHA contracts with the University of Maryland School of Pharmacy to provide intensive, on-going technical assistance and training to Maryland's prevention workforce. Training is provided year round and is organized by specific components related to needs assessment, capacity building, strategic planning, program implementation, and evaluation. BHA utilizes the Center for the Application of Prevention Technologies (CAPT) to provide training and technical assistance to state and local prevention planners and providers. It also contracts with the University of Maryland College Park and Johns Hopkins School of Public Health to provide training and technical assistance in preventing alcohol misuse and high-risk drinking on college campuses and in college communities.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

A community readiness assessment is a component of each local jurisdiction's required SABG Community Needs Assessment.

Does the state have any activities related to this section that you would like to highlight?

Our efforts to provide capacity building training and technical assistance activities to our prevention work force have been on-going, intensive and cumulative. We started this capacity building process with our initial SPF-SIG grant, continued with our Opioid Misuse Prevention Program, then our SPF-PFS grant program, and now our SABG grant program. As our technical assistance team has provided capacity building training and technical assistance to our statewide prevention workforce, it has also continually strengthened its capacity to assist local communities in implementing the SPF process.

Please indicate areas of technical assistance needed related to this section

No need for T/A.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
The strategic plan is currently being updated. The State will forward the plan upon completion.
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based
An ad hoc Evidence Based Workgroup will be convened to review and approve the FY '18 SABG Strategic Plans of each local jurisdiction. BHA has provided a roster of evidence-based prevention programs, strategies and practices that local jurisdictions must adhere to in selecting and implementing their SABG funded prevention activities. This program roster has been developed by

our technical assistance team based on its on-going review of prevention literature on evidence-based practices, including CAPT Decision Support Tools, the CDC Community Guide, the SAMHSA NREPP, and other program registries. The Evidence Based Workgroup will review all jurisdictional SABG Strategic Plans to ensure that the jurisdiction will be implementing and evaluating evidence based practices from the roster that are likely to produce positive outcomes.

Does the state have any activities related to this section that you would like to highlight?

No highlights.

Please indicate areas of technical assistance needed related to this section.

No need for T/A.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) **Information Dissemination:**
Public Awareness Campaigns (TV, radio, print, billboard, etc.); distribution of awareness literature at a wide variety of community events; drug education presentation in schools and community events.
 - b) **Education:**
All Stars; Creating Lasting Family Connections; Dare to be You; Guiding Good Choices; Life Skills Training; Parenting Wisely; and Second Step.
 - c) **Alternatives:**
Alcohol-Free Post Prom Activities; Drug-Free community events (races, rallies, fishing derby, etc.); peer leadership training and events.
 - d) **Problem Identification and Referral:**
Student Assistance Programs; staff referrals to direct services programs such as those described above (such as Life Skills Training, Second Step, etc.).

- e) Community-Based Processes:
Establishment and coordination of community substance misuse coalitions (MSPF Coalitions, OMPP Coalitions, Drug-Free Communities Coalitions); multi-agency coordination and collaboration; town hall meetings; and Communities Mobilizing for Change on Alcohol.
- f) Environmental:
Multimedia Social Marketing Campaigns designed to change substance use behaviors and reduce community contributing factors; advocacy for alcohol and other drug policy enhancements (i.e., social host ordinances, school alcohol policies, alcohol advertising restrictions, alcohol policies at public events); responsible alcohol server training, administrative compliance checks; and TIPS lines.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

- a. All jurisdictions must submit a strategic plan when applying for SABG funding which describes in detail the substances they will be preventing/reducing, the community contributing factors that their prevention activities will be addressing, the target populations they will be impacting, and the evidence based strategies and programs they will be implementing with their SABG funds.
- b. BHA and its technical assistance contractor review these plans, provide feedback as needed and only approve the plans when they meet all of SABG program requirements. These SABG requirements clearly state that funds can only be used for primary prevention activities and cannot supplant other funding.
- c. Jurisdictions provide monthly activity reports to the Maryland MDS prevention data management system and quarterly expenditure reports.
- d. BHA contract managers monitor these program and fiscal reports to make sure that they are aligned with the approved prevention activities they have been funded to provide.
- e. Technical assistance is provided when these activities are not aligned to assist the jurisdiction to get back on track with providing only approved evidence-based primary prevention SABG activities.

Does the state have any activities related to this section that you would like to highlight?

No highlights.

Please indicate areas of technical assistance needed related to this section.

No need for T/A.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

This is included as part of the overall State Strategic Plan, cited above in the Planning section, the State Strategic Plan will be uploaded as an attachment.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
 - Binge use
 - Perception of harm
- c) Disapproval of use
- d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) Other (please describe):

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Array of Services Available

In accordance with state legislation, the Maryland Department of Health (MDH), Medicaid Office of Health Services, and the Behavioral Health Administration (BHA) implemented a new integrated Public Behavioral Health System (PBHS) effective January 1, 2015. The Medicaid Office of Health Services, Behavioral Health Unit, and the BHA oversee and have authority over the PBHS, which includes, policy development, statewide planning, resource allocation, and continuous quality improvement strategies. Beacon Health Options, Inc., (Beacon) is the Administrative Service Organization (ASO) contracted with the Department (MDH) to assist with the management of the PBHS.

Community-based behavioral health services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Opioid Treatment Services
- Substance Use Disorder (SUD) Residential Treatment
- SUD Assessment and Treatment in the School Setting
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Case Management
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health and Substance related laboratory services
- Withdrawal Management

The ASO (Beacon) will make clinical decisions about each participant/consumer based on the clinical features of the participants' case, the medical necessity criteria and/or ASAM criteria.

Under the authority of the PBHS, the ASO bases its decisions on "medical necessity". Medical necessity is met when a participant has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that is able to safely meet the participant's behavioral health and medical needs.

Finally, BHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer-run).

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual

practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and licensed clinical professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

Maryland believes strongly in the benefits of prevention. We will promote doctor-patient conversations about the dangers of opioid use through social media campaigns, create harm reduction street and community outreach programs to encourage individuals to enter treatment, and make strides in reducing the stigma associated with substance related disorders (SRD) through education provided by the media/website/apps. The common thread will be connecting individuals with appropriate support resources. A full array of workforce development and training across the treatment system including Trauma Informed Care (TIC) and technology transfer will provide the skills, knowledge base, and confidence desired by treatment providers and peer support staff. Data analysis and monitoring through a quality improvement system model will provide valuable information to policy makers. We are committed to providing quality and evidence-based services while transforming our statewide system.

Maryland's behavioral health integration efforts also included the movement of its outpatient Substance Use Disorder (SUD) services into a fee-for-service managed care system that has resulted in increases in access both within and across jurisdictions. The upcoming implementation of the Institute for Mental Diseases (IMD) waiver for SUD residential treatment, along with current planning efforts, is expected to allow for similar service expansion in that sector.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- | | |
|---|---|
| a) Physical Health | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| b) Mental Health | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| c) Rehabilitation services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| d) Employment services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| e) Housing services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| f) Educational Services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| g) Substance misuse prevention and SUD treatment services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| h) Medical and dental services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| i) Support services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| k) Services for persons with co-occurring M/SUDs | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

Maryland has a well-established Outcomes Measurement System (OMS) that has been in use by outpatient mental health providers since 2006. In October 2016, Opioid Maintenance Therapy (OMT) providers were incorporated into this system, and cannot receive service authorization or payment without completing an interview. Currently, the Treatment Episode Data Set (TEDS) data is collected only at admission and at discharge, so very limited systematic OMT outcomes data is available. The OMS, however, is completed at intake and about every six months thereafter. Maryland will have a rich source of information about OMT participants from the OMS. Additionally, much of the TEDS like data must be reviewed every six months for concurrent authorization of services. Data elements included are current drug use and current ASAM levels. These data will provide information regarding the outcomes of OMT participants.

Maryland's Governor Larry Hogan signed an Executive Order 01.01.2017.02 declaring a State of Emergency in response to the heroin, opioid, and fentanyl crisis ravaging communities in Maryland and across the country. This declaration activates the governor's emergency management authority and enables increased and more rapid coordination between the state and local jurisdictions. The governor, along with Lt. Governor Boyd Rutherford, also announced \$50 million in new funding to address the crisis, as well as the appointment of the governor's senior emergency management advisor to lead the state's coordinated effort to combat the crisis. The State of Emergency declaration is a result of the initial findings of the Opioid Operational Command Center (OCCC) established by the administration in January to facilitate greater collaboration among state agencies, including health and human services, education, and public safety entities. The OCCC's work made it clear that the state needed greater flexibility to activate emergency teams in jurisdictions across the state and engage local communities. The governor's executive order delegates emergency powers to state and local emergency management officials, enabling them to fast-track coordination among state and local agencies and community organizations, including private sector and nonprofit entities to ensure whole-community involvement.

Maryland has legislation that requires DHMH through BHA to approve a credentialing entity to develop and administer a certification process for recovery residences. This will include the development of guidelines and criteria for the oversight of recovery residences. By October, 2017, the credentialing entity must submit to DHMH a list of the recovery residences that have a certificate of compliance. By November 1, 2017, DHMH must publish a list of each credentialing entity and the credentialing entity's contact information on its website; likewise, a credentialing entity must publish a list of recovery residences that hold a certificate of compliance on its website.

Recovery residences are therapeutic, sober living housing for people who are not in treatment. However, in many instances, they are still receiving treatment. BHA is following the National Association of Recovery Residences (NARR) standards to support recovery residences at the state level. Florida is the only other state in the nation with a similar law. BHA representatives travelled to Orlando, Florida to gather information on how the state has set up recovery houses. We want to learn from their experiences and build on their successes as we move forward

3. Describe your state's case management services

Targeted Case Management (TCM)

TCM for Adults in Maryland is referred to as Mental Health Case Management under the Medicaid regulations 10.09.45. It is overseen by MDH's Medicaid Office of the Behavioral Health Unit. The great majority of services are approved by the ASO (Beacon Health Options) in the fee for service system.

The Behavioral Health Administration (BHA) tracks the annual site visitation work of the local authorities for mental health (CSAs or LBHAs). Each CSA or LBHA must choose a TCM provider through their procurement process once every 5 years. Following the selection process, the TCM provider is given an NPI and MA number and is approved to start serving consumers in the Beacon (ASO) system. By the end of the first year providing services, the CSA or LBHA conducts a site visit of the TCM provider, and after general approval, the CSA/LBHA sends a letter to the provider, copying BHA. BHA then issues a Certificate of Approval for one year to the program. The BHA Coordinator of Case Management keeps track of the CSA/LBHA dates of site visits, type of approval, corrections needed, and Certificates of Approval.

Requests for "uninsured" persons for TCM services are sent by the provider to the local CSA or LBHA for review. If the individual meets the medical necessity criteria, and the local authority is in agreement, they then forward the request to BHA for final approval. These approvals are for 3 months and for the lower level of care requiring 2 encounters per month. Individuals who have Federal Medicaid and meet MNC may be eligible for either TCM level of care, General (2 encounter minimum) or Intensive (5 encounter minimum). Those individuals with Medicaid are approved through the ASO online system.

TCM for children, youth and families is referred to as Mental Health Case Management: Care Coordination for Children and Youth. A newer program than adult case management described above, it began late in 2014 and is governed by separate regulations under COMAR 10.09.90. The program is overseen by the Office of Child, Adolescent, and Young Adult Services. The program is available to children and youth below the age of 18 and, for those who have engaged in the program prior to their 18th birthday, they can continue to receive the service until they turn 22. There are three levels of care coordination available to children and youth under this program: general, moderate and intensive care coordination. These three levels are designed to flexibly meet the changing needs of youth and families.

Selective contracting of providers by local government authorities is similar to the adult program as described above. The quality management protocols and site visits are currently also similar to the adult program, although in the first year of program implementation, the site visit protocol was stepped up to a quarterly schedule and BHA staff attended all visits. The Office of Child, Adolescent and Young Adult Services also processes requests for "uninsured" authorizations as described above, but at a lower frequency and duration, usually because a young person's Medicaid eligibility has temporarily lapsed.

Maryland also offers a 1915(i) State Plan Amendment "Intensive Behavioral Health Services for Children, Youth and Families" in conjunction with Level III Intensive Case Management. If a youth meets the medical necessity criteria for Intensive Case Management, they may be found eligible for enrollment in the 1915(i). This determination is made based on financial eligibility criteria which are set by the federal government at 150% FPL. The youth who meet this financial eligibility criteria are entitled to a number of additional specialized services: these include family peer support, intensive in-home services, a variety of expressive and experiential therapies (e.g. art, movement, equine-assisted therapy) and respite care. Unfortunately, youth who fall above 150% FPL can continue to receive Intensive Case Management but are not eligible for these specialized services. This apparent lack of parity underscores the long identified need for federal statutory change to extend 1915(c) Home and Community Based Waiver authority to children and youth with emotional disorders which would resolve this quandary.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Maryland's effort to reduce hospitalizations and hospital stays include the implementation of crisis response systems that include mobile crisis treatment and services throughout the 24 jurisdictions. Crisis services vary across jurisdictions. Some Crisis Response Systems may include intervention and stabilization, social support to prevent reoccurrences, urgent care efforts, coordination of efforts/linkage with community based services, and in-home supports. As an example, currently there are 12 Mobile Crisis Team (MCT) programs operating in Maryland, and only 25% are available 24/7. Many of the jurisdictions in the more rural areas are just focused on obtaining access to urgent care. The current continuum of crisis response services is:

- 24/7 hotline and/or clinical crisis phone response
- Walk-in Crisis Services
- Mobile Crisis Team (MCT) programs
- Crisis Residential Beds

- Crisis Intervention Team (CIT) programs
- Hospital Diversion
- Criminal Justice Diversion
- 23 Hour Holding Beds
- Emergency Psychiatric Services
- Urgent Care

Assertive Community Treatment (ACT) teams also collaborate to foster integrated care delivery. ACT teams also partner with local emergency departments through peer support engagement efforts.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	250,000	249,628
2. Children with SED	74,759	90,209

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by 5,200. This average loss is approximately 1,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 3%, each year (36,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities. Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
- Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
- Schizophrenic disorder,
- Major affective disorder,
- Other psychotic disorder, or
- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
- Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
- Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
- Schizophrenic disorder,
- Major affective disorder,
- Other psychotic disorder, or
- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
- Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Behavioral Health Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

Narrative Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | |
|---|--|
| a) Social Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Educational services, including services provided under IDE | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Juvenile justice services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) Substance misuse preventiion and SUD treatment services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Health and mental health services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) Establishes defined geographic area for the provision of services of such system | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

CRITERION #4: Targeted services to rural, homeless, and older adult populations

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

TARGETED SERVICES FOR RURAL POPULATION

Maryland recognizes 18 out of the 24 counties/jurisdictions as rural. These rural counties include: Allegany, Calvert, Caroline, Carroll, Cecil, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester. Rural jurisdictions share common characteristics that set them apart from their suburban and urban counterparts, such as geographic isolation, lack of transportation, and lack of access to and availability of health care. This State definition of rural is articulated in the Annotated Code of Maryland, §2-207.

Maryland's Department of Health (MDH), Office of Rural Health (SORH) and Healthcare Workforce Programs, within the Office of Population Health, address the rural health care needs in Maryland through local and federal partnership to develop policy and programs. SORH is federally funded by the Health Resources and Services Administration's Office of Rural Health Policy to provide technical assistance in rural entities throughout Maryland; coordinate rural health resources and activities in the State; encourage recruitment and retention; collect and disseminate information; and participate in local, state and federal partnerships.

Maryland's rural local behavioral health entities (Core Service Agencies, Local Addiction Authorities and Local Behavioral Health Authorities [combined CSA and LAA]) are responsible for planning, and fiscal management at the local level to address the behavioral needs of individuals with mental health, substance use and addiction disorders.

At present, the range of mental health and substance use support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Behavioral health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. Local behavioral health authorities, (CSAs, LAAs, and LBHAs) in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue.

Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs and LAAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs and the LAAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

TARGETED SERVICES TO INDIVIDUALS WHO ARE HOMELESS

State's Operational Definition of:

- Individual experiencing homelessness

The term "homeless individual" is defined as an individual who lacks a fixed, regular, and adequate night time residence; an individual who has a primary night time residence that is a supervised public or privately operated facility that provides temporary living accommodations; and an individual who is residing in places not designed for, or ordinarily used for a regular sleeping accommodation for human beings such as the streets, tunnels, bridges, etc.

- Imminent risk of becoming homeless

"Imminent risk" is defined as those individuals who are living doubled-up where the individual's name is not on the lease; an individual being evicted within 30 days who does not have a place to move to; an individual in arrears in rent/utility payments; and an individual who is being released from an institution such as a local detention center (jail) and the person lacks housing and necessary supports to obtain housing.

- Serious Mental Illness

Persons eligible for the PATH Program must be 18 years of age or over. Priority is given to those who have been diagnosed with a serious and persistent mental illness. Serious and persistent mental illness is defined as having DSM V diagnoses of Schizophrenia, Major Affective Disorders, Bipolar Disorders, Delusional Disorder, Schizotypal and Borderline Personality Disorders, and the disorder is expected to be of long, continued, and indefinite duration.

- Co-occurring Serious Mental Illness and Substance Related Disorders

Individuals are defined as having co-occurring serious mental illness and substance related disorder if the individual is diagnosed with at least one of the diagnosis listed above under serious mental illness and independently meets the diagnostic criteria for substance related disorder. Substance related disorders is defined as a disease which is characterized by a pattern of pathological use of a drug (or alcohol) with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psychosocial.

Veterans:

Homeless veterans are a high priority in the State of Maryland. All PATH sites serve veterans who are Medicaid eligible or uninsured. BHA reviews data from PATH Annual Progress Reports to determine which providers are serving veterans. These providers have demonstrated effectiveness in serving veterans through PATH funds or other resources.

A unique program called Maryland's Commitment to Veterans (MCV) is devoted to total wellness for veterans and their families. Regional Resource Coordinators provide assistance to veterans and their families to support a healthy transition to civilian life. With support from the BHA, MCV provides a solid connection to wellness services, with an emphasis on mental and/or substance related disorder services. The goals are: (1) Promotion of positive behavioral health for veterans and their families, (2) Promotion of the enrollment for veterans in the VA health care system, and (3) Raising awareness of the availability of the behavioral health services for veterans.

Through MCV veterans are linked to behavioral health through the behavioral health system or the VA health care system and can reach a Regional Resource Coordinator using the 24-7 referral line: 1-877-770-4801. Regional Resource Coordinators, who are Mental Health First Aid (MHFA) trained instructors are available to help with questions, concerns, or any obstacle a veteran and/or family member might face. MHFA trains individuals working with veterans in the community on how to assist someone experiencing a mental health crisis. To date, Regional Resource Coordinators trained 256 people working with veterans on Mental Health First Aid. Between October 2008 and June 2016, MCV assisted 9,688 veterans and their families.

Maryland Department of Health (MDH) has many partners that are assisting in making this a successful effort: Maryland Department of Veterans Affairs, Maryland One Stop Career Centers, Maryland National Guard, Maryland Higher Education Commission, Maryland DHCD, and the Maryland Department of Business and Economic Development. In addition, some PATH sites have strong collaborative partnerships and workgroups that meet to address the needs of veterans and seek to secure grant funding to create specialized programs for veterans. One example is the Montgomery County Mental Health Authority which holds regularly meetings that includes participation from the Secretary of the State Department of Veterans Affairs.

Alignment with PATH goals:

Priority is given to those PATH providers who provide street outreach and case management services. Many of the providers provide outreach to the most vulnerable adults who are literally and chronically homeless. BHA projects 1,946 individuals will be enrolled in PATH in FFY 2017 of which 1,695 will be literally homeless. Also, BHA projects 4,093 persons will be contacted by Maryland's PATH providers.

To support further education of the public, PATH funded outreach workers to conduct forums describing PATH services, as well as sharing pamphlets with libraries, hospitals and individuals in the community. Outreach and in-reach services are also provided on the streets, in shelters, and in local detention centers. Case management services are combined with outreach efforts and include linkages to supported employment, community and behavioral health services, permanent housing, public entitlements (which includes a portion of the efforts being dedicated to SOAR).

Alignment with State Comprehensive Mental Health Services Plan:

The PATH Formula grant is coordinated with the State Behavioral Health Plan and the local CSAs' Mental Health Plans. The Assistant Director of Clinical Services and the Director of Housing and Recovery Supports work collaboratively with the Office of Planning at BHA to develop goals and strategies which incorporate outreach and behavioral health services for individuals who are homeless and have a serious mental illness and/or co-occurring substance related disorders. The Director of Clinical Services, Assistant Director of Clinical Services and the Director of Housing and Recovery Supports participate in focus groups and planning meetings to develop the State's Behavioral Health Plan.

Alignment with State Plan to End Homelessness:

Maryland's Interagency Council on Homelessness (ICH) was created by legislation during the 2014 General Assembly Session. Previous interagency efforts were coordinated through the Governor's Taskforce on Homelessness. The ICH coordinates state policy recommendations and working relationships among state, local, and nonprofit agencies concerning efforts to remedy and prevent homelessness across the state. Members of the ICH complete this work by soliciting input from consumers from the advocacy, business and faith communities, and identify supportive services necessary to best serve special populations such as veterans, youth, families and individuals with behavioral health barriers to housing.

Since the inaugural meeting of the ICH, held in September 2014, the body has elected a chair, established four working groups, produced a statewide Homeless Services Framework and completed a comprehensive Annual Report on Homelessness.

The Goals of the Homeless Service Framework are as follows:

GOAL 1 - Increase statewide the number of permanent supportive housing options available to the homeless.*

GOAL 2 - Improve the availability of emergency housing solutions to the homeless that include eviction prevention, lower barrier emergency sheltering, rapid re-housing and cold weather sheltering statewide.

GOAL 3 - Improve the emergency services network for the homeless, by creating partnerships with local stakeholders to create a comprehensive assessment and discharge planning process used at intake and discharge from medical facilities or jails.*

GOAL 4 - Improve the support system that exists for homeless veterans, so that we may end Veterans Homelessness as soon as possible.*

GOAL 5- Ensure access to housing, education, employment, and supportive services for youth and young adults experiencing homelessness or transitioning out of state systems.*

GOAL 6 – Achieve federal requirements of coordinated entry for all Maryland CoCs by January 23, 2018.*

GOAL 7- Reduce barriers to the workforce system and increase training opportunities, employment options and earning potential of those experiencing homelessness.

*Indicates this goal is a federal requirement of the USICH Opening Doors Plan.

The 2016 Annual Report provided a comprehensive overview of the causes of homelessness, and data about those experiencing homelessness in Maryland, as well as an overview of the Federal Requirements outlined by HUD and the United States Interagency Council on Homelessness (USICH). The Department of Human Services (DHS) continues to work collaboratively with the Maryland Department of Housing and Community Development (DHCD) and the Maryland Department of Health (MDH) to convene regular Continuum of Care (CoCs) meetings to discuss the work of the state ICH and the vital role the CoCs play in executing statewide data-driven policy decisions.

BHA also partnered with MHD's Office of Minority Health and Health Disparities to assist with the subcommittee Health and Homelessness. The Director of Minority Health and Health Disparities in 2016 was appointed as the MDH's representative to the ICH. BHA continues to partner with MDH to address the initiatives of the subcommittee group the Director chairs, such as assessing the needs of medical respite in jurisdictions and creating an assessment which identifies the needs of individuals being transitioned from detention centers and institutions.

TARGETED SERVICES TO OLDER ADULTS

Older Adult Behavioral Health is a priority of the Behavioral Health Administration (BHA) as evidenced by the creation of new office in January 2017 called the Office of Older Adults and Long Term Services and Supports. Utilization of public behavioral health services decreases significantly after age 64 according to state data sources the primary reason for this decline is that retired individuals can access Medicare at this age. Medicare coverage of behavioral health services is limited and therefore from a behavioral health perspective, limits access to behavioral health services for older adults. Another factor that impact access to behavioral health care for older adults is that they may be unable to physically get to treatment appointments in the community due to physical or cognitive limitations. Lastly, stigma is a factor that impacts older adult willingness to seek treatment in traditional behavioral health settings.

For these reasons, the Behavioral Health Administration funds some special initiatives that fall outside of the fee for service public behavioral health system through grants managed by local core service agencies. BHA currently funds twenty-one (21) older adult behavioral health contracts (COAs) managed by eleven (11) core service agencies in Maryland through a combination of state general funds and block grant funding. The summative total of the fifteen contracts is \$1,953,781. The contracts can be categorized in three ways: (1) specialized residential, (2) home based clinical treatment, and (3) outreach/ training/ consultation.

BHA's goal is to implement evidenced based practices where possible. In addition to these grant funded projects, BHA has 64 Specialized Geriatric Residential Rehabilitation (RRP) beds in Maryland which offer additional somatic oversight and accessibility.

Additionally, BHA continues to implement PASRR (Pre-admission Screening and Resident Review). The PASRR Program (Pre-Admission Screening and Resident Review) is a federal program governed by the Centers for Medicare and Medicaid Services. This program screens individuals seeking nursing facility care for a history of mental illness and identifies the most appropriate and least restrictive services that will meet the individual's needs. The required evaluations are conducted by Adult Evaluation and Referral Services (AERS) professionals at the local health departments and approved by the Department's Administrative Services Organization, Beacon Health Options. Maryland is currently in the midst of PASRR reform with the goal of reducing nursing facilities stays for individuals with a PASRR related disability. PASRR screening and assessment tools are being modified and the state plans to implement a web based portal for PASRR determinations. BHA is actively involved in these efforts.

In July 2017, BHA started a new program referred to as the Older Adult Behavioral Health PASRR Project. The BHA has received Medicaid Money Follows the Person (MFP) Rebalancing funds to create a new statewide Older Adult Behavioral Health PASRR project. Regional specialists were hired at the local level through Core Service agencies. The regional specialists will be a resource to Aging and Disability Resource Centers, Health Departments, and local agencies and providers. They will assist the entities who are currently involved with nursing facility transition initiatives to coordinate behavioral health services for individuals transitioning to the community. They will also offer expertise and resources to entities involved with the PASRR process to divert and/or reduce nursing facility stays.

Finally, BHA participates in State and National Associations and workgroups such Maryland long term care rebalancing stakeholder meetings, Mental Health and Aging Coalition meetings, and National Association of State Mental Health Program Directors (NASMHPD) Older Persons Division (OPD) for the purpose of improving services to older adult with behavioral health conditions. A representative at BHA assisted with NASMHPD publication in 2016 titled, Improving community Options for Older Adults.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Behavioral Health Administration's (BHA's) budget currently contains state general, special, reimbursable, and federal funds for specialty (or non-primary) behavioral health services.

In FY 2018, a total of \$666.6 million has been appropriated for the BHA. Of this amount, \$347.7 million is for community services, \$296.5 million for State-operated institutions and \$22.4 million for program administration. Utilizing current funding, BHA continues to contract directly with the core service agencies, local behavioral health authorities and the local addiction authorities to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. Federal grants include: this block grant, housing, substance use, opioid prevention and transitional aged youth services. Vendors are reimbursed for pre-authorized services using a fee-for-service system based on a mental health benefits package. This package is the same for MA 1115 Waiver Medicaid recipients, for non-waiver Medicaid eligible recipients, and for those individuals who, because of the severity of their illness and their financial need, qualify for State subsidized services. Medicaid is the most significant insurance coverage type for consumers in the public mental health system. Medicaid covers 80% of all consumers receiving fee-for-service reimbursement. In recent years Maryland has worked to expand Medicaid eligibility through a number of special initiatives.

BHA recognizes that well-trained staff is a critical component of providing behavioral health services. Services include: Children, Adolescents, Young Adults, Adults and Older Adults, Hospital and Community Based, Mental Health and Substance Use Disorders, Population Based Health and Forensic Services. There were 2,637 state hospital and 115 employees in BHA headquarters.

Workforce Development and Training

The Office of Workforce Development & Training (OWDT) continues to collaborate with our stakeholders as well as federal and state agencies including but not limited to SAMHSA, On Our Own of Maryland, Department of Veterans Affairs, Maryland Coalition of Families and the Mental Health Association of Maryland. These collaborations lead to many opportunities to disseminate and promote core competencies for our professional workforces. These professional workforces include behavioral health clinicians, primary care providers, social workers, drug and alcohol counselors, prevention specialists and peer recovery support providers. Core competencies have been identified for each of these workforces and the OWDT adheres to the training needs, recommendations, and exam requirements, as outlined by the various credentialing and licensing boards. The OWDT collaborates with the licensing boards to ensure that continuing education opportunities are ample, accessible, and meet the various criteria required for each level of certification and/or license. The OWDT provides guidance to various boards to assist in the expansion of trained and skilled professionals in the behavioral health field.

The OWDT partners with various higher education providers throughout Maryland by providing assistance on advisory boards responsible for behavioral health curriculum development, and in promoting professional development opportunities. The office provides information on available financial assistance opportunities such as loan forgiveness and loan assistance repayment programs, which demonstrate an increase in the number of students entering the behavioral health field.

Within local jurisdictions, OWDT continues efforts in collaboration and partnerships with Maryland's Local Health Departments, Local Behavioral Health Authorities, and Core Service Agencies by providing training and continuing education opportunities for all behavioral health workforces. Behavioral health professions are promoted by BHA through the provision of access to low cost training offered by the office and its training partners. OWDT offers in-person training opportunities and partners with rural communities and behavioral health providers by offering low cost customized trainings.

OWDT also collaborates with the University of Maryland Evidence-Based Practice Center and the University of Maryland Training Center on the development and execution of BHA conferences, evidence-based trainings and SAMHSA's Region 3 Workforce Development Committee. The OWDT is currently involved in a long-term project with SAMHSA in increasing field placements and internship opportunities and improving employment pathways of our Social Workers. With the University of Maryland School of Social Work partnering on this as well as other stakeholders, we are demonstrating the benefits of infusing current curriculum with Substance Use Disorder topics in the Master of Social Work programs, and strive to demonstrate the benefits of working within the behavioral health field to students enrolled in MSW programs.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i) Screening Yes No

ii) Education Yes No

iii) Brief Intervention Yes No

iv) Assessment Yes No

v) Detox (inpatient/social) Yes No

vi) Outpatient Yes No

vii) Intensive Outpatient Yes No

viii) Inpatient/Residential Yes No

ix) Aftercare: Recovery support Yes No

b) Are you considering any of the following:

Targeted services for veterans Yes No

Expansion of services for:

(1) Adolescents Yes No

(2) Other Adults Yes No

(3) Medication-Assisted Treatment (MAT) Yes No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Are you considering any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, custody issue Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

BHA monitors program compliance related to PWWDC receiving SUD treatment through their Grant Monitoring Form. These programs are required to give preference to pregnant women who seek or are referred for and would benefit from Block Grant-funded services, as well as admit within 24 hours. In addition, those programs that take women with dependent children have certain conditions as well. Programs are monitored to ensure that the entire family is treated and that all services such as medical-both for mother and pediatric, child care, therapeutic and case management are provided. Any additional services needed the program is responsible for providing linkages with community-based organizations for the family. BHA is also to be provided data by the program for pregnant women and women with dependent children.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
- | | | |
|----|--|--|
| a) | 90 percent capacity reporting requirement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) | 14-120 day performance requirement with provision of interim services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) | Outreach activities | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) | Syringe services programs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) | Monitoring requirements as outlined in the authorizing statute and implementing regulation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
2. Are you considering any of the following:
- | | | |
|----|--|--|
| a) | Electronic system with alert when 90 percent capacity is reached | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) | Automatic reminder system associated with 14-120 day performance requirement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) | Use of peer recovery supports to maintain contact and support | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) | Service expansion to specific populations (military families, veterans, adolescents, older adults) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All grant funded MDH/BHA Substance Use and Substance-Related Disorder programs must adhere to certain conditions. In order to monitor compliance, BHA developed the Conditions of Grant Acceptance Form. The form includes the conditions for general, federal and specific funding. Programs receive and sign this certifying that they will comply with the conditions detailed in the document.

BHA used this document to develop the Grant Monitoring Form as a tool for monitoring program compliance related to activities and services for service for persons who inject drugs (PWID). The tool evaluates the program based on compliance in various areas such as outcome measures, the status on the use of evidence based practices, general and specific conditions of grant awards, conditions of federal block grant awards and adherence to COMAR regulations. Each area is rated with either a "Yes", "No", or "Partial" for meeting compliance with conditions of program requirements. If the program is in partial or noncompliance, a Corrective Action Plan (CAP) could be developed to address the requirement. If it is determined that a CAP will not be developed, comments will be provided as to how the requirement will be met by the program otherwise.

The utilization rate is calculated for the previous three month period for each program by each level of care.

Outcome measures are also calculated for the previous three month period. Outcome Measures include:

- % going from intensive outpatient to another level of treatment w/in 30 days of discharge
- % going from detox to another level of treatment w/in 30 days of discharge
- Reduction in # of patients who use substances at completion from non-detox from those using at admission
- Increase in # of employed patients at completion from admission
- Reduction in # of arrests 30 days before discharge from non-detox from those arrested 30 days before admission
- Reduction in # of patients leaving treatment against clinical advice
- Reduction in tobacco use at discharge from non-detox from those using at admission
- % with a Treatment episode of not less than 90 days

The Grant Monitoring Review Form also looks at BHA General and Specific Conditions of Grant Award which includes:

- MFR Performance Measures
- Fee Assessment
- Buprenorphine Initiative
- Gambling and Nicotine Assessments
- Documentation of Opioid Problem
- Length of Stay Evaluation
- Clinical Supervision
- Counselor to Patient Ratio
- Continuing Care and Care Coordination

- Admissions Priority
- Limited English Proficiency
- Sub grantees

Conditions of Federal Block Grant Awards are also reviewed for compliance with:

- Drug-Free Workplace Requirements
- Personnel Record Policy
- Capacity of Treatment for PWID- including waitlist protocols, interim services, and outreach efforts
- Requirements regarding Tuberculosis, HIV, and Services for Women, Pregnant Women, and Women with Dependent Children

Lastly, the form reviews the program's adherence to certain COMAR regulations related to Continuous Quality Review, Program Certification, Family Involvement and Individualized Treatment.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No

2. Are you considering any of the following:

a) Business agreement/MOU with primary healthcare providers Yes No

b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No

c) Established co-located SUD professionals within FOHCs Yes No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

BHA monitors program compliance related to tuberculosis services made available to individuals receiving SUD treatment through their Grant Monitoring Form. The form reviews whether, to prevent the transmission of TB, the program addresses screening patients and identifying high-risk individuals, meets all state reporting and confidentiality requirements and ensures that individuals receive case management services. In addition, programs are expected to ensure that TB services are made available to each individual receiving treatment for substance abuse. Services could include counseling, testing, or medical treatment. Lastly, the tool reviews the program's compliance with requirements to report all individuals with active TB to the local Health Department as required by State laws.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? Yes No

2. Are you considering any of the following:

a) Establishment of EIS-HIV service hubs in rural areas Yes No

b) Establishment or expansion of tele-health and social media support services Yes No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.A§ 300x-31(a)(1)F)? Yes No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No

If yes, please provide a brief description of the elements and the arrangement

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement Yes No
2. Are you considering any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of service for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Are you considering any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) Yes No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) Develop an organized referral system to identify alternative providers Yes No
 - a) Develop a system to maintain a list of referrals made by religious organizations Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Are you considering any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No

- c) Identify workforce needs to expand service capabilities Yes No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

- 1. Does your state have an agreement to ensure the protection of client records? Yes No
- 2. Are you considering any of the following:
 - a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

- 1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
- 2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The number of block grant sub-recipient identified to undergo an independent peer review is estimated to be 5, which is a percentage of all the programs/providers.

- 3. Are you considering any of the following:
 - a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Develop long-term planning for service revision and expansion to meet the needs of specific populations Yes No
- 4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If YES, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No
 - c) Coordination of Various Activities and Services Yes No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

The MDH merged two administrations: The Mental Health Administration and Alcohol Drug Abuse Administration in 2013.

Programs and Services under both administrations will continue to work under their respective regulations (COMAR 10.21 and

COMAR 10.47) until they are licensed under the new Integrated BHA Regulations (COMAR 10.63) that requires programs and services to become licensed. ALL programs must be licensed by March 31, 2018, or they will not be allowed to operate. Thus, we have some programs (the majority) operating under 10.21 and 10.47. The link to BHA regulations follows:
<https://bha.health.maryland.gov/Pages/Regulations.aspx>

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? j n Yes j n No

Does the state have any activities related to this section that you would like to highlight?

BHA's facilitates Quality Management and Monitoring efforts in various approaches. All grant funded MDH/BHA Substance Use and Substance-Related Disorder programs must adhere to certain conditions. In order to monitor compliance, BHA developed the Conditions of Grant Acceptance Form. The form includes the conditions for general, federal and specific funding. Programs receive and sign this certifying that they will comply with the conditions detailed in the document.

BHA used this document to develop the Grant Monitoring Form as a tool for monitoring program compliance related to activities and services for service for persons who inject drugs (PWID). The tool evaluates the program based on compliance in various areas such as outcome measures, the status on the use of evidence based practices, general and specific conditions of grant awards, conditions of federal block grant awards and adherence to COMAR regulations. Each area is rated with either a "Yes", "No", or "Partial" for meeting compliance with conditions of program requirements. If the program is in partial or noncompliance, a Corrective Action Plan (CAP) could be developed to address the requirement. If it is determined that a CAP will not be developed, comments will be provided as to how the requirement will be met by the program otherwise.

BHA promulgates regulations for all community program types (OMHC, PRP for Adults, PRP for Minors, RRP, MTS, RCS, MHVP, Respite Care, TGH for Minors, Group Homes for Adults, etc.). Activities include:

- Reviews deemed status requests
- Conducts fidelity monitoring of EBP programs annually
- Reviews business plans for all new community program applicants
- Conducts compliance audits; issues retraction letters as necessary
- Participates in multi-agency Medicaid fraud workgroup
- Reviews/responds to OIG audits and recommendations for recovery of funds
- Works with the ASO to plan monthly schedule of audits, identify audit trends and monitor retraction activities
- Conducts case resolution conferences with community providers as necessary
- Collaborates with OHCQ regarding any necessary disciplinary actions
- Monitors CSA MOUs, including quarterly audits
- Monitors ASO contract deliverables
- Contracts with Consumer Quality Team (CQT) for visits to PRPs for Adults and State hospital inpatient units
- Contracts with University of MD Systems Evaluation Center for various evaluation and data analysis projects and monitors contract deliverables
- Implements Outcomes Measurement System (OMS) with all OMHCs
- Reviews program applications for regulatory compliance
- Conducts site visits to community programs, including writing reports and reviewing program improvement plans (approval/licensure range allowed by regulation is 6 months up to 3 years)
- Conducts Informal Dispute Resolution conferences as requested by the provider
- Forwards complaints to BHA and CSAs
- Reviews all program applications
- Provides technical assistance to programs
- Investigates complaints
- Monitors grant award conditions for all grant-funded programs
- Monitors program improvement plan implementation
- Monitors compliance with deemed status conditions
- Conducts visits to all RRP sites at least annually, including interviewing residents
- Per the conditions of the ASO contract:
 - Conducts compliance audits to outpatient programs, inpatient programs, and individual practitioners

Conducts consumer surveys annually
Conducts provider surveys biennially
Implements OMS
Produces data reports
Monitors utilization trends

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? Yes No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No

5. Does the state have any activities related to this section that you would like to highlight.

The state supports the TAMAR project, a trauma-specific approach listed as a promising practice with SAMHSA. This education model is available at no charge to all interested parties, anyone who requests this manualized education will receive the materials, training and technical assistance if they choose to implement the model.

The Office of Crisis Prevention, Criminal Justice, Treatment, and Diversion at the Behavioral Health Administration provides lectures, workshops, and training on trauma-informed principles in collaboration with local behavioral health authorities and local health clinics.

The Office of Crisis Prevention, Criminal Justice, Treatment, and Diversion at the Behavioral Health Administration will also work with the Governors Task Force on Human Trafficking on trauma training for clinicians throughout Fiscal Year 2018.

Additionally, the Director of the Office of Crisis Prevention, Criminal Justice, Treatment, and Diversion at the Behavioral Health Administration will provide statewide training on trauma and trauma informed principles.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csjjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? j n Yes j n No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? j n Yes j n No

3. Does the state purchase any of the following medication with block grant funds? j n Yes j n No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? j n Yes j n No

5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) WRAP Post-Crisis
- b) Peer Support/Peer Bridges

- c) Follow-up Outreach and Support
- d) Family to Family Engagement
- e) Connection to care coordination and follow-up clinical care for individuals in crisis
- f) Follow-up crisis engagement with families and involved community members
- g) Recovery community coaches/peer recovery coaches
- h) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Crisis Services

Community crisis services account for many of the services funded by the Behavioral Health Administration grants and contracts. The MHBG supports several crisis response systems in Baltimore City, Anne Arundel and Prince George Counties. Baltimore City has two crisis response and intervention systems, one for children and adolescents and another for adults, much of the rest of the state has more limited resources.

There is considerable variability of the services offered from jurisdiction to jurisdiction. As an example, currently there are 13 Mobile Crisis Team (MCT) programs operating in Maryland, and only 25% are available 24/7. Many of the jurisdictions in the more rural areas are just focused on obtaining access to urgent care. The current continuum of crisis response services is:

- 24/7 hotline and/or clinical crisis phone response
- Walk-in Crisis Services
- Mobile Crisis Team (MCT) programs
- Crisis Residential Beds
- Crisis Intervention Team (CIT) programs
- Hospital Diversion
- Criminal Justice Diversion
- 23 Hour Holding Beds
- Emergency Psychiatric Services
- Urgent Care

In FY 2014 the former Governor, issued a supplemental budget appropriation in early April to address several behavioral health initiatives to further support the expansion of crisis services in Maryland. Approximately \$2.5 million was identified towards the development of crisis intervention teams. Almost every county has established crisis intervention teams, though they are not necessarily all available 24/7. Additionally, nearly all counties offer short term, state-funded crisis respite beds as both an alternative to, and a step-down from, psychiatric inpatient services. Every county already has access to a 24/7 behavioral health crisis hotline and emergency department psychiatric services. Core Service Agencies have prepared local All Hazards Disaster Behavioral Health Plans delineating prevention and response activities in the event of a natural or man-made disaster. The Plans have been coordinated with local health departments, Emergency Medical Systems, and other designated responders in each jurisdiction.

Crisis Intervention Training (CIT) is a training program developed to help police confront behavioral health emergencies in which a person poses or appears to pose a danger to themselves or others. The local Core Service Agencies receive funding from BHA to develop teams in collaboration with local law enforcement in their communities using best practices. In addition to training, CIT is built on strong partnership between law enforcement, behavioral health provider agencies, and individuals and families affected by behavioral health conditions. The ultimate goal of CIT is diversion from the criminal justice system.

Residential Crisis: Residential Crisis services are short-term, intensive mental health and support services provided in a community-based, non-hospital, residential setting which are designed to prevent a psychiatric inpatient admission, to provide an alternative to psychiatric inpatient admission, or to shorten the length of inpatient stay.

Crisis Efforts to Address Opioid Related Deaths

In January 2017, Maryland's Governor Larry Hogan signed an Executive Order declaring a State of Emergency in response to the heroin, opioid, and fentanyl crisis ravaging communities in Maryland and across the country. This declaration activates the governor's emergency management authority and enables increased and more rapid coordination between the state and local jurisdictions. The governor, along with Lt. Governor Boyd Rutherford, also announced in new funding to address the crisis, as well as the appointment of the governor's senior emergency management advisor to lead the state's coordinated effort to combat the crisis.

The State of Emergency declaration is a result of the initial findings of the Opioid Operational Command Center (OCCC) established by the administration in January to facilitate greater collaboration among state agencies, including health and human services, education, and public safety entities. The OCCC's work made it clear that the state needed greater flexibility to activate emergency teams in jurisdictions across the state and engage local communities. The governor's executive order delegates emergency powers to state and local emergency management officials, enabling them to fast-track coordination among state and local agencies and community organizations, including private sector and nonprofit entities to ensure whole-community involvement.

Since forcefully recognizing and identifying the rapidly growing opioid and heroin epidemic during the 2014 gubernatorial campaign, Governor Hogan and Lt. Governor Rutherford have made proactively addressing this crisis a cornerstone of the administration's agenda. In 2015, Governor Hogan signed an executive order creating the Heroin and Opioid Emergency Task

Force, chaired by Lt. Governor Rutherford. The task force developed 33 recommendations focused on prevention, treatment, and enforcement to aggressively combat the opioid and heroin crisis.

During the 2017 Legislative Session, Maryland's Heroin and Opioid Prevention Effort (HOPE) and Treatment Act (SB 967/ HB 1329) was passed. This is another comprehensive approach to address Maryland's behavioral health crisis. The HOPE Act has mandates to establish behavioral health crisis treatment centers, expansion and promotion of a statewide 24/7 crisis hotline and requires hotline staff to be trained to screen callers for mental health and substance use disorder needs, as well as conduct risk assessments for overdoses and suicides.

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
 - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? j n Yes j n No
 - b) Required peer accreditation or certification? j n Yes j n No
 - c) Block grant funding of recovery support services. j n Yes j n No
 - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
See attached document.

2. Does the state measure the impact of your consumer and recovery community outreach activity? j n Yes j n No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
See attached document.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
See attached document.

5. Does the state have any activities that it would like to highlight?

BHA's National Recovery Month includes events that will disseminate information with 300+ Peers, Supervisors of Peers, and behavioral health providers statewide. The Maryland Department of Health, Behavioral Health Administration and the University of Maryland Training Center in celebrating the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Recovery Month will hold an Annual Recovery Month kick-off event, Join the Voices of Recovery: Strengthen Families and Communities, on Friday, September 8, 2017. The agenda for the Annual Recovery Month kick-off event includes the following:

- A reading of Governor's Proclamation, Brendan Welsh, CPRS, Director, Office of Consumers Affairs, Behavioral Health Administration
- Maryland Addiction and Behavioral-health Professionals Certification Board (MABPCB) Updates, Denise Camp, CPRS, RPS, Vice President, MABPCB
- Celebration and Recognition of Carroll Conquest - A Life of Service and Recovery: Representatives from the Behavioral Health System Baltimore (BHSB) and Tyrell Moyd, PRS, Director, Penn-North Recovery Center
- The Breadth of Peer Recovery Services in Maryland: Peer-led panel discussion of how peer recovery specialists are making a difference in various settings throughout Maryland
- Celebration: Lunch and light refreshments provided, 12:00 p.m. to 12:30, Rice Auditorium. Following lunch, for those interested, there will be a 1.5 hour workshop on Self-Care. You will need to sign up separately from the recovery day kick-off celebration, follow both registration links below. At the conclusion of the workshop, you will receive 1.5 CEUs in the Wellness/Recovery domain for your participation which can count towards CPRS application or recertification hours.

Additionally, the following information will be disseminated during National Recovery Month Events:

- BHA's National Recovery Month Events page @ <https://bha.health.maryland.gov/Pages/National-Recovery-Day.aspx> that lists recovery celebration events being held throughout National Recovery Month.
- The first ever Outstanding Leadership Award, in honor of the late Mr. Carroll Conquest and his many achievements as a peer advocate and leader in the behavioral health field. We hope that you and all of the many peers, peer allies, and family members you interact with will join us for this special event.
- BHA's Annual Peer Networking Conference

Please indicate areas of technical assistance needed related to this section.

See attached document.

Footnotes:

17. Recovery

Introduction

Maryland's commitment to the principles of recovery and resiliency is long standing. This commitment to further define a recovery-oriented system has been carried out by the Behavioral Health Administration (BHA). BHA's mission and vision speak to promoting recovery, resiliency, health and wellness for individuals who have or are at risk for emotional, substance related, addictive, and/or psychiatric disorders through coordinated, quality systems of care that are supportive of individual rights and preferences, to improve their ability to function effectively in their communities. BHA is committed to remaining a system that focuses on the wellbeing of those they serve; both while in care and after they have successfully integrated back into their community, as defined by the individual. In 2008, regulations governing the provision of outpatient mental health and psychiatric rehabilitative services (PRPs) were amended to include language that outlined strengths and recovery, as well as expectations that treatment services were to be provided that focused on facilitating individual recovery and resiliency. The Administration continues to promote recovery in all aspects of the behavioral health care system.

In keeping with this philosophy, the Public Behavioral Health System (PBHS) incorporated recovery approaches such as person centered planning, self-directed care, peer recovery support, and consumer/participant/family education, as well as the promotion and expansion of access to employment, education wellness, and affordable housing. Over the years, the system has also promoted and/or provided access to training for behavioral health providers in step with these concepts.

The FY 2018 State Behavioral Health Plan, offers several strategies that continue to promote the expansion of many of these recovery support services and that encourage the continued promotion of resiliency. Some of these strategies include: the Recovery Support Service Integration (RSSI) Workgroup, which will work toward the implementation of a recovery support service delivery model that supports integrating recovery into practice across behavioral health, service settings and within the community by using EBP tools to track recovery outcomes and making recommendations for best practices. A newly created recovery support service integration (RSSI) Web site will be utilized to improve the exchange of information. A series of public education, training and electronic communication activities are planned to increase awareness of recovery and resiliency among children youth and adults, in addition to the establishment of Maryland Recovery Net (MDRN) partnerships with service providers according to areas of need within the state and implementation of the Resilience Initiative. The plan includes the continuation and expansion of recovery housing for women with children to support the recovery efforts of women and their families, as well as increasing Recovery Support Care Manager Services for Pregnant/Postpartum women and their families. The state plans to work with the Florida Alliance of Recovery Residences to develop the Recovery Capital Model in Maryland and a Recovery Capital Pilot has already been developed.

The plan also includes strategies to expand peer workforce development through the peer specialists' certification process and peer leader training opportunities.

House Bill 1411 titled "Health- Recovery Residences Certification" was enacted under Article II 179(c) of the Maryland Constitution on May 28, 2016 and became effective on October 1, 2016. The legislation requires the Maryland Department of Health (MDH) to establish a credentialing entity to certify recovery residences by October 1, 2017. A "recovery residence" means a service that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders or addictive disorders or co-occurring mental health and substance-related disorders or addictive disorders, and that does not include clinical treatment. Any recovery residence that advertises, represents, or implies to the public that it is a certified recovery residence must receive a certificate of compliance by the credentialing entity. Additionally, Recovery Residences that receive state funding must have a certificate of compliance. As stated in the legislation, the credentialing entity must establish certification requirements, establish processes to administer the application, certification and recertification process; monitor and inspect recovery residences, conduct on-site inspection before issuing a certificate of compliance, and issue a certificate of compliance on approval of the application process and the inspection. The Behavioral Health Administration (BHA) will be the credentialing entity issuing the certificate of compliance and has established the Maryland Certification of Recovery Residences (MCORR) to develop and administer the certification and recertification process for recovery residences. BHA advises that any recovery residence that receives funding from the BHA must meet the certification requirements and certain quality and environmental standards. Residences seeking a certificate of compliance will be required to complete an application, submit other required documents and participate in mandatory trainings. Applications will be reviewed for compliance. An onsite field inspection will be required, as well as submission of a policy and procedures manual that complies with National Alliance of Recovery Residences (NARR) 2015 standards. A certificate of compliance will be issued by MCORR when the applicant has successfully met all MCORR requirements and is valid for one (1) year from the date of issuance. All recovery residences are inspected annually and are subject to audit inspections throughout the year on a random basis. Maryland will continue to make concerted efforts to address the requirements of HB1411 by maintaining Recovery Residences Certification Trainings for Recovery Housing.

3. Recovery and Recovery Support Services for Adults with SMI

The Office of Adult and Specialized Behavioral Health Services supports the comprehensive system of behavioral health services and supports as the coordinator of four units: Adult Services, Treatment and Recovery Services, Specialized Behavioral Health Services, and Women's Services. The Office oversees statewide planning, development, administration, and monitoring of community and residential based behavioral health services and supports.

In collaboration with the Office of Adult and Specialized Behavioral Health Services, the Adult Services unit ensures that a comprehensive system of mental health services and supports are available and accessible and participates in the statewide planning, design, development,

implementation and monitoring of these services. Individuals served by block grant funds have an availability of recovery support services and the Block Grant supports community bond programs and recovery support services that are not reimbursed by Medicaid and address the needs of the uninsured.

The **Public Behavioral Health System (PBHS)** for Adults is managed in collaboration with local behavioral health authorities in Maryland's twenty-four jurisdictions. Recognizing that co-occurring conditions are common, consumers of the PBHS are provided seamless linkages to services through a system of integrated care. The focus is always on prevention, intervention, treatment, behavioral health, support, recovery, and resilience. Services are based on eligibility and medical necessity criteria which have been established for each level of services outlined below:

- **Psychiatric inpatient care;**
- **Psychiatric Partial Hospitalization Program (PHP);**
- **Respite;**
- **Outpatient Mental Health Center or Individual Mental Health Practitioner;**
- **Psychiatric Rehabilitation Program (PRP);**
- **Residential Rehabilitation Program (RRP);**
- **Mobile Treatment;**
- **Targeted Case Management (TCM);**
- **Supported Living;**
- **Non Evidence-Based Practice Supported Employment (SE); and**
- **Residential Crisis**

The Clinical Services Division ensures an integrated system of behavioral health treatment and recovery services are available and accessible to individuals experiencing substance-related disorders. The unit also aims to increase access to appropriate clinical and recovery support services, improve treatment outcomes; and to provide education on, and increase the public's awareness of the risks associated with substance use.

Clinical Services

Clinical and behavioral services are offered through a continuum of treatment modalities/levels of care that promote public health and safety of individuals, families, and communities. The modalities are community and jail-based and consist of Intensive Outpatient, Outpatient, Inpatient and Residential treatment (Halfway House), DWI/DUI education, detoxification services, and Opioid Maintenance Therapy which uses pharmacological (medication assisted) interventions to provide treatment and recovery support to opioid-addicted patients.

Halfway House

Low intensity residential treatment setting that provides onsite therapy for residents.

Recovery Support Services

Maryland RecoveryNet

Develops partnerships with service providers statewide and funds access to clinical and recovery support services for individuals with substance use/co-occurring disorders treatment and recovery support needs. All Maryland RecoveryNet service recipients receive Care Coordination through which they can access a menu of services which includes state funding for Halfway House and Recovery Housing, Transportation, Employment Services, Vital Records, Medical and Dental services, and other unmet needs as expressed by the service recipient and/or as identified by the Care Coordinator. All services are designed to assist recipients in remaining engaged in their recovery while promoting independence, self-sufficiency, and stability.

Recovery Housing

Supportive Transitional Housing is a sober living facility that provides supportive housing to individuals that do not require the higher intensity of a halfway house setting. Individuals may be early in recovery, transitioning from homelessness or have other living arrangements that do not offer safe and recovery oriented environments. This housing type is not monitored or regulated.

Continuing Care

Care for individuals who no longer need intensive level of care and allows flexibility in the frequency of contact between clinician and patient, phone-based risk assessment (recovery check-up) and counseling, face-to-face sessions, transfer back to a higher level of care if warranted, and referral for support services (e.g., housing, employment, access to medical care, etc.) as needed.

Care Coordination

Designed for individuals with a high risk for relapse as a way to improve recovery outcomes. Individuals are assisted with access to various recovery support services and other follow up services.

Recovery Community Centers (RCC)

The sense of shared identity and mutual support of persons who are part of the social world of individuals in recovery. BHA has 24 funds RCCs. They are designed to be places where those in recovery can seek a safe space and can seek out resources and services related to both somatic and behavioral health care.

Peer Support/Recovery Coaching:

Services that help those in recovery develop supportive peer relationships which will help them acquire recovery skills and develop healthy relationships. The services are facilitated by Certified Peer Recovery Specialists (CPRS)

On Our Own of Maryland (OOOMD) is a statewide consumer organization that has created its own network of support groups to provide alternative types of services to the traditional mental health system. The organization provides opportunities for peer-operated supports and has local affiliates across the state. BHA, in collaboration with the CSAs /LAAs has supported On Our Own of Maryland's initiatives to transform its consumer network toward a wellness and recovery-oriented system and to enhance peer support activities and the use of best practices within the community. These collaborations include:

- **The Empowerment Partnership Project:**
 - Dedicated to helping transform the lives of consumers through training that provides resources/tips to individuals to build/ maintain a recovery centered life.
 - Promotes *Recovery Conversations*, a new digital library of audio and video interviews about various facets of recovery.

- **Anti-Stigma Project (ASP):**
 - Helps participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change.
 - Each workshop is team-facilitated by trainers with extensive and varied experience in mental health addictions, recovery, education, and communication.
 - Workshops tailored to address specific populations/situations such as cultural competency, housing, co-occurring disorders, or the reduction/elimination of seclusion and restraint.
 - Workshops are free to mental health and substance use programs, clinics, or hospitals that receive full or partial public funding from the state. Their wide spectrum of venues also include local Wellness & Recovery or Recovery Community centers, housing authorities, homeless shelters, and statewide conferences and universities.

- **Wellness and Recovery Action Plan (WRAP)**
 - Ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement, and incorporate WRAP within community mental health programs.
 - Training includes the core concepts of recovery, daily maintenance, early warning signs and action plans, breakdown and crisis plans, and post crisis plans that provides training in consumer-operated programs.
 - WRAP also addresses BHA's increasing efforts to actively involve consumers and families in quality improvement and evaluation activities. There are more than 300 WRAP facilitators trained.

Specialized Behavioral Health Services Unit

The Specialized Behavioral Health Services Unit is responsible for developing, monitoring and coordinating services for individuals 18 years of age and throughout the life span with mental health conditions or co-occurring substance-related disorders who have special needs. Populations include individuals who are homeless, deaf or hard of hearing, incarcerated in local detention centers and/or trauma survivors. In addition, the unit oversees specialized programs developed with state, federal, and local funding targeted to special populations.

- **Maryland Community Criminal Justice Treatment Program (MCCJTP):** delivers both clinical treatment and case management services of justice-involved individuals.
- **Datalink:** A partnership between the DHMH/BHA, DHMH's Office of Health Services, the Department of Public Safety and Correctional Services (DPSCS), ASO/ Value Options[®] Maryland, CSAs and the local detention centers. The purpose of Datalink is to promote the continuity of treatment for individuals with serious mental illness who are detained in the detention center.
- **Crisis Intervention Team (CIT):** a training program developed to help police confront behavioral health emergencies
- **Crisis Response Services:** Crisis response systems collaborate and partner with local law enforcement agencies to ensure those with behavioral health needs receive appropriate levels of treatment rather than incarceration in local jails
- **Continuum of Care Programs:** provides tenant and sponsor-based rental assistance and supportive services to Individuals and families through Public Behavioral Health providers
- **Trauma, Addictions, Mental Health and Recovery Program (TAMAR):** the State's trauma education project, providing services to individuals 18 and older who are detained in participating detention centers
- **Projects for Assistance in Transition from Homelessness (PATH):** provides flexible community and detention center-based services to individuals who are homeless and have a mental health condition.
- **Deaf and Hard of Hearing Services:**
- **Chrysalis House Healthy Start Program:** aims to provide appropriate treatment and mother/child interventions to women with mental health conditions, substance-related disorders, and disorders stemming from traumatic experiences.
- **SOAR:** aims to increase access to the disability income benefit programs for eligible adults who are homeless or who are at risk of homelessness and have a mental health condition and/or a co-occurring substance-related disorder.
- **Homeless Identification Project:** provide funds to pay the cost of a Maryland identification card and/or birth certificate in order for individuals who have a mental illness or co-occurring substance-related disorders and are homeless or imminent risk of homelessness to access community resources.

Women's Services Unit

The Women's Services Unit develops and coordinates BHA's efforts to provide evidence-based services for substance-related disorders treatment and recovery for Women and their families.

The

Unit manages contracts for substance-related disorders residential treatment services for pregnant women and women with dependent children, as well as provides technical assistance and training to Local Health Departments and treatment providers.

The Office of Consumer Affairs (OCA) gives oversight to 25 Wellness and Recovery Centers (WRCs), peer-operated centers located in the community, which offer linkages to many resources such as workshops, support groups, opportunities for friendship, socialization, and advocacy. They work in collaboration with consumer/participants across the state to promote new initiatives that facilitate recovery in treatment and community living, shape peer recovery approaches as these resources become more wide-spread, and promote trainings and workshops that enhance a life style in recovery. The OCA has worked diligently over the last several years to increase the sustainability and the accountability of WRCs established across the state to support the transition of individuals who have a mental illness into the community. While these centers are a safe place for consumers to convene, socialize, and work on important skills, it is also meant to be a bridge to quality community living. Over the years there has been an increased involvement of the WRCs in surrounding community organizations and activities to allow the centers and their members to become more active members of the greater community. The WRCs utilized a federal Olmstead Planning Grant in FY 2010 to contract with peer support counselors who work with consumers to support their transition to and ability to remain in the community. This peer program continues and is part of the efforts to establish the Peer Certification program and the availability of peer support in a variety of settings.

The OCA conducts a project known as LEAP (Leadership Empowerment Advocacy Project), which trains individuals to advocate for policy change, become educated in advocacy, direct peer groups, while learning to develop communication and leadership skills at a systems level. Since its inception in 1990, LEAP graduates continue to: serve on committees and federal and state advisory boards; as well as participate in the state planning process for the Public Behavioral Health System (PBHS). OCA also conducts venues and projects that enhance decision making, leadership, and self-direction such as, the Self-Directed Care (SDC) program which began as a pilot in Washington County and continues to assist individuals with the development and implementation of their personal "recovery" plans which include directing the use of their benefits to access public behavioral health services, education goals, and non-traditional support services.

The Health Homes (HH) program offers participants enhanced care coordination services from providers with whom they regularly receive services, including psychiatric rehabilitation programs, mobile treatment service providers, and opioid treatment programs. This community-based approach, (not a residential program) enhances person-centered care by

empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. BHA participated in the HH implementation phase as conducted by Medicaid, through supporting the provision of outreach and technical assistance to the more than 75 providers. BHA also participated in the HH Committee and collaborated with Medicaid in the encouragement of increased adoption of the HH model in Medication-Assisted Treatment (MAT) programs. The emphasis was on creation of infrastructure within existing programs to allow the adoption of the model, thus increasing the availability of the HH service in MAT programs.

Recovery Community Centers (RCCs) are centers designed to be a safe haven for those in recovery to convene and a place where interested persons in recovery can obtain a multitude of services to support a healthy and recovering lifestyle, conveying a sense of shared identity and mutual support for persons in recovery. BHA now has twenty funded Recovery Community Centers. Services include: 12-step support meetings, Meditation sessions, Care Coordination/enrollment into MD RecoveryNet, Peer Support group, Recovery Coaching, computer access, and discussions on HIV, mental health, and tobacco use. Some RCCs serve as an access point linking individuals needing somatic care, behavioral health care, and/or insurance

Assertive Community Treatment/Mobile Treatment (ACT) is an intensive, community-based service which provides assertive outreach, treatment, rehabilitation, and support to individuals with severe and persistent mental illness (SPMI) who may be without a home or for whom more traditional forms of outpatient treatment have been ineffective. Services are provided by a mobile, multidisciplinary team in the individual's natural environment. Of the 29 mobile treatment (MT) teams in Maryland, twenty (20) are EBP ACT. In FY 2014 3,667 individuals with mental health disorders received mobile treatment services. Maryland has expanded Assertive Community Treatment (ACT) assessment tool developed through initial funding by the Washington State Mental Health Division, Department of Social and Health Services, Health and Recovery Administration. Named the Tool for Measurement of Assertive Community Treatment (TMACT), this instrument will eventually replace the current mechanism for gauging adherence to the established ACT model. The Dartmouth Assertive Community Treatment Scale (DACTS) has been the assessment tool used to monitor Maryland ACT services since 2002, and to which reimbursement rates are tied.

Housing

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the well-being and stability of persons with serious mental illnesses residing in the community. BHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with serious mental illnesses (SMI) in need of intensive services and support to eventually integrate into the community. Currently there are 2,507 RRP beds in the system and a total of 4,012 individuals with SMI received RRP services in fiscal year 2016. BHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including psychiatric rehabilitation programs (PRPs), case management, and other supports to enable them to live in housing of their choice.

BHA actively collaborates with both the Maryland Department of Housing and Community Development (DHCD) and the federal Housing and Urban Development (HUD) to promote access and receipt of affordable housing through specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. In collaboration with other state agencies, BHA and DHCD will work together to finance affordable, quality, independent, integrated housing opportunities for persons with very low income and disabilities who met certain eligibility criteria.

To assure that consumers of mental health services have a range of housing and other residential options, BHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable, safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing with accompanying support services as requested and needed by the consumer. BHA has worked toward efforts to increase availability of housing vouchers. Several CSAs have supported local housing authorities in applications for HUD Mainstream Section 8 vouchers and Flexible Housing Choice Vouchers. However, due to changes in the Federal budget priorities and the increase in the cost of all housing, access to new housing vouchers for individuals with disabilities is limited. Despite this, BHA will continue to work with CSAs to expand mainstream rental opportunities that enhance affordable housing options for individuals with serious mental illnesses. At the provider level, many mental health providers have also helped consumers successfully pursue HUD Housing Choice programs including the Housing Choice Vouchers and other rental assistance services. Additionally, BHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through MDH's Administration-Sponsored Capital Program. BHA has identified housing as its priority for receipt of these bond monies.

BHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies, as well as non-profit developers and

mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized federal and state government-supported housing opportunities, as well as local county resources and private foundations.

Supported Housing services provide off-site rehabilitation and support for individuals with severe and persistent mental illness (SPMI) who are able to live in independent housing of their choice with flexible, individualized supports. This office collaborates with other agencies and offices to promote affordable housing choices. Including affordable housing programs that allow individuals with SMI to live in their own subsidized residences, become primary lease holders, and have access to services from the PBHS. Services are encouraged but are not required; they are optional to the individual. BHA, in collaboration with the Office of Capital Planning, Budgeting, and Engineering Services' (OCPBES) Administration-Sponsored Capital Program, processes requests for the MDH Administration-Sponsored Capital Program (Community Bond) which provides capital grant funds for prioritized community-based services such as the development of affordable housing and recovery housing for individuals with behavioral health disorders, as well as funding for housing for individuals with SUD. Projects are highly encouraged that expand, support, or enhance recovery support services and show a commitment to safe and affordable long term housing opportunities with tenant/landlord lease/ agreements (i.e., sober living, peer run, transitional, and recovery housing). To date, more than 664 housing units have been developed through the OCPBES grant (Community Bond) funding in partnership with community housing development organizations, mental health provider organizations, and other entities providing affordable housing.

Supported Employment

Supported employment (SE) services provide job development and placement, job coaching, and ongoing employment support to individuals with serious mental illness (SMI) or emotional disturbance for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences, and skills. This level of service is available for individuals ages 16 and above.

BHA's relationship with the state Division of Rehabilitation Services (DORS) is another example of Maryland's collaborative strengths and commitment to supported employment. Outstanding integration between BHA and DORS at the state level and among CSAs, programs, and local DORS offices, has been recognized as exceptional by national leaders in implementation of evidence-based practices. DORS and BHA jointly applied for and were awarded a grant from the Johnson and Johnson – Dartmouth Community Mental Health Program (J & J – Dartmouth Program), designed to further promote EBP SE services. The number of SE programs grew considerably and as of 2015, there are 65 approved community mental health provider sites across Maryland that provide SE services and supports to customers with SMI, 5 of which have

received training and technical assistance in EBP SE implementation, and 26 of which currently meet EBP SE fidelity standards in order to demonstrate eligibility for an enhanced EBP rate in recognition of the additional services provided. The EBP SE Implementation Initiative in Maryland has enhanced the quality of SE services, increased competitive employment outcomes for SE consumers (average of 57% in competitive employment among EBP sites since inception of initiative. In FY 2014, 3,431 consumers were served in Supported Employment.

Additionally, BHA partners with the National Alliance on Mental Illness of Maryland (NAMI MD) to implement the Johnson & Johnson – Dartmouth College Community Mental Health Program, Family Advocacy Team Project. The purpose of the project is to increase awareness of Evidence-Based Practice (EBP) Supported Employment (SE) among family members of persons with serious and persistent mental illness. Armed with information about the positive impact of employment and the incentives in place to protect benefit loss, families will be better prepared to provide necessary supports when their loved ones move into the work force.

BHA also takes note of the increased number of individuals employed each year from the evidence-based initiatives – supported employment and Ticket-to-Work. Supported employment services, in collaboration with the Maryland State’s Department of Education - Division of Rehabilitation, provide: job development and placement; job coaching; and ongoing employment support to individuals with serious mental illness or emotional disabilities for whom competitive employment has not occurred, has been interrupted, or has been intermittent. Evidence-based Practice Supported Employment (EBP-SE) services enable eligible individuals (for individuals ages 16 and older) to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences, and skills. The Ticket to Work Program also helps people who receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) to return to meaningful work, maintain employment, and to pursue ongoing career advancement. This free, voluntary program is a statewide administrative employment structure, sponsored by the Behavioral Health Administration, which connects selected supported employment programs, and the CSAs within which the supported employment programs operate, into a single Employment Network consortium.

Children with SED

The Children’s Services Division of BHA is charged with developing a system of care for young people and their families ranging from early childhood all the way through to the time when young people reach the age of majority and legally become adults. The system of care is designed to meet the needs of individuals within this age range who have mental health conditions, substance-related disorders, and those who have both. The Division evaluates the network of services that the BHA funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. The Division also manages a number of special projects and is responsible to work with all other child serving agencies at

both the State and local levels to assure a highly coordinated and individualized approach to care.

The mission of the **On Our Own of Maryland (OOOMD) Transitional Age Youth (TAY) Outreach Project**, in existence since 2012, is to empower youth with mental health/substance use struggles to share their experiences and speak out about the kinds of supports and services they'd like to see within the behavioral health system where they receive care. This project hopes to foster an understanding that the life experiences of young adults are full of unique insights and support for other young adults and that all young adult peers, joining together, can successfully advocate for a behavioral health system that honors their experiences, listens to their voices, and meets their specific needs effectively and sensitively. This project gives young people, who have overcome some of their hardships, an opportunity to reach out with hope and insight to others who may be struggling, and to a system in need of guidance from youth experience. Through mutual strength-based peer support and self-advocacy; issues of concern, topics of interest, and methods for change both within individuals and within the larger behavioral health system are represented and defined. There are workshops and activities that help young adults find their way to tell their story through art, words, or any medium young adults choose, and the opportunity to talk with peers about the issues that affect their lives.

Early Interventions Programs/First Episode Psychosis Programs

MDH BHA, (SOM) and the University of Maryland Medical System have collaborated to offer specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. The programs use an integrated approach to address the health and mental health needs of young adults, including providing support for co-occurring substance-related disorders with metabolic-related disorders, and other co-occurring medical conditions. These programs are committed to reducing disability by equipping individuals at risk and their families with tools to manage their illness, move successfully through the developmental stages of growth, and establish a life of their choosing.

Transition planning services emphasize resilience as they assist young people (emerging adults) with mental illnesses and emotional disabilities as they prepare for adult life. Transition-age services and supports are available to youth beginning at age 16. Services and supports are designed to prepare and facilitate achievement of goals related to relevant transition domains, such as employment, career, and educational opportunities, living situations, personal effectiveness, well-being, community contribution and life functioning. Services integrate traditional and nontraditional supports in developmentally appropriate and effective youth-guided local systems of care with the system goal of expansion of the evidence informed service provision throughout the state. The value placed on youth and family member participation continues as a major priority of the child and adolescent behavioral health system of care.

The **Maryland Coalition of Families (MCF) for Children’s Mental Health**, a statewide child and family advocacy group, continues to raise awareness and develop local family support activities. The Coalition’s mission is to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the PBHS. The Coalition participates on more than 22 state and local policy shaping committees. At the current time over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system. MCF established a **Family Leadership Institute (FLI)**, an intensive 60-hour experience which trains parents and caregivers to become more effective leaders and advocates for children with behavioral health needs, locally and at the state level. This training is provided for six weekends over a three-month period. FLI has continued graduating families every year for the last 13 years to become advocates in their communities and in the state. The 13th Family Leadership Institute was held this year with twenty-two graduates, including mothers and fathers, as well as grandmothers, aunts, foster and adoptive parents from across Maryland. This session increased the number of trained family advocates to more than 300 over the period of the Institute’s existence.

In partnership with other federal grants, BHA has supported **Taking Flight**, an MCF program for youth leadership development. It is a youth council comprised of young adult leaders, ranging in ages from late teens to mid-twenties, with backgrounds and involvement in different systems (mental health, foster care, LGBTQ, etc.) who are using their experiences to advocate for positive system changes. A goal of the council is to empower and support young adult transition and to facilitate system collaboration in an effort to promote acceptance and educate the Maryland community in order to reduce stigma. Activities include youth & young adult speaking panels, an annual statewide art project, storytelling training, and collaboration to host an annual Young Adult Leadership Retreat.

Family Psycho-education (FPE) is an approach for partnering with individuals and families to treat serious mental illnesses. FPE practitioners develop a working alliance with individuals and families in the recovery process by providing information on mental illness; assisting helps to build social supports; and enhancing problem solving, communications and coping skills. Three sites are currently implementing FPE. Efforts are underway to explore implementation of EBP-FPE with transition age youth (TAY) programs supported through the Healthy Transitions (HT) and Maryland Early Intervention Program.

The strength of Maryland’s Public Behavioral Health System (PBHS) comes mainly from its long-time collaboration with consumers, family members and advocacy organizations. Therefore, Maryland maintains an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. BHA maintains this focus on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency. Individuals completing the Peer training, serving on the boards, and/or utilizing program services funded by the block grant, such as CPRS, C-CAR, WRAP, transitional-age youth, First Episode and other programs are often asked to act as representatives on workgroups, committees, and councils that inform the system and drive

policy making choices. Maryland's strong, well-developed network of consumer, family, and advocacy participation continues to play an essential role in the ongoing success of the PBHS.

4. RECOVERY AND RECOVER SUPPORT SERVICES FOR INDIVIDUALS WITH SUD

The Behavioral Health Administration funds and provides oversight for eight **Adolescent Recovery Clubhouses** that are located in DC Metro Area, Central, and Southern Maryland. This statewide recovery-oriented support is designed for youth ages 12–17 receiving treatment for substance use disorders, including opioid use disorders, co-occurring (mental health and substance-related) disorders, or following discharge from treatment. Each unique clubhouse uses evidence-based and promising practices to provide screening, intervention, and recovery support to adolescents. Through various approaches to substance use intervention and recovery, the clubhouse's recovery-oriented model supports diminishing the triggers and cues that led to past substance use and engages youth-driven peer activities such as educational/vocational, family events, life skills, recovery planning, and social/recreational opportunities to engage adolescents in more enriching and healthy ways.

The **Maryland Overdose Response Program (ORP)**, a public health initiative providing overdose education and naloxone distribution to community members across the state, has trained over 37,000 Marylanders since its launch in early 2014. The program provides free educational resources for training patients and other laypersons on responding to an opioid overdose with naloxone. The Maryland General Assembly passed a law that went into effect on October 1, 2015 that expanded public access to naloxone. Additionally, if someone is trained, is prescribed naloxone and administers naloxone to someone believed to be experiencing an opioid overdose, they and the prescriber may be protected from civil liability under an existing state "Good Samaritan" law. Licensed physicians or advanced practice nurses with prescribing authority may issue a standing order to delegate the authority for dispensing naloxone to an ORP certificate holder that completes the MDH authorized training.

The Maryland **Linking Actions for Unmet Needs in Children's Health (LAUNCH)** continues to gather data and to implement new programs, many of which are piloted in Prince George's County. Project LAUNCH funds **Community Counseling and Mentoring Services (CCMS)**, which has been implemented as a substance use prevention program. The Program is entitled **Beginning Awareness Basic Education Studies (BABES) World**. BABES World is a primary prevention program designed to give children a lifetime of protection from substance use disorders. BABES accomplishes this by assisting young people to develop positive living skills and providing them with accurate, non-judgmental information about the use of alcohol and other drugs. In FY 2016, LAUNCH collaborated with CCMS to train a cadre of nine staff to implement the 6-week program with 500 children and 20 teachers. Also, CCMS, through Project LAUNCH, funds two full-time Mental Health Consultants who served 30 classrooms, which accounted for 491 children, in FY 2016. Also, funded through LAUNCH, the Prince George's County Child Resource Center hired two full-time Mental Health Consultants who served 11 child care centers, 50 classrooms, and 581 children in FY 2016. Additionally, LAUNCH joined other partners to sponsor the Maryland Coalition for Families an Early Childhood Family

Leadership Institute (FLI) in December of 2016 and the Children's Mental Health Matters campaign in May 2017.

5. HIGHLIGHTS

Peer Recovery Support

Recently OCA has focused on peer certification and is coordinating efforts with the offices of Treatment and Recovery; Forensic Services, Maryland's Commitment to Veterans, and Workforce Development and Training to widen the availability of peer support services to various populations across the state. The OCA and the Office of Workforce Development and Training particularly have been collaborating to successfully implement the process of training and certification for Peer Support.

Maryland's **Certified Peer Recovery Specialist (CPRS) program**, in conjunction with the Maryland Addiction and Behavioral Health Professional Certification Board (MABPCB), provides State certification for individuals who provide direct peer-to-peer support services to others who have mental health, substance use, or co-occurring disorders. The knowledge, skills, and abilities of the core competency curriculum for certification of Peer Recovery Specialists has been established through the initial Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Policy Academy, which was convened in 2013 to support education, planning, and implementation of recovery supports. From the Academy two curricula are used in the certification process: The Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy core training for substance use disorder Specialists and the Wellness Recovery Action Plan (WRAP) facilitators training. The CCAR Recovery Coach Academy® focuses on providing individuals with the skills needed to guide, mentor and support anyone who would like to enter into or sustain long-term recovery from an addiction to alcohol or other drugs; this includes engagement and communication skills. It also prepares participants by helping them to actively listen, ask really good questions, and discover and manage their own issues. WRAP training will continue to be delivered statewide as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement and continue to incorporate WRAP within community mental health programs.

Currently the OCA is working with administrative staff; peer support specialists; community and family members; and stakeholders to deliver endorsement training for CPRS's in specialized areas, such as forensics; child, youth and adolescents; aging; family; and veteran peer support services. The forensics training has already been developed and, since the spring of 2016, has been delivered multiple times. Additionally, incarcerated individuals at Eastern Correctional have been provided training through CCAR, and for those individuals who will remain incarcerated, this training will allow them to serve others seeking recovery within the system. For those who will be transitioning back into the community, this training can be used as a professional development tool. If the individual seeks certification after returning to their community, they already have the knowledge, skills and abilities taught through the Peer

Domain Modules to perform the duties that are assigned to a Peer in any number of community based Wellness Recovery Centers, Recovery Community Centers, and Recovery Wellness Centers. Due to their lived experience, Certified Peer Recovery Specialists (CPRS's) can, with specialized training and guidance, draw from their own journey of recovery to inspire hope and provide support to others who are facing similar situations.

Currently there are 121 Certified Peer Recovery Specialists the state of Maryland. In addition to the workforce of CPRS's developing across all regions of the state, there are individuals in each local jurisdiction that are in varying stages of their certification process seeking training, preparing for the examination, and/or completing required experience hours. Additionally, the OCA is working in partnership with Maryland's Commitment to Veterans to develop cultural competency training and support for veterans/military and their families.

The mental health system has engaged peers in a variety of roles and the substance use disorder field, with the implementation of the **Recovery-Oriented System of Care (ROSC) system**, is carving out a more integrated role for Peer Recovery Support Specialists. The principles of the ROSC approach have been carried forward to include availability of training opportunities for workforces that address recovery-oriented services and supports through efforts such as the establishment of an integrated ROSC Learning Collaborative that involves state agencies, faith-based service providers, behavioral health treatment and recovery support service providers, criminal justice professionals, individuals and their family members. The Peer Integrated Care Advisory Council of Maryland is comprised of consumers of behavioral health services (addictions, mental health, and co-occurring) representing all jurisdictions in Maryland who use their lived experiences to provide feedback to the BHA through the OCA. The Council advises and consults to the OCA regarding policies and procedures that educate, empower and advocate for consumers, including quality improvement initiatives that focus on consumer rights, community building and the promotion of integrated care.

In the spring of 2017 OCA held its third annual Peer Summit of all Certified Peer Recovery Specialists (CPRS) and those seeking certification. The summit brought together peers from mental health, substance-related, and co-occurring disorders and is a team building approach to the unification of peer support throughout the state of Maryland. As a result of the Peer Summit, feedback the State of Maryland is partnering with the University of Maryland in order to diversify peer training initiatives.

Veterans

Maryland's Commitment to Veterans (MCV) provides a confidential forum for veterans and family members to discuss challenges they are facing and links families to needed resources. Regional Resource Coordinators cover the entire state of Maryland and assist approximately 450,000 Maryland veterans and their families in coordinating comprehensive wellness and behavioral health services.

Public Awareness/Education/Training

BHA-sponsored workshop was presented in June 2016, at the Cultural and Linguistic Competence Peer Recovery Support Specialist Training. The workshop, *Building Bridges to Recovery: Delivering Culturally and Linguistically Appropriate Peer Recovery Support Services*, consisted of an in-depth exploration of existing Peer Recovery Support service delivery models and core competencies and included a discussion on the continued development of cultural and linguistic competence in recovery-oriented services. Attendees consisted of Peer Support Specialists across the state.

In FY 2017-18 BHA will continue to support the **National Alliance on Mental Illness of Maryland's (NAMI MD)** public education and training efforts. NAMI is an approved trainer of the Maryland Addiction and Behavioral-health Professionals Certification Board (MABPCB) for the four domains of Peer Support certification - Advocacy, Ethics, Mentoring and Education, and Recovery and Wellness.

September is SUD Recovery Month, which is highlighted with recognition from the Governor through proclamation as an opportunity to share both individual and family member recovery experiences, as well as the presentation of workshops. The FY 2017 Recovery Day workshop, ***Faces and Voices of Recovery Your Story Has Power***, was a focused advocacy training on sharing recovery messages with the community and engaging in media interviews on topics related to personal recovery. Participants left with a better understanding of how to tell a dynamic and inspiring message based on their lived experience in recovery.

An Emotional Wellness Campaign was developed to expand outreach and disseminate the message that resilience and emotional wellness is a vital component of overall well-being at every stage of the lifespan. In FY 2017, the campaign tools were developed to assist the public to easily identify with awareness activities similar to those employed by anti-smoking campaigns, such as logos and taglines, etc. This included the creation of The Lifespan Resilience poster, which will accompany various applications of the core concepts of resilience that can be used by individuals across age groups. The poster is set for a fall distribution via campaign partnerships that include Behavioral Health Integration in Pediatric Primary care (B-HIPP), Maryland Coalition of Families (MCF), Mental Health Association of Maryland, Inc. (MHAMD), and the Children's Mental Health Matters Campaign, among others.

The **"Children's Mental Health Matters"** public awareness campaign is a highly successful project of Maryland Coalition of Families (MCF), held jointly with the Maryland Mental Health Association, a volunteer nonprofit citizen's organization that brings together consumers, families, professionals, advocates, and concerned citizens for unified action. This annual project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, provide an overview on issues such as

bullying, and garner public support for innovative system development through a major public awareness campaign.

Evidence-Based Practices

Evidence-Based Practices (EBPs) refers to a specific practice or service that consists of a set of standardized, replicable interventions for which rigorous scientific research exists to demonstrate the effectiveness of the interventions when implemented as designed in achieving meaningful, positive outcomes for individuals who have received the service. The successful implementation of EBP program fidelity is measured by a scale which assesses the degree to which the services adhere to the core principles and essential program elements of the practice which have been shown by research to be critical to the effectiveness of the service. EBP programs that have been rated high in fidelity on an empirically-validated fidelity scale by trained fidelity evaluators have been shown to achieve superior outcomes relative to those programs that have been rated low in fidelity.

Maryland's BHA, in partnership with the University of Maryland School of Medicine, Department of Psychiatry, **Evidence-Based Practice Center (EBPC)** promotes, monitors, and evaluates the development and implementation of EBP programs and services. The EBPC, which is funded through the federal mental health block grant, is in the 13th year of active implementation of Evidence-Based Practices (EBPs) for adults. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Additionally a Co-Occurring Disorders Specialist is working to move the system towards Dual Diagnosis Capability, and is also monitoring the activities of two programs implementing Integrated Dual Disorders Treatment. Recently, efforts have been implemented to improve services for Transition Age Youth and Older Adults. Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by the BHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score minimum thresholds on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate. Training, technical assistance and consultation is also provided to programs interested in implementing one of the models.

Tracking, Measuring and Evaluation

Consumer feedback in service delivery is valued throughout Maryland's system of care. One approach in obtaining this feedback is through the **Consumer Quality Team (CQT)**. CQT is dedicated to improving quality oversight of the public behavioral health system. CQT is a consumer/family-run organization, authorized by BHA, and funded in part through this block grant, to conduct site visits (announced and unannounced) of programs in the public mental/behavioral health system. CQT obtains first-hand information from consumers about their experiences in programs and state hospital settings and takes an active role in addressing issues directly at the program level and, as needed, at other system levels. Through monthly and quarterly meetings, information is shared via Site Visit Reports and regular Feedback Meetings.

In FY 2014, efforts were implemented to begin site visits to Residential Treatment Centers (RTCs) for youth. Interviews were conducted with young people and their families. In FY 2015 more than 500 individual requests were addressed through the CQT process. Site visits included: Ninety-five (95) psychiatric rehabilitation programs (PRPs), thirty-three (33) inpatient adult units, and all the units in eight (7) youth RTCs. CQT also began conducting Housing Surveys with consumers in PRPs during FY 2014 as part of the State's Hospital Discharge Initiative. These surveys were conducted with consumers to address feedback on housing and living preferences in the community. Highlights of what consumers across Maryland identify as key trends and issues are reported in CQT's Annual Report: www.cqtm.org. Both consumers and program staff have recognized significant program changes made as a result of the reports.

The **Outcomes Measurement System (OMS)** collects information and data from individuals in outpatient settings in areas such as living situation, school attendance, health status, and satisfaction with recovery. Based on self-reports, this information is captured and reported monthly on OMS' public Web-based DataMart. OMS data has also been monitored as it relates to individuals with co-occurring substance-related and mental health disorders.

A statewide client perception of care survey of adults and parents/caretakers of children and youth, regarding their experiences with PBHS services, is conducted annually. The survey includes results such as the percentage of adult consumers who report that they deal more effectively with daily problems or percentage of parents/caretakers who report that their child is better able to control his/her behavior. The percentages are based on answers of respondents who agree and strongly agree with survey questions. Survey results are included in BHA's Managing for Results (MFR) submission.

Maryland RecoveryNet (MDRN) and State Care Coordination both also utilize a Satisfaction Survey. Those results are maintained by the respective program leads. Both programs require providers to collect satisfaction data at scheduled intervals or upon discharge from the program.

In addition to capturing numbers of individuals served and the utilization of specific services such as inpatient, outpatient, psychiatric rehabilitation, case management, etc., BHA also takes note of: the increased number of individuals employed each year from the evidence-based initiatives such as Supported Employment (SE) and Ticket to Work; the number of people moving out of residential rehabilitation programs (RRPs) into the community; the number of people receiving services from peer specialists; and the number of people placed into affordable/supportive housing through MDH Community Bond and other housing initiatives.

Conditions of Awards for Wellness and Recovery Centers require a specified number of outreach sessions to consumers in hospitals, outpatient mental health centers and other sites that provide mental health services. These results are reported back to the Core Service Agencies/Local Behavioral Health Authorities. Often the feedback to BHA is anecdotal. Advocacy organizations such as OOOMD collect stories and interviews from individuals served

in the system that are shared through the Web sites to encourage and inform the public and involved participants.

The **Maryland Behavioral Health Advisory Council** has also been a forum for positive and useful feedback from consumers and advocates for the system. Its committee structure connects with the Administration and encompasses areas of prevention, planning, behavioral issues across the lifespan, criminal justice, and cultural competence. In several instances, over the years, an issue was brought up in the Council meeting and then shared with system leadership/staff to be addressed/resolved.

Health and Wellness and Prevention

As part of Maryland's commitment to wellness and prevention, BHA promotes and maintains strategies to enhance tobacco-use quit rates among individuals in the behavioral health system as well as staff in behavioral health treatment services settings. Expanded training of behavioral health treatment agency staff and treatment providers continues in order to promote and facilitate the provision of smoking cessation classes and guidance for nicotine reduction to individuals with mental health and substance-related disorders. Smoking cessation services and pharmacotherapies are being provided as a component of providers' therapeutic services. BHA continues its collaboration with **Maryland Quitting Use and Initiation of Tobacco (MDQuit) Resource Center**, whose mission is to link professionals and providers to state tobacco initiatives, to provide evidence-based, effective resources and tools to local programs, to create and support an extensive, collaborative network of tobacco prevention and cessation professionals, and to provide a forum for sharing best practices throughout the state of Maryland. MDQuit utilizes tools and resources, such as use of nicotine replacement therapy (NRT), medications, and referrals to Maryland Quitline. BHA collaborates with the MDH Prevention and Health Promotion Administration (PHPA), the Center for Tobacco Prevention and Control (CTPC), other public health and somatic care agencies, and community-based organizations to expand public awareness of available smoking cessation services for individuals with behavioral health disorders.

Maryland provides support to the statewide **National Alliance on Mental Illness of Maryland (NAMI MD)** organization and its local affiliates. NAMI adheres to the concept that empowering family members and consumers is a critical factor in recovery and provides education and outreach programs, trainings, advocacy, and support. BHA worked successfully with NAMI MD in promoting a kick-off event for NAMIWALKS, a successful annual event that promotes MAY MENTAL HEALTH MONTH. NAMI MD has developed a strong Family-to-Family Education presence in the state. The **"In Our Own Voice"** program is an informational outreach program on recovery. **"Peer-to-Peer"** is a unique, experiential learning program for people with serious mental illness, who are interested in establishing and maintaining their wellness and recovery. Also, NAMI MD has two initiatives to support the integration of physical and mental health – NAMI MD's **"Healthy Hearts and Minds"** education program as well as an information dissemination project.

Accreditation

Beginning January 2018 under new BHA regulations all programs must be licensed to provide community behavioral health treatment, care, or rehabilitation services. All accreditation-based programs must have accreditation from a MDH approved accreditation organization. The following programs will be required to have an accreditation-based license:

- Group Homes for Adults with Mental Illness programs;
- Integrated Behavioral Health programs;
- Intensive Outpatient Treatment Level 2.1 programs;
- Mobile Treatment Services (MTS) programs;
- Outpatient Mental Health Center (OMHC) programs; Outpatient Treatment Level 1 programs; and Partial Hospitalization Treatment Level 2.5 programs.

Most programs will need to be accredited in order to be licensed, however there are a few program types that must be licensed but do not require accreditation. To operate in Maryland the following programs need to have a valid and current non-accreditation-based license to provide community-based behavioral health services:

- Substance-Related Disorder Assessment and Referral Programs;
- DUI Education Program; and
- Early Intervention Level 0.5 programs.

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

- Does the state's Olmstead plan include :
 - housing services provided. Yes No
 - home and community based services. Yes No
 - peer support services. Yes No
 - employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No

- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Individuals who are ready to be discharged from the state hospitals are being prioritized for transitions into programs overseen by the department such as Residential Rehabilitation Program, Capitation, and Housing First Pilot Program. The State has also adopted the Housing First and Permanent Supportive Housing to ensure individuals have a choice of where they would like to live and what services they would like to participate in.

Does the state have any activities related to this section that you would like to highlight?

Housing First Pilot Program:

The Behavioral Health Administration (BHA) in collaboration with the local behavioral authorities in Baltimore City, Montgomery, and Prince George's counties to serve individuals who are homeless or at risk for homelessness, discharged from a state psychiatric hospital, or transitioning from RRP to find permanent housing.

Community Bond:

BHA prioritizes applications for state community bond which expands the capacity for permanent supportive housing throughout the State. Entities who apply for the assistance in creating and/or expanding permanent affordable housing for individuals, prioritize individuals who are transitioning from institutions and residential rehabilitation programs.

811 via Maryland Partnership for Affordable Housing:

The Department of Health/BHA partners with the Department of Disabilities, Maryland's Housing Finance agency, the Maryland Department of Housing and Community Development in administering the Harry and Jeanette Weinberg Housing Opportunities

Initiative for Persons with Disabilities and US Department of Housing Urban Development's Section 811 Project Rental Assistance Demonstration. This program links individuals who are transitioning from institutions or at risk of institutionalization or moving to independent renting or homeless as defined by HEARTH Act to permanent housing.

Please indicate areas of technical assistance needed related to this section.

No assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? j n Yes j n No
 - The recovery and resilience of children and youth with SUD? j n Yes j n No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? j n Yes j n No
 - Juvenile justice? j n Yes j n No
 - Education? j n Yes j n No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? j n Yes j n No
 - Costs? j n Yes j n No
 - Outcomes for children and youth services? j n Yes j n No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? j n Yes j n No
 - Mental health treatment and recovery services for children/adolescents and their families? j n Yes j n No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? j n Yes j n No
 - for youth in foster care? j n Yes j n No

- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

BHA has reorganized and renamed its organizational unit for child and adolescent services. This unit is now called the Office of Child, Adolescent and Young Adult Services. Responsibilities for oversight of substance use disorder services for this age group have been added to the charge of the office, as have responsibilities for young adults and First Episode Psychosis programs.

The Children's Cabinet- Maryland's Interagency System of Care

Maryland's interagency system of care is guided and operationalized by the Children's Cabinet. The Children's Cabinet was originally created in 1987 by the Governor as the Subcabinet for Children and Youth. It was renamed the Subcabinet for Children, Youth, and Families in 1990. Established by statute in 1993, the Subcabinet worked to improve the structure and organization of State services to children, youth, and families (Chapter 556, Acts of 1993). Authorization for the Subcabinet expired June 30, 2005, and in its place, the Governor authorized the Children's Cabinet in June 2005 (Executive Order 01.01.2005.34).

The Children's Cabinet has seven ex-officio members. The Executive Director of the Governor's Office for Children chairs the Cabinet. Cabinet Secretaries from the following departments sit on the Children's Cabinet: Department of Budget & Management; Department of Disabilities; Department of Health; Department of Human Services; Department of Juvenile Services; and the Department of Education.

Eight goals for child well-being have been set for the Governor's Office for Children by the Children's Cabinet. They are defined

as:

- 1) Babies Born Healthy;
- 2) Healthy Children;
- 3) Children Enter School Ready to Learn;
- 4) Children Successful in School;
- 5) Children Completing School;
- 6) Children Safe in their Families and Communities;
- 7) Stable and Economically Independent Families; and
- 8) Communities that Support Family Life.

In April 2015, the current Governor assigned four initiatives to the Office for Children. The Governor's charge was to reduce the impact of parental incarceration on children, families, and communities; improve outcomes for disconnected youth; reduce childhood hunger; and reduce youth homelessness.

Out of State Placements

An excellent example of the effectiveness of the Children's Cabinet occurred earlier this year when the Comptroller of the State identified that the child welfare agency had placed a number of children with developmental disabilities in numerous out of state placements where there were questions about the quality of care delivered. The Children's Cabinet was mobilized to return all of these children to placements within the State in a short period of time, but more importantly to establish protocols to avoid future placements of this nature.

Given the established history of high level executive oversight and interagency coordination provided by the Children's Cabinet, Maryland has gained extensive experience in developing a system of care specifically for youth and young adults with emotional disabilities and substance use disorders. Our state was one of the first four states to be awarded a grant under the inaugural SAMHSA CMHI program in 1993. The resulting program, the East Baltimore Mental Health Partnership, was a significant watershed for system of care development for children and youth in our state. Similarly, our state was selected in the first cohort of awardees for the SAMHSA Healthy Transitions Initiative in 2009, a grant program that was the first federal initiative for system of care development for transition aged youth and young adults with emotional disorders.

SAMHSA System of Care Grants

The system of care philosophy and approach in Maryland has firmly taken root and grown exponentially from these early endeavors using initial SAMHSA funding and support. At the time of this writing, one third (8) of Maryland's 24 jurisdictions are actively involved in SAMHSA funded system of care development projects, included three jurisdictions that are simultaneously working on separate projects for very young children and for young adults.

Description of the Major State Level Agency Partners in the System of Care

- Department of Human Services – (social services including child welfare) - The social service sector in Maryland is primarily housed in the Department of Human Services (DHS). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, and formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. Other DHS social services, outside of child welfare, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers).

Of special note is a program entitled Mental Health Supportive Services (MHSS) that is funded through the DHS to local jurisdictions for Mental Health Mobile Crisis and Stabilization Services. DHS and BHA monitor these services that are designed to support foster care youth in their placements, and to avoid hospitalizations. Improved outcomes have been documented in the areas of a reduction in acute admissions, and disrupted placements. Due to these successes, some of the funding through MHSS has now been able to be used for family support services, prevention of foster care placements, and education. This has also allowed mental health to provide early intervention services for identified youth, while still being able to respond to mobilize services during times of crisis.

- Maryland State Department of Education (MSDE)

MSDE and the BHA have worked on integrating School Based Mental Health (SBMH) services since the 1990's. The Center for School Mental Health (CSMH – located at the University of Maryland -Baltimore, is a nationally funded center for TA for school-based behavioral health services. These efforts also include a focus on early childhood mental health and school readiness. Through these partnerships the CSMH, MSDE, and BHA has been supported in successfully applying for a number of grants that serve to improve SBMH services across Maryland. There has also been the development of a number of Children's MH on-line modules that are geared to school personnel. As systems become more integrated, there is the recognition that substance use services, along with mental health, need to be available through local school districts. Planning and decision making efforts are now in process regarding the components of an integrated behavioral health SOC as it relates to educational settings.

School-Based Behavioral Health Interventions - To address the need for multi-system involvement due to the high number of children and youth who are frequently involved in more than one specialized system, the state is working to strengthen the connection between available behavioral health services, and recovery support services and educational services in the Maryland public school system. The BHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). BHA and MSDE collaborate to provide services to

children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. Additionally, the mental health block grant supports school-based mental health initiatives that foster diversion to hospitals and RTC's, as well as funding that address school expulsion and bullying.

Additionally, school-based behavioral health interventions are available in Maryland along with more comprehensive School Wellness Centers that provide somatic and behavioral health services to students will be expanded and made available in school settings across the State. The University of Maryland, School of Medicine will partner with the BHA and provide technical assistance for the development of school mental health services. In addition, Maryland has made a significant investment in early childhood mental health by focusing on mental health programs placed in Head Start Centers that will provide mental health consultation to day care center staff around the State. The day care mental health services efforts were developed to prevent the unnecessary expulsion of young children from child care settings because of perceived behavioral problems.

• Department of Juvenile Services

The Behavioral Health Administration and the Department of Juvenile Services (DJS) have a history of cooperation at State and local levels to support behavioral health services to DJS youth in need of these services. These behavioral health services focus on the needs of youth in the care of DJS both before and after adjudication and disposition by the juvenile court.

BHA promotes behavioral health services by supporting substance use counseling within the juvenile detention centers. The BHA Child and Adolescent (C&A) staff provide training for DJS direct care staff on an as needed basis. The BHA Psychopharmacology Learning Collaborative continues working with psychiatrists who provide services to youth in the juvenile justice system to assess the use and administration of psychotropic medication to youth in DJS custody.

Given the prevalence of behavioral health problems in youth with DJS contact, as well as concerns youth with behavioral health problems may be at higher risk for DJS contact, BHA has extended the partnership with DJS to include substance use disorder services consistent with the new charge of the unit. DJS and BHA will develop and implement additional treatment and related recovery supports, for individuals with DJS involvement, including early diversion from juvenile justice and criminal justice systems as appropriate. These developments will be planned, monitored and evaluated collaboratively by DJS and BHA in phases over the next three years.

Does the state have any activities related to this section that you would like to highlight?

Early Childhood Mental Health Services

Maryland supports programs and activities for children with SED by applying available funding for prevention and treatment for SED's in early childhood, as most mental health disorders have their roots in childhood. The main strategy is to incorporate mental health services into existing early childhood programs and other community settings for infants and children up to 5 years of age. The mental health component of the Maryland Infant and Toddler Program provides services for young children is continually strengthened by activities part of the Early Childhood Mental Health Initiative which supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

Maryland Project LAUNCH

Maryland is in the final phases of implementing LAUNCH (Linking All Unmet Needs in Children's Health) a five-year grant awarded to MDH and the BHA by SAMHSA is a comprehensive early childhood intervention strategy designed to coordinate key-child-serving systems and integrate behavioral and physical health services to ensure that children are able to thrive in safe, supportive environments and enter school ready to learn in the pilot community of Prince George's County. The population served by this grant are children from birth to 8 years living in Prince George's County within an identified Transforming Neighborhood Initiative Area. Maryland LAUNCH will establish State and Local Young Child Wellness Councils promote infrastructure develop at the local and state level. In addition, Maryland LAUNCH will provide training on developmental screening and assessment tools for primary care providers, early childhood educators, and home visiting programs. The project has successfully placed mental health consultants in early child care and education settings through a partnership with community Counseling and Mentoring Services. The Maryland LAUNCH grant provides support for the following efforts:

- To enhance the collaboration among State and local child-serving agencies;
- Increase the use of early screenings, assessments, and mental health consultations in a range of early child care and educational settings;
- Increase integration of behavioral health and primary care;
- Enhance home visiting with an emphasis on social and emotional development supports;
- Provide family strengthening and parent skills training to parents and families;
- Provide training on developmental screening and assessment tools for primary care providers, early childhood educators, and home visiting programs; and
- Mental health consultation capacity will be enhanced by hiring master's level early childhood mental health consultants to work in a variety of settings. Primary care providers will be trained in identifying and referring children with developmental concerns to

appropriate services to better coordinate behavioral and primary care.

Family strengthening programs will be expanded to reach families receiving mental health consultation services to those involved with or at risk for involvement with the child welfare system

Adolescent Treatment Grant—MD BHAY

A CSAT Adolescent Treatment grant was awarded to the State for FY15. This grant is being used to pilot evidence-based substance use prevention, treatment, and recovery services. Substance use services have been placed in schools in Baltimore County and Baltimore City. MD-BHAY is designed to bring innovative treatment services to adolescents and transition-age youth (TAY), ages 12-24, with either a substance use or co-occurring disorder (COD). The project will initially be piloted in two schools and two community-based health clinics, and then expand to at least two additional schools and clinics by the completion of the grant.

The project will also enlist stakeholders and critical partners as it seeks to develop integrated approaches to sustainable financing, and also to support the dissemination of evidence-based practices to treat these populations. The project is located at The University of Maryland's School of Medicine's Center for School Mental Health. Additional project partners include the University of Maryland, Department of Psychiatry, the Epoch Counseling Center, Harbel Community Organization, Chestnut Health Systems, and Maryland Coalition of Families for Children's Mental Health. MD-BHAY is designed to increase access to and improve the quality of treatment for youth, ages 12-24, with substance use and co-occurring substance use and mental health disorders. Due to chronic systemic gaps in care and recovery supports for this population, MD-BHAY this project is enhancing statewide infrastructure, delivering evidence-based treatment in school and community settings, and developing funding and delivery mechanisms to sustain these changes.

Transitional Age Youth

For youth and young adults, individuals between the ages of 16 and 25 years, transitioning into adult responsibilities, negotiating between the child-and adult serving systems requires additional coordination. Maryland had developed many partnerships between community agencies and mental services to make the process of transitioning between child and adult services more manageable. Transitional care and services provided by Maryland for children with SED in the following settings are available for those moving between institutions and the community, from one educational setting to another, in-home to out-of-home placements, as well as from out-of-state to in-state placements. As special efforts are underway with residential providers in state to reduce the utilization of out of state placements, which has been showing a downward trend over recent years. As stated earlier, Maryland's 1915(i) program is designed to help address transitions that youth, young adults and their families may encounter through an array of services developed to address the unique challenges for individuals who are not fully participants in adult programs. The specific needs of this population transitioning into adulthood can include co-occurring disorders, developmental disabilities, traumatic brain injury, somatic conditions, and also involves needs for LGBTQ youth and young adults; justice-involved youth and young adults; homeless youth and young adults; and youth and young adults in the deaf and hard of hearing community. The following programs and grant-funded efforts address issues related to supported services important for youth transitioning into the community.

Maryland Healthy Transitions (MD- HT) Grant

Maryland has received a Healthy Transitions grant from SAMHSA, building on considerable joint efforts between the offices of adult services and child and adolescent services to address the special needs of the emerging adult population. Responsibility for this grant was recently transferred to the newly reorganized Office of Child, Adolescent and Young Adult Services The Maryland Healthy Transitions (MD-HT) project will seek to raise awareness of the mental health challenges faced by transition-aged youth (TAY) age 16-25, increase the early identification of mental health conditions among TAY, and provide services and supports to meet the needs of TAY as they transition into adulthood.

The MD-HT project was developed in full partnership with two communities in Maryland, where two local laboratories will be located, Howard County and the Southern Maryland Tri-County region. Collaborative support will be provided by consumers, youth, and families and multiple local and state agencies and stakeholders. Additional partnerships have been established between BHA, The Howard County Mental Health Authority and the Charles County Core Service Agency (CSA), two provider agencies, Humanim, Inc. and Pathways, Inc., The University of Maryland School of Medicine, Evidence-Based Practice Center (EBPC), The University of Maryland School of Medicine, Department of Child and Adolescent Psychiatry, On Our Own of Maryland (OOO-MD); The Governor's Interagency Transition Council (IATC), and The Maryland Early Intervention Program (EIP). Other grant initiatives are Project AWARE and Systems of Care. The project will utilize collaborations and partnerships to leverage a solid infrastructure within Maryland's child and adult public health systems to meet project goals.

MD-HT will utilize Maryland's past and current TAY initiatives which include strategies such as family and youth involvement, evidence-based practices, several methods for improving access to care, as well as policy changes at the state and local level. Supported Programs that serve TAY in a successful transition into adulthood include: Supported Employment, Assertive Community Treatment, and Family Psychoeducation that. Through these supported services, the MD-HT will serve 60 youth in the FY20--, and approximately 80 youth per year thereafter for a total unduplicated count of 380 individuals.

Consumer and Family Collaborative Initiatives

As discussed earlier, a partnership with On Our Own (OOOMD) and the Maryland Coalition of Families (MCF) around young adult leadership development has been very successful in developing increased availability of peer support for young adults and opening channels for young adult voices to be heard. OOOMD's Director of Network and Peer Services provides oversight to the activities of the Statewide Consumer Network Grant Project, technical assistance to local Wellness & Recovery Centers, Transition

Aged Youth outreach, and liaisons with local and state agencies. The Director was also a recipient of SAMHSA's Young Adult Advocate Voice Award (2013). In collaboration with BHA, OOOMD, implements the Transitional Age Youth Outreach Project. The TAY Project is an initiative of On Our Own of Maryland which introduces young adult peer with lived experience with mental health or substance use systems to the peer support, policy, and advocacy fields. The project coordinates and hosts events, support groups, leadership opportunities and trainings for and by young adult consumers throughout the state with the end goal of developing a sustainable young adult network within the peer education and advocacy network of OOOMD. Upcoming efforts include a Young Adult Peer Support & Leadership Retreat. The goal of this retreat is to further support the young adult peer network within Maryland, and to provide leadership skill-building and training on advocacy and wellness issues of interest to young adults. The leadership retreat will host 40-50 young adults ages 18-29 who are peer advocates within programs across Maryland including The Healthy Transitions Initiative, the OOOMD and MCF networks and others that support young adults with behavioral health experiences. The retreat center will provide a number of team-building activities including ropes courses, games, zip-lines, rock-climbing, yoga, and many other activities. Workshops and activities supporting topics such as Leadership Skills, Social Justice through Art, Becoming an LGBTQ Youth Ally, and Storytelling in Peer Support & Advocacy will be led and facilitated by peers in all of the participating programs.

Other collaborative efforts that support youth involvement and activities include:

Taking Flight: Maryland Coalition of Families for Children's Mental Health Young Adult Council

This grant is intended to cultivate a group of young adult leaders who work to empower and support young adult transition and to facilitate system collaboration in an effort to promote acceptance and education and reduce stigma. Housed within the Maryland Coalition for Families, it works closely with other young adult peer efforts in the statewide consumer organization.

What Helps What Harms Maryland Initiative

What Helps, What Harms Maryland is a year-long project initiative recently launched by OOOMD's T.A.Y. Project in partnership with Maryland Coalition of Families' Taking Flight, which will infuse the youth and young adult voice into strategic policy actions and planning structures for systemic change in the state of Maryland. As we have the full support of the Behavioral Health Administration (BHA), the project will use the information obtained during these groups to leverage the young adult voice and include its insight in service planning for the behavioral health service system in Maryland. Discussion forums will be held with young adults, ages 18-29 years old, who have and/or are receiving services in any Maryland service system.

What Helps What Harms is an initiative developed for young adults to spend time with one another in facilitated discussions that allow them to analyze their community network, resources, services, and environment. The discussion prompt will be simple so that the conversation remains truly directed by the young adult participants. It will ask "Of all the systems you have been involved with (education, mental health, physical disability services, juvenile justice, peer-run services, employment services, etc.) What about its set-up, services, and service delivery has helped you to move forward into adulthood, to achieve recovery and other related positive issues. Similarly, it asks what has harmed you or created barriers for you moving forward, and what changes would you make that would benefit you in reaching your goals and becoming who you want to be.

7. Does the state have any activities related to this section that you would like to highlight?

Prevention Initiative for Youth Through Maryland's Opioid Rapid Response (M.O.R.R.)

Student Assistance Program (SAP) Teams

Youth and their families are a priority and a critical component of our State's proposed plan to address the opioid crisis. Specifically, we propose to augment our existing efforts to prevent, treat, and recover from Opioid Use Disorder via the use of prevention, early identification and intervention, and recovery support for our child and adolescent population through implementation of Student Assistance Program (SAP) teams in targeted areas. The goal is to provide training to SAP Team Members to support the development of their skills to identify, provide brief intervention, and make referrals to community based behavioral health providers. This work will be done in a manner that will address health disparities and maintain cultural and linguistic competence. We propose to provide SAP Teams and school support personnel with a series of online and in-person trainings using the train-the-trainer model to support sustainability beyond the grant period.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? j n Yes j n No
2. Describe activities intended to reduce incidents of suicide in your state.
Statewide Suicide Reduction Initiatives

There are several activities and initiatives highlighted that are intended to reduce incidents of suicide in the State of Maryland.

MD-SPIN

MD-SPIN is a five-year, SAMHSA-funded program created by The Maryland Department of Health (MDH, formerly DHMH), Behavioral Health Administration (BHA), with a grant from the Substance Abuse and Mental Health Administration (SAMHSA), provides suicide prevention training and technical assistance to advance a comprehensive suicide prevention and early intervention service system for youth and young adults, ages 10 to 24. MD-SPIN is implementing Kognito gatekeeper training for K-12 teachers, counselors, administrators, nurses and other staff, higher education faculty, staff and students, primary care providers, and families of veterans to help with identifying, approaching, and referring youth and young adults, ages 10-24, who are exhibiting signs of psychological distress. The goal is to train the gatekeepers in these settings to prevent suicidal ideation/suicide attempt. MD-SPIN team members continue to work with schools; higher education campuses; staff and students; primary care providers; and families of veterans.

Ask Suicide Questions (ASQ)

The ASQ (Ask Suicide Questions) screener is being implemented in pediatric emergency departments (Johns Hopkins Hospital, Johns Hopkins Bayview Hospital, University of Maryland Medical Center Hospitals, and Kennedy Krieger Institute). ASQ is a recently developed, non-proprietary instrument to screen for suicide risk during the ED triage phase with patients ages 10-21 years. The pediatric ED at Johns Hopkins Hospital has agreed to make the ASQ a universal screening tool and the University of Maryland Medical Center (UMD) has implemented the ASQ for patients with a chief psychological complaint as of July 2015. The MD-SPIN ED team continues to reach out to additional EDs to obtain interest and participation in implementing the ASQ.

Maryland Crisis Hotline

One of the major goals of the FY 2015 plan was to create a social marketing campaign to promote the Maryland Crisis Hotline. The Maryland Crisis Hotline (formerly the MD Youth Crisis Hotline) is staffed and available 24 hours per day, seven days a week, and 365 days per year to Maryland residents experiencing a mental health crisis. A marketing campaign developed to raise awareness of the Hotline to the general public to the change of the hotline from being youth-focused to service members across the lifespan. Since then, the Hotline has increased in capacity and now serves all Maryland residents. The hotline is publicized at health fairs, community fairs and activities, professional/consumer conferences, etc. to make consumers and providers aware of the hotline and increase knowledge of the hotline among individuals who may be having suicidal ideation.

"There is Hope" App

The implementation of an App called "There is Hope," which provides users with suicide prevention information, and a link to the Maryland Crisis Hotline will continue to increase and broaden the public's awareness of suicide as a major public health issue.

Suicide Prevention Conference

MD-SPIN team members will again participate on the Behavioral Health Administration Suicide Prevention Conference planning

committee to assist in planning the October 4, 2017, suicide prevention conference.

Legislation

Lauryn's Law (originally passed in 2015), requires school counselors seeking certification or renewal in Maryland to have the skills to understand and respond to indicators of mental illness and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse, as well as to identify resources to help students in crisis. The Law was expanded in 2017 to include all K-12 teachers. Teachers will be required to receive suicide prevention training every year beginning July 1, 2018. The Maryland State Department of Education is currently working to develop policies for this law.

Partnerships

Maryland will adopt and use several frameworks across various settings to eliminate suicide in the state. As participants in the Zero Suicide Academy, training was provided which resulted in the development of a Framework based on a partnership between the Suicide Prevention Resource Center (SPRC), National Action Alliance for Suicide Prevention, Substance Abuse Mental Health Services Administration (SAMHSA).

FY2016 Suicide Prevention Plan (See Attached): Suicide Reduction Initiatives/Strategies

The Suicide Commission's initial Suicide Prevention Plan, submitted to the Governor in 2012, updated in 2016 created new statewide initiatives to address current needs and promote activities intended to reduce incidents of suicide in the state of Maryland. The plan, in effect for two years, was been updated in 2016 will be used to guide suicide prevention efforts over the next two years. All of the strategies and initiatives included in the FY2016 Suicide Prevention Plan follow the Public Health Model, and operate at the following three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated subpopulation.

The FY2016 Suicide Prevention Plan addresses the following four goals:

1. To increase and broaden the public's awareness of suicide
2. To enhance culturally competent, effective, and accessible community-based services and programs;
3. To assure effective services to those who have attempted suicide or others affected by suicide attempt or completion.
4. To use existing suicide data sources to identify gaps in services and to guide ongoing intervention efforts.

The FY2016 Suicide Prevention Plan recommends the following strategies to reduce incidents of suicide in the state of Maryland:

RECOMMENDED STRATEGIES

Strategy 1: Utilize various state data sources of suicide information on ideation, attempts, and death to gain a deeper understanding of the services gaps in Maryland, as well as to guide prevention and intervention efforts. In addition to identifying existing data sources, the State will collaborate with the Maryland Violent Death Reporting System to acquire data to understand circumstances around suicide deaths. The State will also connect with local school jurisdictions to examine ideation data among youth (attempts/gestures) and use data from local suicide prevention research at various universities to guide best practices in Maryland. The data from calls to the MD Crisis Hotline will be used to inform targeted initiatives.

Strategy 2: Recognize and address the needs of high-risk populations, such as:

- a. Disconnected youth
- b. Bullying victims (school and workplace)
- c. Individuals with substance use disorders
- d. Unemployed, middle-aged males
- e. Older adults

The needs of these and other high-risk populations should be addressed across prevention, intervention, and postvention services through a three-step process which should include:

- Research and identification of risks and needs;
- Identification of Evidence Based or Promising Practices that are specific to those needs; and
- Utilization of research to identify other special populations who may be at high risk.

Strategy 3: Identify opportunities to improve behavioral health workforce, as well as gatekeepers, school staff, and healthcare workers throughout Maryland on suicide prevention and intervention strategies. Increased training opportunities remains a major priority for Maryland and a major part of the Zero Suicide framework. Collaboration opportunities with other state agencies and initiatives will be key in pushing this initiative forward. Other priorities will include increasing the adoption and uptake of

Kognito Gatekeeper Training Program for school staff, veterans, LGBTQ youth, and university faculty and students and expanding the training of pediatric emergency department staff of screening, assessment, and follow-up of individuals who report a chief complaint of psychological distress. We will continue the promotion and training of Mental Health First Aid throughout Maryland and identify new Evidence-Based training opportunities for BHA staff and Maryland residents.

Strategy 4: Develop more opportunities to engage and support Maryland residents with lived experiences of suicide (attempt and loss survivors). It is strongly felt that individuals with lived experience should be more involved with state suicide prevention efforts and maintain continued support through behavioral health services. To accomplish this the State will enhance and expand existing support groups for loss and attempt survivors and collaborate with groups such as the Maryland Coalition of Families to work with youth and young adults who have lived experiences with suicide and provide supports to those individuals. In addition, feedback from those with lived experience will be used to help guide Commission initiatives. Evidence-based intervention strategies, such as the Sources of Strength project, will be utilized to aid individuals in their recovery.

Strategy 5: Expand suicide prevention outreach efforts and education to more rural sections of the state, such as the Eastern Shore, Western Maryland, and Southern Maryland. The less-populated regions of the State have different needs, infrastructure, and geographical design than the other more urban parts of the State, therefore, we will make a more consistent effort to engage these regions in the State's suicide prevention efforts. To do this we will increase our collaboration with Core Service Agencies in these areas and reach-out and engage local behavioral health community and faith-based organizations. Furthermore, we will connect with local hospitals to increase access to screen, assessment, and follow-up provided by their emergency departments for individuals who come in with a chief complaint of psychological distress.

Strategy 6: Increase and broaden the public's awareness of suicide as a major public health issue through various means. To increase the public's awareness we will advance the previous success of the marketing campaign through the development of online videos that promote the Maryland Crisis Hotline, which can be viewed on YouTube and the BHA website; disseminate print materials; continue to promote trainings and other local events through Facebook and Twitter; and provide resources to youth and parents related to cyber-bullying and social media threats.

Strategy 7: Collaborate with other state agencies and departments recently funded through SAMHSA grants in the area of behavioral health. Collaborating with other state agencies and departments through sharing of resources, training opportunities, and sharing information across multiple grants will help us reach our individual grant goals, as well as, help to improve the mental health status of Maryland residents. These grants include:

- Maryland's Suicide Prevention and Early Intervention Network (MD-SPIN), which provides suicide prevention training, resources, and technical assistance to advance a comprehensive suicide prevention and early intervention service system for youth and young adults, ages 10 to 24. The purpose of MD-SPIN is to reduce the premature loss of lives from suicide by increasing the number of at-risk youth who are identified, referred, and receive quality behavioral health services. High-risk populations of focus include LGBTQ, transition age youth, veterans and military families, and youth with emotional and behavioral concerns. Target settings are schools, colleges/universities, juvenile services facilities, primary care, and emergency departments.
- Maryland Behavioral Health for Adolescents and Young Adults (MD-BHAY) works to increase access to and improve the quality of treatment for youth, ages 12 to 24, with substance use and co-occurring substance use and mental health disorders. Due to chronic systemic gaps in care and recovery supports for this population, this project is enhancing statewide infrastructure, delivering evidence-based treatment in school and community settings, and developing funding and delivery mechanisms to sustain these changes.
- Project Aware: The Maryland State Department of Education (MSDE) has received a cooperative agreement to enhance access to behavioral health in schools by implementing community and school-wide violence prevention programs and building internal capacity for school staff to identify and address mental health issues through the dissemination of Youth Mental Health First Aid

Zero Suicide Strategies

The Zero Suicide Initiative includes the following strategies:

- 1) screening for suicide risk, 2) assessing clients who screened positive for suicide risk, 3) developing safety plans for clients at risk for suicide, 4) providing lethal means counseling to clients at risk for suicide, 5) contacting clients at risk for suicide within 8 hours of a missed appointment, 6) contacting clients within 24 hours after discharge from the hospital or emergency department.

Thousands of individuals in Maryland hospital settings have already been screened with the ASQ suicide risk screening (#1 above). Those who screen positive are provided a suicide risk assessment (#2 above). After being assessed, Dr. Mary Cwik provides routine training on safety planning and lethal means counseling at no cost (# 3 and 4 above). A new pilot project has recently been started to test the value of providing text-based caring follow-up messages to individuals discharged from the hospital or emergency department after being treated or suicidal ideation or attempts, which would speak to strategies #5 and #6.

In addition to the above, MD-SPIN continues to train the workforce/gatekeepers (k-12 teacher, counselors, administrators, nurses and other staff; higher education faculty, staff and students; primary care providers; and families of veterans) and refer youth and young adults, ages 8-24, to mental health treatment when they test positive for suicide risk factors on the ASQ screener in pediatric emergency departments.

3. Have you incorporated any strategies supportive of Zero Suicide? j n Yes j n No
4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? j n Yes j n No
5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? j n Yes j n No

If so, please describe the population targeted.

The MD-SPIN ED team at Johns Hopkins University is pilot testing a follow-up text message program to provide a connection with ED patients who were referred for mental health follow-up/treatment. A computerized program sends a positive text message to a discharged patient and includes a link to the Maryland Crisis Hotline in case the discharged patient is experiencing difficulty or distress.

The MD-SPIN ED team at Johns Hopkins University is pilot testing a follow-up text message program to provide a connection with ED patients who were referred for mental health follow-up/treatment. A computerized program sends a positive text message to a discharged patient and includes a link to the Maryland Crisis Hotline in case the discharged patient is experiencing difficulty or distress.

In addition, the BHA convened a stakeholder workgroup to develop recommendations regarding the Maryland Crisis Hotline (MCH), what services it should provide, how it should be structured, and how it should function. The final report will include recommendations that may result in improved access to life-saving information, intervention, and connection to appropriate community resources for suicide prevention, substance use, and mental health disorders services.

Does the state have any activities related to this section that you would like to highlight?

BHA's 29th Annual Suicide Prevention Conference will take place on Wednesday, October 4, 2017, at Martin's West, 6817 Dogwood Road, Baltimore, Maryland 21244

Please indicate areas of technical assistance needed related to this section.

No TA needed at this time.

Footnotes:

Maryland Commission on Suicide Prevention 2016 Plan to the Governor



Behavioral Health Administration

Larry Hogan, Governor

Boyd Rutherford, Lt. Governor

Gayle Jordan-Randolph, M.D., Deputy Secretary for Behavioral Health

Barbara Bazron, Ph.D, Executive Director, Behavioral Health Administration

Al Zachik, M.D., Director, Child and Adolescent Services, Commission Chair

Brandon J. Johnson, M.H.S., Suicide and Violence Prevention Coordinator

EXECUTIVE SUMMARY

The Maryland Department of Health and Mental Hygiene (DHMH) and Behavioral Health Administration (BHA) continue to see suicide prevention as a major priority. Suicide deaths in Maryland are increasing, despite remaining under the US suicide rate. As these numbers continue to raise across the country, the impact of suicide deserves increased attention now more than ever. The Governor's Commission on Suicide Prevention meets quarterly and provides guidance to the Behavioral Health Administration on current suicide prevention efforts and emerging themes developing in suicide prevention. Commission members reach out to BHA staff throughout the year to provide suggestions and feedback on current initiatives.

The work of the Commission is aligned with national suicide prevention efforts, especially in the State's historic and continuing emphasis on youth suicide prevention. The Commissioner's initial plan was submitted to the Governor in 2012. This updated plan will build upon the progress of the previous plan, as well as create new initiatives that fit the current needs of the State.

A State Coordinator of Suicide Prevention has been hired to provide community education on suicide prevention signs, risk factors, intervention, and initiatives as well as take responsibility for the execution and continued revision and update of the Suicide Prevention Plan. As of the report, the State Coordinator has done over 60 presentations throughout the State on suicide prevention efforts at local schools, churches, health events, and conferences. The Coordinator also serves as the Grant Manager of the Garrett Lee Smith grant awarded to the State from SAMHSA.

As the previous plan mentions, strategies and initiatives are based on the Public Health Model, and operate at three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated sub-population.

Four goals of the plan:

1. Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern.
 - i. Increase evidence-based or best practice training opportunities for professionals;
 - ii. Increase awareness through community education; and
 - iii. Increase State policy and leadership efforts.
2. Enhance culturally competent, effective, and accessible community-based services and programs;
3. Assure effective services to those who have attempted suicide or others affected by suicide attempt or completion.
4. Use existing suicide data sources to identify gaps in services and to guide on-going intervention efforts.

THE REPORT

BACKGROUND

On October 7, 2009, Governor Martin O'Malley issued Executive Order 01.01.2009.13, establishing the Governor's Commission on Suicide Prevention (the Commission). Over the course of six years, 21 Commissioners brought their professional expertise and personal experiences with suicide and its consequences to bear in crafting their recommendations.

The work of the Commission is aligned with national suicide prevention efforts, especially in the State's historic and continuing emphasis on youth suicide prevention. The Commissioner's Plan initial plan was submitted to the Governor in 2012. This updated plan will build upon the progress of the previous plan, as well as create new initiatives that fit the current needs of the State.

In 2012, the Commission released its first State Plan to the Governor on Suicide Prevention. The plan has been in effect for two years, with updates and successes of the plan documented below. This plan will use the progress made and lessons learned from the previous plan to guide suicide prevention efforts for the State over the next two years.

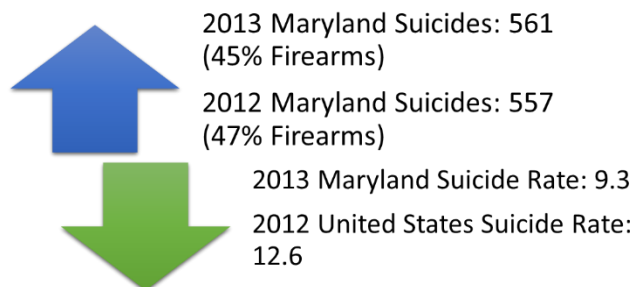
In 2014, Maryland was accepted into the Zero Suicide Academy, which provided training on a Framework developed through a partnership between the Suicide Prevention Resource Center (SPRC), National Action Alliance on Suicide Prevention, Substance Abuse Mental Health Services Administration (SAMHSA). The Zero Suicide framework consists of the following goals:

1. Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. Develop a competent, confident, and caring workforce.
3. Systematically identify and assess suicide risk among people receiving care.
4. Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. Use effective, evidence-based treatments that directly target suicidality.
6. Provide continuous contact and support, especially after acute care.
7. Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk

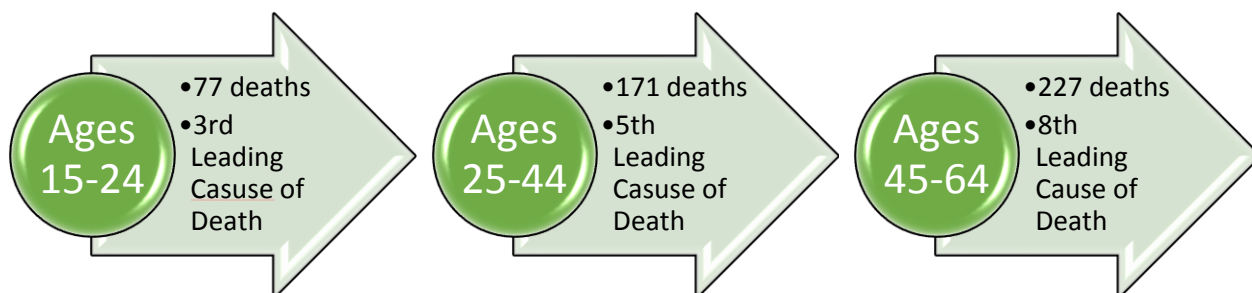
Maryland will adopt this model and use this framework across various settings to eliminate suicide in the state.

SUICIDE IN MARYLAND

There was an increase in suicides in Maryland from 2012 to 2013. Despite the unfortunate increase in the overall number of suicides in Maryland, the state suicide rate remains well below the National average (Table 1).



Below is information regarding the ages of suicides in Maryland in 2012. Suicide is the third leading cause of death among Maryland residents ages 15-24 (Table 2).



COMMISSION WORK: HIGHLIGHTS OF THE 2012 PLAN INITIATIVES

Maryland Crisis Hotline

The Maryland Crisis Hotline has increased in capacity and now serves all Maryland residents, regardless of age. The Hotline is a decentralized hotline, consisting of six crisis centers located throughout the State. More recently, the hotlines have received new funding to increase outreach efforts on suicide prevention with youth. The hotline staff, additionally, have also received training and funding to answer substance use related disorder calls. The hotline staff at all of the crisis centers in the network will be able to respond to these types of calls.

Suicide Prevention Marketing Campaign

A marketing campaign was developed, which includes brochures, t-shirts, posters, information cards, and pens to raise awareness of the Maryland Crisis Hotline and to inform the public that the

hotline is available to all Maryland residents, regardless of age. The goal of the campaign is to raise awareness of the general public of the expansion of the hotline to serving individuals across the lifespan. The materials are being distributed at local behavioral health events as well as local conferences, awareness walks, and to local schools. Each year, the Maryland Coalition of Families sponsors a “Children’s Mental Health Matters” week where events take place across the state to promote children’s mental health. This year, we contributed 2,500 promotional materials in packages on information to be sent to Maryland families.

Maryland Suicide Prevention and Early Intervention Network (MD-SPIN)

Kognito Gatekeeper Training Progress: K-12 Overview

MD-SPIN is a five-year, SAMHSA-funded program created by The Maryland Department of Health and Mental Hygiene, Behavioral Health Administration, with a grant from the Substance Abuse and Mental Health Administration (SAMHSA). MD-SPIN provides suicide prevention training, and technical assistance to advance a comprehensive suicide prevention and early intervention service system for youth and young adults, ages 10 to 24.

Online gatekeeper training by Kognito’s Training Games and Simulations for Health have been used to train educators, health, and behavioral health providers, youth peers, and families in suicide risk assessment in youth across settings. Kognito’s online, self-paced, and narrative-driven simulations range from 30-60 minutes, provide organizations with high-quality, easy-access, and cost-effective solutions for training a broad and diverse audience in using engaging and effective learning tools that include practice and real-time, personalized feedback.

The availability of the Kognito gatekeeper training programs was promoted to local jurisdictions. For K-12 school professionals, modules include Kognito At-Risk Trainings for Elementary, Middle, and High School teachers. The Middle and High School training modules were available at the onset of the MD-SPIN program. The trainings are free to all Maryland teachers and other school staff such as social workers, school counselors, nurses, administrators, and volunteer staff. An internal implementation plan for the widespread dissemination plan for Kognito was created to systematically move the training throughout the State. The Maryland State Department of Education (MSDE), which is represented on the Commission is disseminating information about the Kognito trainings to school staff in various jurisdictions. Data extracted from the state is being used to target a few counties with higher suicide prevention rates among youth, such as Montgomery County and Baltimore County. Presentations on the features and functionality of Kognito are being shared at professional development meetings and to student services leadership to market the program to supervisors and leaders within the local school systems. Continuing Education Units (CEUs) as well as Credits for Professional Development (CDPs) are available to any teachers, nurses, school counselors, therapists, or social workers who complete modules on the Maryland Kognito website. Additional marketing of the Kognito program took place at the Maryland 26th Annual Prevention Conference. Grant staff provided a workshop on Kognito and the features of the program to attendees of the conference. The conference averages around 400 attendees per year. The Kognito K-12 program is also promoted through the State’s suicide prevention social media sites on Facebook and Twitter, as well as the Behavioral Health Administration’s website.

Kognito and Higher Education

Kognito On-Campus, LGBTQ and Veteran modules were added to the Maryland Kognito portal for faculty and students. Four colleges and universities are partners on the grant; Salisbury University, Coppin State University, University of Maryland Baltimore County (UMBC), and Howard Community College. Each of the institutions of higher education have marketed and promoted the Kognito gatekeeper trainings to their students, faculty, and staff.

The campuses connect with various student and special interest groups on campus to promote the training to current students as well as incoming freshman. The list of active colleges continues to expand to additional institutions, such as, Morgan State University, Johns Hopkins University, Towson University, and University of Maryland, Eastern Shore. Connections to colleges are being made through Commission members. A total of 30 colleges and universities have expressed interest in the pro

Table 3: Kognito Usage Through September 2015

Course	Activated	Completed	Completion %
<i>At-Risk for High School Educators (ARHS)</i>	451	310	68.74%
<i>At-Risk for Middle School Educators (ARMS)</i>	290	243	83.79%
<i>Step In, Speak Up! (SISU)</i>	112	103	91.96%
<i>At-Risk for Elementary School Educators (ARES)</i>	133	96	72.18%
<i>At-Risk for Students (ARUS)</i>	128	93	72.66%
<i>At-Risk for Faculty & Staff (ARUF)</i>	241	188	78.01%
<i>LGBTQ on Campus for Students (LGBTQS)</i>	79	69	87.34%
<i>LGBTQ on Campus for Faculty & Staff (LGBTQF)</i>	139	123	88.49%
<i>Veterans on Campus: Peer to Peer (VOCP2P)</i>	84	67	79.76%
<i>Veterans on Campus for Faculty & Staff (VOCF)</i>	129	116	89.92%
<i>Family of Heroes (FOH)</i>	17	NA	NA
Total	1803	1408	78.83%*

Emergency Department Screening Assessment and Follow-up

With the help of the Commission and its members, MD-SPIN is implementing evidence-based screening, brief means restriction and safety planning interventions, and follow-up protocols in the emergency department (ED) at Johns Hopkins Hospital and University of Maryland Medical Center. The Ask Suicide Screening Questions (ASQ) is a recently developed, non-proprietary instrument to screen for suicide risk during the ED triage phase with patients ages 10-21 years. In the development study across three pediatric EDs, the ASQ demonstrated good sensitivity and specificity when compared to the Suicide Ideation Questionnaire (SIQ) for ED patients with psychiatric and non-psychiatric concerns. Results from JHU ED screening data captured through the ASQ demonstrated feasibility for use in the pediatric emergency department. The Johns Hopkins Hospital has adopted the ASQ screening tool and is doing screening and assessment of youth who are brought into the ED with a chief complaint of psychological distress. The pediatric ED director at Johns Hopkins Hospital has agreed to make the ASQ a universal screening tool, with implementation of that effort taking place in year 2 of the grant. University of Maryland Medical Center (UMD) has implemented the ASQ for patients with a chief psychological complaint as of July 2015. UMD ED staff has participated in means restriction and safety planning trainings provided by MD-SPIN staff.

At-Risk Populations

The State Coordinator of Suicide Prevention currently sits on various State workgroups who advocate for the needs and rights of the LGBTQ population. There is also an increased collaboration with DHMH staff working with the veteran population as well as with efforts at Aberdeen Proving Ground to work with active duty and veterans in regards to suicide prevention. There have been presentations and information to local organizations who provide job training services to the unemployed. Progress is still being made on incorporating individuals who have attempted suicide or individuals who have experienced a suicide loss. This population remains a priority in the 2015 Plan.

RECOMMENDED STRATEGIES 2015-2017

Strategy 1: Utilize various state data sources of suicide information on ideation, attempts, and death to gain a deeper understanding of the services gaps in Maryland, as well as to guide prevention and intervention efforts.

Timeframe: Immediate Implementation

- Collaborate with the Maryland Violent Death Reporting System data to understand circumstances around suicide deaths
- Connect with local school jurisdictions to examine ideation data among youth (attempts/gestures)
- Use data from local suicide prevention research at various universities to guide best practices in Maryland

- Use data from calls to the MD Crisis Hotline to inform targeted initiatives
- Identifying existing data sources for suicide data

Strategy 2: Recognize and address the needs of high-risk populations, such as:

- a) **Disconnected youth**
- b) **Bullying victims (school and workplace)**
- c) **Individuals with substance use disorders**
- d) **Unemployed, middle-aged males**
- e) **Older adults**

Timeframe: Long-term Implementation (2 years)

The needs of these and other high-risk populations should be addressed across prevention, intervention, and post-vention services through a three-step process which should include:

- Research and identification of risks and needs;
- Identification of Evidence Based or Promising Practices that are specific to those needs; and
- Utilization of research to identify other special populations who may be at high risk.

Strategy 3: Identify opportunities to improve behavioral health workforce, as well as gatekeepers, school staff, and healthcare workers throughout Maryland on suicide prevention and intervention strategies:

Timeframe: Immediate and Long-term Implementation (2 years)

Increased training opportunities remains a major priority for Maryland and a major part of the Zero Suicide framework. Collaboration opportunities with other state agencies and initiatives will be key in pushing this initiative forward, as well as:

- Increase adoption and uptake of Kognito Gatekeeper Training Program for school staff, veterans, LGBTQ youth, and university faculty and students.
- Expanding training of pediatric emergency department staff of screening, assessment, and follow-up of individuals who report a chief complaint of psychological distress.
- Continue promotion and training of Mental Health First Aid throughout Maryland.
- Identify new Evidence-Based training opportunities for BHA staff and Maryland residents.

Strategy 4: Develop more opportunities to engage and support Maryland residents with lived experiences of suicide (attempt and loss survivors).

Timeframe: Long-term Implementation (2 years)

Individuals with lived experience should be more involved with state suicide prevention efforts and maintain continued support through behavioral health services. To accomplish this:

- Enhance and expand existing support groups for loss and attempt survivors.
- Collaborate with groups such as the Maryland Coalition of Families to work with youth and young adults who have lived experiences with suicide and provide supports to those individuals.

- Use feedback from those with lived experience to help guide Commission initiatives.
- Utilize evidence-based intervention strategies, such as the Sources of Strength project, to aid individuals in their recovery.

Strategy 5: Expand suicide prevention outreach efforts and education to more rural sections of the state, such as the Eastern Shore, Western Maryland, and Southern Maryland.

Timeframe: Long-term Implementation (2 years)

The less-populated regions of the State have different needs, infrastructure, and geographical design than the other more urban parts of the State. We will make a more consistent effort to engage these regions in the State’s suicide prevention efforts.

- Increase collaboration with Core Service Agencies in these areas.
- Connect with local hospitals to increase access to screen, assessment and follow-up provided by their emergency departments for individuals who come in with a chief complaint of psychological distress.
- Reach-out and engage local behavioral health community and faith-based organizations.

Strategy 6: Increase and broaden the public’s awareness of suicide as a major public health issue through various means.

We will advance the previous success of the marketing campaign through:

- The development of online videos that promote the Maryland Crisis Hotline which can be viewed on YouTube and the BHA website.
- Disseminate print materials.
- Continue to promote trainings and other local events through Facebook and Twitter.
- Provide resources to youth and parents related to cyber-bullying and social media threats.

Strategy 7: Collaborate with other state agencies and departments recently funded through SAMHSA grants in the area of behavioral health.

Sharing of resources, training opportunities, and information across multiple grants will help reach individual grant goals, as well as, help to improve the mental health status of Maryland residents.

These grants include:

- Maryland’s Suicide Prevention and Early Intervention Network (MD-SPIN): provides suicide prevention training, resources, and technical assistance to advance a comprehensive suicide prevention and early intervention service system for youth and young adults, ages 10 to 24. The purpose of MD-SPIN is to reduce premature loss of lives from suicide by increasing the number of at-risk youth who are identified, referred, and receive quality behavioral health services.
 - High-risk populations of focus include: LGBTQ, transition age youth, veterans and military families, and youth with emotional and behavioral concerns.
 - Target settings are schools, colleges/universities, juvenile services facilities, primary care, and emergency departments.
- Maryland Behavioral Health for Adolescents and Young Adults (MD-BHAY): Increasing access to and improve the quality of treatment for youth, ages 12 to 24, with substance use

and co-occurring substance use and mental health disorders. Due to chronic systemic gaps in care and recovery supports for this population, this project is enhancing statewide infrastructure, delivering evidence-based treatment in school and community settings, and developing funding and delivery mechanisms to sustain these changes.

- Project Aware: Maryland State Department of Education (MSDE) has received a cooperative agreement to:
 - Enhance access to behavioral health in schools;
 - Implement community and school-wide violence prevention programs; and
 - Build internal capacity for school staff to identify and address mental health issues through the dissemination of Youth Mental Health First Aid.

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

A 2015 Executive Order from Maryland's Governor established the Inter-Agency Heroin and Opioid Coordinating Council, authorizing the establishment of the Opioid Operational Command Center (OOCC) to reduce the harmful impacts of opioid addiction on Maryland communities. The creation of the OOCC is assisting in breaking down governmental silos and aids in the coordination of federal, state, and local resources, working directly with both local and federal organizations and agencies, as well as 12 state agencies and departments. These agencies include: the Governor's Office of Crime Control and Prevention; Department of Health; Maryland Emergency Management Agency; Maryland State Police; Maryland State Department of Education; Department of Human Services; Department of Juvenile Services; Department of Public Safety and Correctional Services; Maryland Institute for Emergency Medical Services Systems; Maryland Higher Education Commission; Maryland Insurance Administration; and the Office of the Attorney General. As a direct result from increased collaboration, the center will collect and collate data that will be used to save lives.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

21. Support of State Partners

Collaborations with Other State Agencies

The Behavioral Health Administration (BHA) continues to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance use, and other services and community supports. On a local level the **Core Service Agencies (CSAs)**, **Local Addiction Authorities (LAAs)**, and the **Local Behavioral Health Authorities (LGHAs)** do an excellent job of collaborating with local resources, as evidenced in their annual reports. The development of the State Behavioral Health Plan is a result of the existing collaborative/interagency efforts and cooperation, and public and private partnerships. Overall, alliances have been strengthened and new partnerships have been formed to further build upon the infrastructure, to coordinate care, and improve service systems. BHA is confident these successful partnerships will continue to support implementation of the priorities identified in our plan as exemplified in the specific interagency activities described.

State Medicaid Agency

BHA has worked with **Maryland's Medical Assistance (MA)** program on State Plan Amendments (SPA) and Waiver Programs such as the 1915 (i) SPA for Children, Youth and Families and Telehealth Program. The Section 1915(i) SPA amendment entitled "**Intensive Behavioral Health Services for Children, Youth and Families**" is designed to provide intensive care coordination utilizing the wraparound practice model with a set of highly specialized services not otherwise available to Medicaid recipients. The 1915 (i) SPA provides home and community-based services for children and youth with emotional disturbances and their families, as well as a full range of Medicaid somatic and behavioral health benefits. Participants also have access to a number of additional specialized services. These include respite care, family peer support, intensive in-home services, crisis and stabilization services, expressive and experiential therapies, for example, art, music, and equine assisted therapy, with a unique program of participant-directed customized goods and services. The new Targeted Case Management program and 1915(i) service package are specifically designed to both divert and to transition youth from Residential Treatment Centers (RTC's) that are currently the primary institutional setting used for children and adolescents with SED in Maryland.

Services for behavioral health are carved out of the HealthChoice system, the mandatory managed care program for Maryland Medicaid enrollees. These services are delivered according to the 1115 waiver under the Public Behavioral Health System's (PBHS) fee- for -service (FFS) System. Under a renewed **Institution for Mental Diseases (IMD) Waiver**, community residential clinical services for individuals with substance use disorders (SUD) are being transferred to FFS on a rolling basis. By January 2018, specialty community residential clinical services for women and children with substance use disorders and individuals certified under Health General Article 8-507 will be available. In January 2019, providers of community residential services to level 3.1 and halfway houses will be added to the FFS system. BHA continues to review provider billings and refers providers of concern to the Maryland Medicaid Fraud Control Unit.

Maryland Medicaid is the source of finance for BHA's FFS system and works in concert with Maryland's **Administrative Services Organization (ASO)**, **Beacon Health Options**, to provide oversight of the expanded Medicaid population. BHA participated in the **Maryland Medicaid (MA) Advisory Committee** and in the **Medial Care Organization's (MCOs)** monthly medical directors meetings. BHA also works with Maryland's MA program on issues and state plan amendments such as: Money Follows the Person,

the 1915 (i) Waiver for psychiatric rehabilitation service, telemental health services, and the Medicaid Emergency Psychiatric Demonstration.

Criminal Justice Partnerships

BHA has partnerships with other state agencies assisting individuals with mental and/or substance use disorders who have contact with the criminal justice or juvenile justice systems. The Office of Forensic Services cooperates with the **Department of Public Safety and Correctional Services (DPSCS)**, in regards to individuals who require civil certification to BHA facilities, who hold the status of mandatory release, and/or who present with complex cases. The Administration collaborated with DPSCS for the expansion of **DataLink**, a data sharing initiative to promote the continuity of treatment for individuals with serious mental illness who are detained in the detention center. BHA also partnered with DPSCS to start the **Chrysalis House Healthy Start Program**, which provides services and supports to women in the correctional system who are dually diagnosed, have trauma issues, and who are pregnant or have infants.

BHA works with the **Department of Juvenile Justice (DJS)** to plan mental health services and oversee behavioral health programs for youth within their juvenile detention centers. They also consult with the DJS on initiatives involving children's mental health issues and participate in protocol reviews, joint meetings and symposiums, and provide trainings to DJS and judges. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court. The BHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis. In FY 2010, the Director of Child and Adolescent Services began a Psychopharmacology Learning Collaborative consisting of psychiatrists who provide services to youth in the juvenile justice system. The focus of the Collaborative is to examine the use and administration of psychotropic medication to youth in custody.

Partnerships in Education

The **Maryland State Department of Education (MSDE)** and the BHA have worked on integrating School Based Mental Health (SBMH) services since the 1990's. The partnership with MSDE includes collaborating on mutual concerns involving the mental health needs of children in school and in early childhood settings.

BHA and MSDE collaborate to provide services to children and youth and to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the **Individuals with Disabilities Education Act (IDEA)**. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services.

The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the **Maryland Infant and Toddler Program**, which provides services for young children governed by IDEA, is strengthened by the activities of the **Early Childhood Mental Health Initiative**. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

There has been a long standing Education Mental Health Leadership Committee, that is now the **Community of Practice (CoP)** in Maryland. The **Center for School Mental Health (CSMH)** is the nationally funded center for TA and excellence and is a key part of the CoP. These efforts also include a focus on early childhood mental health and school readiness. Through these partnerships, the CSMH, MSDE, and BHA has been supported in successfully applying for a number of grants that serve to improve SBMH services across Maryland. There has also been the development of a number of Children's MH on-line modules that are geared to school personnel. As systems become more integrated, there is the recognition that substance use services, along with mental health, need to be available through local school districts. Planning and decision making efforts are now in process regarding the components of an integrated behavioral health SOC as it relates to educational settings.

BHA and MSDE also collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. The mental health block grant supports school-based mental health initiatives that foster diversion to hospitals and RTC's, as well as funding that address school expulsion and bullying. School Wellness Centers that provide somatic and behavioral health services to students will be expanded and made available in school settings across the State.

Maryland continues to implement **LAUNCH (Linking All Unmet Needs in Children's Health)**, a five-year grant awarded to MDH and the BHA by SAMHSA. LAUNCH is a comprehensive early childhood intervention strategy designed to coordinate key-child-serving systems and integrate behavioral and physical health services to ensure that children are able to thrive in safe, supportive environments and enter school ready to learn. It is piloted in Prince George's County. The project has successfully placed mental health consultants in early child care and education settings through a partnership with community Counseling and Mentoring Services.

Joint efforts with the **Division of Rehabilitative Services (DORS)**, a division of MSDE, continue regarding the Maryland Mental Health Workforce Initiative, including the continued implementation of the evidence-based practice model of **Supported Employment (SE)** and the dissemination of shared data and outcomes.

Child Welfare/Department of Human Services

BHA works with DHS/SSA to address the needs of children and adolescents in the foster care, child welfare and out of home placement systems. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. BHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PBHS as a performance indicator.

DHS provides a spectrum of effective community-based services and supports including services for children in homeless families and homeless youth. BHA has funded and provided technical assistance to a project for young children who are homeless, children living with their mothers and other family members in family shelters throughout Baltimore City. This outreach focuses on family shelters across the entire city. The unmet needs of youth that are homeless are extensive, however the exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. BHA has been participating in the efforts of DHS and local communities to implement the Homeless Management Information System statewide.

A collaboration that was recently taken over fully by the Medicaid Pharmacy Program, required pre-authorization for prescriptions of anti-psychotic medications for all Maryland youth 1-17 years old. The review was conducted by the University of Maryland School of Pharmacy and has a peer to peer consultation process in which the prescribing doctor can confer with the child psychiatrist at the University of Maryland School of Medicine. This program has reduced anti-psychotic drug use in the Medicaid youth population by more than 50 percent since its inception in 2011.

BHA also worked with DHS as a state partner on Maryland's SOAR initiative and planning for the expansion of community access to SSDI/SSI benefits. BHA provided funding to local health departments for required substance use disorder (SUD) screening of individuals applying for temporary cash assistance, food stamps, and child welfare benefits. Individuals found to have SUD were required to be referred for treatment.

Other BHA Partnerships

Emergency Management

BHA continues its partnership with **the Maryland Emergency Management Administration (MEMA)**, and **The Office of Preparedness and Response**, through ongoing trainings and presentations that are offered to state facilities and involved state agencies.

The Maryland Behavioral Health Advisory Council

An important source for Advocacy for a comprehensive, broad-based, person-centered approach to provide access to the services and supports for people with behavioral health needs and serves as a link with state agencies seeking collaboration for improved behavioral health services. The membership of the Council is comprised of representatives of most principal state agencies such as behavioral health, education vocational rehabilitation, criminal justice, housing, and social services.

Maryland Department of Disabilities (MDOD)

BHA collaborates with MDOD in the development and implementation of cross-agency initiatives such as Money Follows the Person, transition-age youth projects, and the identification of action steps to promote affordable housing efforts.

Governor's Office of Deaf and Hard of Hearing (ODHH)

BHA continues to act as liaison to and monitor services provided by providers who received state funding through CSAs/LBHAs to provide signing therapists in outpatient mental health settings, supported employment, psychiatric rehabilitation programs and residential rehabilitation programs. BHA offers technical assistance to the LAAs/LBHAs and monitors contracts for Deaf Addictions Services at the University of Maryland as they reconfigure behavioral health services for individuals who are deaf or hard of hearing.

Maryland Department on Aging (MDoA)

BHA interfaces with MDoA through participation in meetings and workgroups around Maryland Access Point (MAP), Maryland's No Wrong Door approach to long-term services and supports. BHA supports MDoA in this endeavor by providing behavioral health information for the MAP Web. BHA also provides training and consultation in fostering interagency connections between the local areas on aging and the local behavioral health authorities, CSAs/LBHAs; specifically in identifying older adult participants eligible to receive services through the PBHS.

Maryland Department of Veteran's Affairs (MDVA)/ Maryland National Guard (MNG)

BHA collaborates with representatives of the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, The Maryland National Guard, and the Maryland Defense Force to assist veterans and their families with coordinating behavioral health services for the veteran. **Maryland's Commitment to Veterans (MCV)**, a program under BHA, continues its collaboration with other state agencies and community providers to provide training to MDVA staff on a variety of subjects, including *Veterans and Suicide*. Also, MCV, in collaboration with the executive leadership of MDVA and the VA, formed the Chesapeake Veterans Alliance, which serves the Maryland VA health care system and participates with the SSI/SSDI Outreach, Access and Recover (SOAR) Initiative and the Homeless ID Project.

Developmental Disabilities Administration (DDA)

Clinical and leadership meetings continue, as well as meetings between DDA staff, state hospital staff, community based PBHS providers, and Brain Injury Waiver Providers Council. BHA and DDA coordinate on training around brain injury with BHA providing a trainer for DDA-sponsored training events. BHA has worked closely with DDA regarding implementation of the new Home and Community- Based Settings Rule. OFS staff communicate weekly with DDA to assist in evaluating court-involved individuals.

Maryland Health Care Commission (MHCC)

BHA collaborates with MHCC on health policy studies involving mental health services, reimbursement rates for hospitals and issues involving health insurance coverage and the uninsured population.

Health Services Cost Review Commission (HSCRC)

BHA and HSCRC meet periodically to update the rate-setting process for hospital rates for inpatient services.

Office of Health Care Quality (OHCQ)

BHA collaborates with OHCQ in relation to regulatory and compliance meetings and activities. Program specific issues and issues related to regulatory interpretation and compliance continue to be discussed and addressed.

MDH Prevention and Health Promotion Administration

BHA collaborates on Maryland's implementation of the Nurse-Family Partnership, an evidence-based, nurse home visiting program for low-income, first-time parents and their children and works closely with the administration on the Early Childhood Mental Health.

Academic Partnerships

Child Mental Health Institute

A collaboration between the Child Psychiatry Divisions at University of Maryland and Johns Hopkins University Medical Schools, Maryland Coalition of Families for Children's Mental Health and University of Maryland Evidenced Based Practice Center. The Institute's primary focus is on evidenced based practices for child and adolescent mental health, including Evidence Based Practices research, statewide implementation and outcomes monitoring. The Youth MOVE (Motivating Others through Voices of Experience) initiative is part of the Children's Mental Health Institute.

Systems Evaluation Center (SEC)

BHA contracts with the Systems Evaluation Center (SEC), a component of the Behavioral Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Psychiatric Services Research to assist with evaluation and data infrastructure activities. As BHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. SEC will continue to collaborate with BHA and key stakeholders to identify areas of interest related to the PBHS that could be analyzed using multiple databases. These databases include claims, authorization, and the consumer perception of care survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

1. Has your state added any new partners or partnerships since the last planning period?

A 2015 Executive Order from Maryland's Governor established the **Inter-Agency Heroin and Opioid Coordinating Council**, authorizing the establishment of the **Opioid Operational Command Center (O OCC)** to reduce the harmful impacts of opioid addiction on Maryland communities. The creation of the O OCC is assisting in breaking down governmental silos and aids in the coordination of federal, state, and local resources, working directly with both local and federal organizations and agencies, as well as 12 state agencies and departments. These agencies include: the Governor's Office of Crime Control and Prevention; Department of Health; Maryland Emergency Management Agency; Maryland State Police; Maryland State Department of Education; Department of Human Services; Department of Juvenile Services; Department of Public Safety and Correctional Services; Maryland Institute for Emergency Medical Services Systems; Maryland Higher Education Commission; Maryland Insurance Administration; and the Office of the Attorney General. As a direct result from increased collaboration, the center will collect and collate data that will be used to save lives.

2. **Has your state identified the need to develop new partnerships that you did not have in place?**

No

3. **Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act (IDEA).**

Housing Services

Maryland has a track record of entering into partnerships to develop creative approaches to addressing the housing needs of low income persons with disabilities. Maryland has convened committees with representation from state governmental agencies, service providers, housing organizations, and consumer groups to address the housing needs of the Medicaid populations that have led to cooperative agreements, program and policy changes, resource development and implementation of demonstration projects that further the state's affirmative efforts to implement the Olmstead Decision. In 2009, Maryland's DHMH and **Department of Housing and Community Development (DHCD)** developed a strategic plan for the development of affordable housing for persons with mental illnesses and/or developmental disabilities. The plan encouraged the use of supportive housing, tenant-based and project-based rent subsidies. The BHA continued its collaborative work with the DHCD through involvement with the Maryland Partnership for Affordable Housing (MPAH) and the Department of Disabilities (MDOD) to implement the HUD Section 811 Project Rental Assistance (PRA) program.

BHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local public housing authorities (PHAs), and county agencies, as well as non-profit developers and mental health providers, to assist with helping individuals to step down from their placement in the community to more independent housing. These partnerships promote access to housing development that is affordable with assistance from specialized federal and state government-supported housing opportunities, as well as local county resources and private foundations.

Housing services are offered through the BHA-funded "Residential Rehabilitation Programs (RRPs)," which are homes designed to foster a consumer's ability to reside in the community following an inpatient stay in a BHA psychiatric facility. Supported housing providers, as well as a few developers applying for tax credits through the Department of Housing and Community Development (DHCD), are working on blended funding and resources already established in the community to serve individuals coming out of the state hospitals or stepping down from RRP and BHA conducts an ongoing group with RRP providers, CSAs, and state hospitals to reduce the number of vacancies in RRP.

Maryland's Behavioral Health Administration has the unique opportunity to partner with the Department's Office of Capital Planning, Budget and Engineering Services to prioritize the Administration-Sponsored Capital Program grant (Community Bond) financing for the development of affordable housing projects as well as projects that move individuals from RRP into the community so that state psychiatric facilities can transition eligible individuals ready for discharge into RRP. Through this program, BHA continues to encourage the expansion of permanent supported housing through which individuals with psychiatric disabilities may access an array of flexible service delivery programs,

including psychiatric rehabilitation programs (PRPs), case management, and other supports to enable them to live in housing of their choice. This Program may also include projects that provide transitional housing models (often time limited) with specific supports that often serve a specific population, such as veterans or individuals with forensic backgrounds, whose needs can be better met in the community rather than an inpatient setting. Community Bond projects are often leveraged with HUD housing vouchers or DHCD, county, or other funding sources that provide rental subsidies to the tenants. The MDH sponsored "Capital Bond Program" provides annual funding for the development of additional housing units with a focus on Supported Housing. BHA, along with other housing partners, developed pilot programs throughout the State (e.g. "Bridge Subsidy") to promote additional affordable housing choices. Also, collaboration with local Public Housing Authorities has resulted in additional opportunities for consumers to access integrated community housing through federal programs.

The Adult Services Unit of BHA is a fully engaged member of Maryland Partnership for Affordable Housing (MPAH), a cross-disability coalition of state agencies, advocates, and individuals with disabilities that are committed to creating affordable housing opportunities for persons with significant disabilities and extremely low income.

Community Support Services

Maryland's BHA, in partnership with the University Of Maryland School of Medicine (SOM), Department of Psychiatry, Evidence-Based Practice Center promotes, monitors, and evaluates the development and implementation of EBP programs and services. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Assertive Community Treatment/Mobile Treatment is an intensive, community-based service which provides assertive outreach, treatment, rehabilitation, and support to individuals with severe and persistent mental illness (SPMI) who may be without a home or for whom more traditional forms of outpatient treatment have been ineffective. This program is designed to reduce recidivism by helping consumers to develop skills so they can live in the community. The program is customized to meet individual needs, and is delivered by a team of mental health clinicians who are available 24 hours a day.

The PBHS is managed in collaboration with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) and the Administrative Services Organization (ASO). The CSAs and the LAAs are entities at the local level that have the authority and responsibility, in collaboration with BHA, to develop and manage a coordinated network of Maryland's public behavioral health services in a defined service area. They are responsible for assessing local service needs and planning the implementation of a comprehensive local mental health delivery system that meets the needs of eligible individuals of all ages. Additionally, CSAs and the LAAs are important points of contact for consumers, families, and providers in the PBHS and develop partnerships with other local, state and federal agencies.

Community crisis services account for many of the services provided by this network and also for much of what BHA funds through grants and contracts. The MHBG supports several crisis response systems in Baltimore City, Anne Arundel and Prince George Counties. There is considerable variability of the services offered from jurisdiction to jurisdiction, however, almost every county has established crisis intervention teams. Additionally, nearly all counties offer short term, state-funded crisis respite beds as both an alternative to, and a step-down from, psychiatric inpatient services. Residential Crisis services are short-term, intensive mental health and support services provided in a community-based, non-hospital, residential setting which are designed to prevent a psychiatric inpatient admission, to provide an alternative to psychiatric inpatient admission, or to shorten the length of inpatient stay.

MDH, BHA, SOM and the University of Maryland Medical System have collaborated to offer specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. These programs are committed to reducing disability by equipping individuals at risk and their families with tools to manage their illness, move successfully through the developmental stages of growth, and establish a life of their choosing.

Since FY 1994, the Baltimore City CSA, has operated a capitation project. The Capitation Project is a unique program in Baltimore City that provides a comprehensive range of coordinated services to individuals with a serious mental illness who are able to live in the community, but have difficulty managing their various treatment and service needs independently. Individuals enrolled in Capitation have access to staff 24 hours per day, 7 days a week. Individuals receive psychiatric evaluation and treatment; clinical assessment; medication management, administration, and monitoring; individual, group, and family therapy; support with daily living skills; assistance with locating housing; entitlements coordination; supported employment services; and case management. Two vendors were selected, Johns Hopkins Bayview (Creative Alternatives) and Mosaic Health Services (Chesapeake Connections) were selected to operate the program. When consenting to Capitation services, individuals are agreeing to a limited benefit package within the PMHS. This means that individuals still have access to the full range of services, but the Capitation provider authorizes and pays for services instead of the administrative services organization

In partnership with On Our Own of Maryland (OOOMD), BHA developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also WRAP facilitators, facilitate consumer discharges and provide ongoing support during the consumers' transition into the community from three state facilities: Springfield, Eastern Shore, and Finan Hospital Centers.

Maryland has a well-established Children's Cabinet that is staffed by the Governor's Office for Children (GOC) and addresses high level policy issues related to coordination for which MDH/BHA is an active member. BHA meets regularly with senior staff from the participating child-serving agencies to plan services across agencies for children, youth and families. GOC and BHA are active partners in implementing the **Wraparound and Psychiatric Residential Treatment Facility (PRTF) Waiver Initiative** for Maryland. The waiver provides home and community-based services to children as alternatives to PRTF's.

Educational and Developmental Services

Maryland has two Home and Community-Based Services Waivers under Section 1915(c) of the Social Security Act. One targets autistic children and the other target seriously emotionally disturbed individuals residing in residential treatment centers.

The 1915(c) Home and Community-Based Service Waiver allows autistic children in need of an Intermediate Care Facility for the Mentally Retarded (ICF-MR) to receive the necessary waiver services to maintain them in the community. Children who are diagnosed with Autism Spectrum Disorder and who qualify for the waiver receive the following services in the community:

- Respite Care
- Environmental Accessibility Adaptations

- Family Training
- Supported Employment Day Habilitation
- Residential Habilitation
- Targeted Case Management Program

Families are eligible for respite care, environmental modifications to their home, and family training that are not provided through local school systems, early intervention programs, or Medicaid as determined by the Waiver Plan of Care Team. The child also receives health insurance at no cost to the family.

The Medicaid Autism Waiver is implemented by MSDE, in collaboration with, MDH, Department of Disabilities, Department of Human Resources/Department of Social Services, and Department of Juvenile Services. Multiple service initiatives for children and students, age's birth through 21, are coordinated for 1000 children receiving services in their home and community.

The Community Pathways Waiver, a community-based services (HCBS) waiver, is overseen by DDA and the state's Medicaid office. The waiver provides services in the community as an alternative to the individual receiving them in an institution.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
See Attachment.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i Yes No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No
3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.
See Attachment.
Does the state have any activities related to this section that you would like to highlight?
See Attachment.
Please indicate areas of technical assistance needed related to this section.
See Attachment.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation – letter of support, etc.

The Behavioral Health Advisory Council's was involved in the State's Planning Process and the FY 2017 State Behavioral Health Plan in the following ways:

The FY 2018 State Behavioral Health Plan – Stakeholder Involvement

BHA hosted its annual Stakeholders meeting on April 21, 2017 to gain input and participation on the development of the FY 2018 Behavioral Health Plan. Representatives from the Council, who also represent multiple organizations, were in attendance. This broader stakeholder meeting afforded participants the opportunity to provide input on recommendations that impact policy and the development of initiatives that enhance a system that addresses the needs of individuals across the lifespan. Strategic concepts were developed and recommended under four priority areas: integrated system of care, access and quality of services, building improved service outcomes through enhanced capacity to collect, analyze and track data, and promotion of wellness, health and safety for individuals in the PBHS. These recommendations included:

- Expansion of behavioral health workforce
- Inclusion of peer input at all levels
- Increased proper training, technical assistance, education, and funding to behavioral health providers
- Expansion of public awareness
- Increased education of police and emergency facilities on behavioral health
- Expansion of stigma reduction, early intervention and prevention activities for police, schools, families (sibling support)
- Tracking of data outcomes of best practices utilized in Maryland with the goal of replication

Strategic Framework for FY2018 Behavioral Health Plan

Concurrently, BHA's Executive Team had been actively engaged in the process of establishing goals for the FY 2018 Behavioral Health Plan. The goals fall within the following four domains, part of the Balanced Scorecard approach:

- Customer Needs
- Internal Business Processes
- Learning Innovations
- Finances

Thus, input from the Stakeholders' meeting with strategies developed by BHA's leadership were incorporated into a draft FY 2018 Behavioral Health Plan.

The FY 2018 State Behavioral Health Plan – Council Review

The Planning Committee of the Council met on July 18, 2017 to review the initial draft of this FY 2018 Behavioral Health Plan. Some of the Committees recommendations included:

- Specific terminology and abbreviated names (emergent or non-emergent, 8-507, etc.) should be briefly explained. Special initiatives or grants that are named should be briefly described within the text of the strategy.
- Administration could increase outreach efforts with universities to establish a standard of study in every medical department/school of addiction as a required course of study.
- Emergency rooms and hospitals across the state to be better equipped to handle opioid epidemic; having facilities and trained professionals to increase access to overdose treatment (naloxone), detox services, counseling, and treatment beds.
- Lessen the criminalization of addiction with increased training and education of prosecutors, judges, and probation officers in the proper treatment of individuals presenting with SUD.
- Identify areas in the plan where input from peers/consumers can be utilized. Invite peer/consumer organizations to participate in areas such as development of quality and outcome standards (ROSC) and participation on work groups, such as the Opioid Treatment Program (OTP) Quality Implementation and State Care Coordination.
- BHA could expand recognition and support of additional grassroots, non-profit advocacy organizations, beyond the ones mentioned in the Plan. This may increase activities through additional funding. Make available on state and local Web sites a listing of peer organizations representing consumers of behavioral health services.
- SBIRT screening should be available in all schools
- Use of generic rather than specific names of the various medically assisted therapies (MATs) or of the pharmaceutical company in the document.
- Would be beneficial to cite the legislation or the task force behind specific strategies.
- Strategies would be enhanced by clarifying what population they serve if not the system in general.

The final draft of the FY 2018 Plan was reviewed by the Planning Committee in August 2017, along with elements of the combined MHBG and SABG.

The Committee and the Council commended the state's efforts toward continued behavioral health integration and the ongoing efforts to expand the implementation of crisis response services as a key component of the Public Behavioral Health System.

1a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The mechanism used by the Behavioral Health Administration (BHA) to plan and manage the delivery of quality and effective public behavioral health services (PBHS) include incorporating the following key elements that will support the development and implementation of a recovery-oriented, integrated system of care with clearly defined quality and outcome standards. The focus has been on the planning and implementation of mental health, substance use prevention, intervention, and treatment services in the five areas listed below:

- **Local Planning Level:** The Public Behavioral Health System (PBHS) is managed in collaboration with the Core Service Agencies (CSAs), local Addiction Authorities/Local Behavioral Health Authorities LAAs/LBHAs and twenty-four County Health Departments. LAAs at the local level have the authority and responsibility, in collaboration with BHA, to plan, develop, and manage a coordinated network of Maryland's public behavioral health services in a defined service area. Plans from LAAs and LBHAs have been written to describe how the local behavioral health entities plan, develop and manage a full range of prevention, intervention, treatment and recovery services. Plans from and LBHAs were written to describe how the local behavioral health entities include discussions that identify any issues or initiatives within the jurisdiction that are important in understanding the local plan in the context of the broader system. The Plans also described what activities are planned or implemented that support BHA priorities of moving toward an integrated system of care and improving access and quality of services throughout the continuum of care.
- **Regulations:** BHA developed new regulations to guide the development of an integrated behavioral health system in Maryland. The regulations, COMAR 10.63.01-10.63.06 became effective May 23, 2016.
- **Accreditation:** Technical assistance and supports were provided as the provision of services for SUD moved from a grant funded system to a Fee-for-Service system in January, 2017. Programs are required to be accredited in order to be licensed to provide community-based behavioral health by January 1, 2018. The process began in 2017 and all license applications must be submitted by January 1, 2018. Additionally, credentialing requirements have been developed and are being implemented for Recovery Residences.
- **Fee-for-Service:** Effective January 1, 2017, the fee-for-service pay structure for SUD ambulatory services was implemented. Extensive support was provided by BHA to local behavioral health authorities and providers in various jurisdictions expressing the need for assistance in preparing to make these changes by January 2017. A data group was set up, as requested by jurisdictions, for public behavioral health system (PBHS) based data to assist in the management of their local systems. Additional training was provided by the ASO, Beacon Health Options, in December, 2016. Specialized residential grants such as 8-507 (court-ordered) residential treatment, pregnant women with children residential programs, residential services for parents with a child CPS involved, and mothers born with drug exposed newborns residential services will move from grants to fee-for-services in January 2018.
- **CURES Act Initiatives:** Maryland is responding to the opioid overdose crisis through emphasizing a broad, multi-faceted approach. It encompasses prevention, enforcement, treatment and recovery efforts and also addresses the priorities identified in the Heroin and Opioid Prevention Effort (HOPE) Act. Maryland's Hope Act is a comprehensive behavioral health measure aimed at expanding treatment options for those with mental health and substance use disorders and allocating additional resources to reducing opioid dependency. Another source of funding that

supports these efforts is a grant under the CURES Act which was awarded to Maryland's Department of Health from the U.S. Department of Health and Human Services, administered by SAMHSA. These funds are to be used for the prevention and treatment of opioid use over a two year period. Eighty percent of the funds will go to local jurisdictions. The rest will be used to fund other efforts and programs on the state level such as: collaboration between federal, state and local law enforcement; increased state regulatory oversight of controlled dangerous substances; increased number of beds in residential drug treatment centers; and improvements to the statewide crisis hotline.

1b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities?

The Council has successfully integrated substance misuse prevention and treatment/co-occurring disorder issues. The Behavioral Health Advisory Council, established through legislation effective October 1, 2015, has been in existence for two years. During this time, the Council established By-laws, elected officers and implemented a committee structure, which is guided by issues of equal importance to mental health and SUD across the lifespan. The by-laws supported the legislative requirements to have an integrated balance between mental health and substance use within all areas of the Council. This includes membership, co-chairs (one from each area) and the committees as well, which are, whenever possible, to have a balance in representation of both mental health and substance use among its leadership and its members. The committees have focused on issues which impact the lives of individuals with serious mental illness (SMI), serious emotional disturbance (SED), and who have a behavioral health disorder.

Committees report regularly to the entire Council, which affords members the opportunity to have an integrated approach to remaining informed, planning, and fostering a mechanism for a collaborative voice on issues of concern, as members provide important input into the planning and policy development of the PBHS. These committee structures and workgroups also allow the Council to further enhance their abilities to monitor progress towards goals and strategies identified in plans and the federal Block Grant applications.

Additionally, the format of the bi-monthly meetings allow the sharing of projects, initiatives, conferences and community events that are important to each area yet that are also a source of information to be shared among the representatives of both mental health and substance use. The meetings have also encouraged sharing of initiatives and projects from other addictive disorders such as gambling and tobacco cessation. Some examples of shared information are: groundbreaking documentaries such as "Throw Away People" and "Written Off"; conferences of advocacy organizations such as On Our Own of Maryland, NAMI, and the Mental Health Association of Maryland; events such as "This is My Brave"; Crisis Intervention Training initiatives; and mechanisms in place in Maryland casinos to assist individuals at risk for gambling addiction.

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, etc.)?

The Maryland Behavioral Health Advisory Council's membership represents the diversity of the population served. Of the 53 members, there is one Hispanic individual, one Asian American and 11 African Americans. The Deaf and Hard of Hearing communities are represented by a member of the Governor's Office of Deaf and Hard of Hearing. Sign language interpreters are available at meetings. There are two members representing youth who are under the age of 27. Two members are family members with a young child and, in addition to a representative of the Maryland Department of Aging, there are at least 12 members over the age of 50. In addition to the four representatives from the local County Behavioral Health Advisory Councils (one from each region of the state), members represent rural, suburban, and urban areas of the state. There are also non Council members who participate in the Council committees to add to the diversity. Additional information can be found in the Behavioral Health Council Composition by Member Type chart elsewhere in this Block Grant section.

The Maryland Behavioral Health Advisory Council consists of 54 members - 28 in statute Ex-Officio members (or designees) representing state and local government, the Judiciary, and the Legislature; 12 members appointed by the Maryland Department of Health (MDH) Secretary, representing behavioral health provider and consumer advocacy groups; and 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. According to the legislation, membership is to be appointed/selected composed of balanced representation from areas of mental health and substance use disorders and a range of geographical areas of the state. Membership is also representative of ethnic, gender, cultural, and across the lifespan (parents of young children with behavioral health disorders), and linguistic (American Sign Language) diversity. The membership and committee structure of the new Behavioral Health Advisory Council also meets the federal requirements for the behavioral health planning section, Title XIX, subpart 3 of the Planning Law 99-660.

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders; how as it advocated for individuals with SMI or SED?

Senate Bill 174 (2015) established the new Council, in October 2015, to promote and advocate for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state. The Council is also responsible for promoting and advocating for a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that supports and fosters wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The council is composed of consumers/participants, family members of persons with behavioral health disorders, behavioral health professionals, representatives of other state agencies, and other interested citizens who serve as important sources of advice and advocacy in Maryland. Members provide important input into the planning and policy development of the PBHS. The Council has implemented a solid committee structure to further enhance full participation of members and other stakeholders to monitor the system of care, to facilitate and inform the planning process and policy making decisions of BHA, and to maintain the connection with local behavioral health entities. These committee structures

provide work that have impacted or influenced advocacy and give greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents (including SED issues), adults and older adults (including issues of SMI), criminal justice, and crisis services.

Most importantly, the membership of these committees and the ad hoc committees below are not limited to Council members alone. This allows a larger base of interested people, including people with behavioral health disorders in recovery, community stakeholders, and people knowledgeable in the specific field, to become a part of the process that addresses pertinent issues and informs the system. Each committee has its goal of developing recommendations for input and advocacy for the Public Behavioral Health System (PBHS) in Maryland, related to the Council's overarching mission and duties. There are two standing committees:

Standing Committees - As listed currently in the Behavioral Health Advisory Council By-Laws

A. Executive Committee:

The Executive Committee shall be composed of the Council Co-Chairs, together with any standing committee and ad hoc committee chairs and co-chairs. The Executive Committee shall meet as needed. The Executive Committee responsibilities include, but are not limited to: preparing, reviewing or approving testimonies, other public presentations, documents, or reports submitted on behalf of the Council especially when review and approval of the entire Council is not possible for timely submittal of items of critical importance, etc. Another duty of the Executive Committee is to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

B. Planning Committee:

The Planning Committee addresses efforts that comply with the Federal Mental Health Block Grant (MHBG) requirement. The duties of this committee include participation in a yearlong planning process comprised of development, review, and final recommendation of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The committee also identifies focus areas/issues to be monitored and makes recommendations to the Council. As mentioned, the Planning Committee provided initial and final reviews of BHA's Behavioral Health Plans, including the strategies linked to the federal block grant applications. Additionally, the Committee reviewed the Implementation Report of the FY 2016 Behavioral Health Plan in November and made recommendations for future planning efforts that support access and coordination of care.

C. Prevention Committee:

The Prevention committee addresses efforts that comply with the Federal Substance Abuse Block Grant (SABG)/Strategic Prevention Framework Grant (SPFG) which began in September, 2015 and ends September, 2020 at \$1.6 million per year. The Prevention Committee serves as Maryland's required Strategic Prevention Framework Advisory Committee (SPFAC). This is a requirement for recipients of Strategic Prevention Framework grants from SAMHSA for monitoring progress and strengthening the initiative. The focus during the second phase of the initiative is to prevent and reduce under-age drinking and

youth binge-drinking. The Committee reviewed youth substance use and consequences data, such as the Maryland Youth Risk Behavioral Survey (YRBS) and the Substance Use and Outcomes 2015 Epidemiological State Profile. The Committee identifies system gaps through a needs assessment and facilitates a process for analyzing and ranking the substance use and consequences data, using the rankings to support priorities and make recommendations.

The membership and committee structure of the new Behavioral Health Advisory Council meets the federal requirements for the behavioral health planning (in statute - section, Title XIX, subpart 3 of the Planning Law 99-660), as well as the requirements for Strategic Prevention Framework grants from SAMHSA (focusing on substance abuse prevention and treatment or co-occurring disorder issues, concerns).

Ad Hoc Committees

These committees have been formed, as needed, to address specific duties, needs, or issues as deemed appropriate by the Executive Committee or Council:

A. Lifespan Committee I: Children, Young Adults, and Families:

The duties of this committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a system of care for behavioral health services and supports for children, young adults and families, including individuals with SED. The committee has been reviewing crisis services for children and adolescents in other states as well as Maryland and assessing them for how they handle integration related issues. As a result, the committee identified recommendations that they shared with the Crisis Services Committee. Committee members also identified priorities in the areas of stigma reduction, including expanding awareness and use of tools such as Youth Mental Health First Aid and increasing communication and education about the opioid epidemic. The Committee is also looking into the amount of MHBG funding for Children and Adolescent services.

B. Lifespan Committee II: Adults and Older Adults:

The duties of this committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of behavioral health services and supports for adults and older adults including individuals with SMI, other mental health and/or substance-related disorders. The Committee welcomed the challenge to identify recommendations to further improve the PBHS. Key focal points of the Life Span II Committee included but were not limited to: Overdose prevention – saving lives through naloxone access and stabilizing the expanding opioid epidemic; promotion of anti-stigma efforts – addressing the stigma of mental health and substance use disorders; and timely access to a full range of continuum of care – Crisis intervention, housing (recovery housing, supported housing), wrap around services, supported employment, and effective standards of care.

C. The Cultural and Linguistic Competence Committee:

The primary objective of the Cultural and Linguistic Competence Committee is to assist the Council in its role of gathering and disseminating information about the role culture

plays in the delivery of behavioral health services and generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services. The committee is drafting recommendations on jurisdictions' linguistic services, need for more residential services for individuals who are deaf or hard of hearing especially in regard to opioid and heroin crisis. The CLC committee is in the process of identifying and recommending strategies for the delivery of behavioral health services to be included in the development of the BHA's Cultural and Linguistic Competence Strategic Plan and future planning activities.

D. Criminal Justice/Forensics Committee:

The purpose of this committee is to advise the Administration regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems. Committee members have been focusing on: The clarification of the Maryland's Health General 8-505 and 8-507, which describe orders for commitment of individuals to a behavioral health facility or residential treatment by the court; efforts to ensure that a statewide diversion system provides access, sufficient capacity, and high-quality care to individuals requiring substance use treatment; the impact of barriers faced by individuals eligible for discharge from state facilities, and the reduction of the waiting list for state hospital beds; implementation of the Justice Reinvestment Act, Senate Bill 1005, that manages and allocates criminal justice populations in a more cost effective manner, and reinvests savings in strategies that decrease crime; and examining gaps in Maryland's current substance use treatment system. The Committee has been looking into the impact on the transfer of grants to fee for service structure, and issues related to staffing requirements for SUD Residential services. The Committee will continue to evaluate issues around quality of care delivered throughout the state and develop a set of recommendations to submit to the Governor.

E. Crisis Services Committee:

Enacted through House Bill 682/Senate Bill 551, this bill requires the Behavioral Health Administration, in consultation with various stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and seven days a week. The Executive Committee of the Behavioral Health Advisory Council serves as the Steering Committee to guide the process for the development of the Maryland Crisis Services Strategic Plan. Additionally, this Committee has tied its work to the Department's/BHA Forensic Services Advisory Council to further support the recommendations to increase the availability of community crisis services.

Throughout the year Council members continued to gather and share pertinent information from people in recovery, families, and other involved stakeholders through full Council presentations on a variety of topics such as those that focused on the progress of the Crisis Services Committee, overview of the Federal Block Grants (SUD and MH), progress reports from all Council committees, update on Maryland Medicaid and support for maintaining benefits of the Medicaid expansion despite challenges to the ACA, and monitoring of the activities of the Maryland OOC through regular reports.

Activities related to this section that you would like to highlight:

The Maryland Senate Bill 551 Behavioral Health Advisory Council – Crisis Services Strategic Plan Committee – Additional Information

Maryland Legislation requires the Council, in consultation with agencies, health providers, and stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available in all jurisdictions, and that the Maryland Behavioral Health Crisis Response System is accessible to individuals in need of mental health and substance use crisis services. The Council steering committee, consisting of the Executive Committee was also assisted in its work, until the summer of 2017, by BHA's Consultant for Crisis Services.

The Council officers decided that it would be more efficient to form a steering committee, consisting of the officers and the Co-Chairs of each Council committee, to guide the process of making recommendations and developing a strategic plan. The BHA supported this process by providing a consultant, to assist with the process and the collection of background data. The first was held on July 29, 2016 and some of the process activities for this work were delineated. The committee began by formulating a definition for clinical crisis walk-in services and mobile crisis teams. Secondly, the committee developed and administered a survey to gather certain information from CSAs/LAAs/LBHAs, interested stakeholders, and the public at-large.

The Web survey questions were designed to generate feedback related to the availability of clinical crisis walk-in Services and mobile crisis teams as well as to help identify priorities that will be used in the development of the strategic plan. Initially, the survey was piloted for Council members and then went live for the public from mid-October 2016 to January 31, 2017. Information about the survey and the links were widely disseminated through agency, advocate, and community networks throughout the state. Meanwhile, an Interim Report on the development of the strategic plan, required by statute, was submitted through the Council's annual report to the Governor in December 2016. In early 2017, the survey results from the more than 1,000 respondents were completed and the analysis informed an environmental scan that looked at existing local and national models, including best and promising models, use of incentives, existing collaborations such as connections with Crisis Intervention Teams (CITs), what and how staff are utilized, training requirements, and gaps in services.

The Crisis Committee is currently using the results of the Survey and Environmental Scan to inform components of the Plan. A draft plan is being developed for public comment and a final Strategic Plan will be submitted to the Governor and to the Legislature by December 31, 2017.

Please indicate areas of technical assistance needed related to this section that you would like to highlight.

Three Committee members also participated in SAMHSA's National Learning Community (NLC) for Technical Assistance for Strategic Planning. Although the focus of the NLC is to assist the Council in developing its own strategic plan for the state, Maryland has chosen to utilize the technical assistance to enhance its process of developing the state Crisis Services Strategic Plan. One Council Co-Chair and one Co-Chair of the Planning Committee have been attending the monthly Web conferences since January 2017.



State of Maryland Behavioral Health Advisory Council

Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor – Dennis R. Schrader, Secretary, MDH

Maryland's Behavioral Health Advisory Council's Planning Committee Plan Review Teleconference Meeting- Minutes for the FY 2018 Draft Behavioral Health Plan

August 30, 2017

10:00am – 12:15pm

Attendees: Dennis McDowell and Dori Bishop, Co-Chairs; Julie Jerscheid; Lisa Lowe; Lynn Mumma; Jeff Beck for Lori Rugle; Cynthia Petion, Hilary Phillips, Sarah Reiman, and Robin Poponne

Members were provided with a draft of the plan prior to the meeting for review. This draft had been previously reviewed by BHA leadership and their feedback has been incorporated. Hilary Phillips gave an overview of the changes in the Plan. The major difference between the drafts has been the addition of evaluation criteria to strategies, including the addition of percentages and numbers for evaluating criteria, in order to provide more clarity and reduce ambiguity. In addition, the goals of the plan reflect the four perspectives of the Balanced Scorecard strategic framework:

- Customer Needs
- Internal Business Processes
- Learning Innovations
- Finances

Planning Staff answered questions about the review process and the next steps prior to the beginning of the review. The Committees feedback will be considered in the final revision and a revised draft will be resubmitted to the Committee by September 1st for additional feedback. The Committee was also encouraged to provide any additional written feedback if necessary. The Plan will also be provided to the full Council for recommendations and feedback as well.

Recommendations resulting from this review are as follows:

- The Committee felt strongly that the Office of Consumer Affairs be listed as a header along with the other BHA divisions/units as it represents the peer/consumer advocacy groups and partners. An acknowledgment page of all stakeholders should also be included at the front of the document.
- The Committee wanted clarity regarding the number of schools that would be used for the school-based assessment and counseling services in Goal 3, Strategy 3.2c. BHA will look into this and there may need to be targets established for 2018 and 2019.

c/o Behavioral Health Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473

TTY: (800) 735-2258

- The Committee was glad to see the focus on ways to increase peer certification. They look forward to an enhanced process as BHA looks more closely at ways to increase professional acceptance among peers.
- In relation to Strategy 3.2e it was expressed how Emergency rooms and hospitals across the state need to be better equipped to handle opioid epidemic and the need to have facilities and trained professionals have better access to overdose treatment (naloxone), detox services, counseling, and treatment beds. Meanwhile the EDs need places to refer the great amount of people coming to them with needs for SUD treatment. The strategies do give support but more is needed. BHA stated that some of this is supported through the HOPE Act.
- Some strategies quote a goal to increase the numbers served for a specific initiative and the Committee question where the programs are getting their numbers and if they have baseline numbers. It was stated that there is an underutilization of resources and it would be beneficial for future planning efforts to include a capacity baseline. BHA explained that the numbers come from the directors of the divisions based on the current activities of the initiatives.
- It was good to see that overdose prevention emphasized best practices in their continuing efforts.
- It was good to read that the recovery residences are beginning to undergo a standard certification process. It is expected that the programs will receive as much or more attention as the physical environment. BHA explained HB 1411 and how Maryland will be modeling the process used in Florida, which is the only other state that currently has legislation regarding certification of recovery houses.
- The issue of capacity and treatment access was also raised in relation to 8-505 and 8-507 placements, specifically in relation to Strategies 5.9 and 5.10 and again for 6.11 and 6.12. For 6.11, as of January 2018, the Fee for Service system will be in place and should allow for more providers. BHA is working on getting more information for Strategy 6.12 as it is too vague. In addition, responsible BHA staff will collaborate with its partners to address the mandates of the legislation. The Committee would still like for more creative options to be explored to obtain additional providers.
- The Committee questioned if FAST would be included in this Strategy. BHA was not sure but will inquire.
- There are questions concerning budget allocations for local initiatives. All members were encouraged to read the conditions of awards within the plans of their jurisdiction to become informed of the budget process.
- In addition to the plan, the quarterly or annual reports provided by special initiatives such as SOAR or CQT are good sources of information.
- Members would like to see enhanced coordination of care efforts when an individual is seen by a telehealth provider and other provider(s), especially concerning aftercare planning.
- As mentioned in prior meetings it is important to support consumer/peer participation in the local as well as statewide planning processes.

Additional Comments:

1. The Committee sought clarification on the contact persons for various BHA units/divisions and names, it was explained that not one specific person, but the entire program staff, is responsible for the work.
2. It was explained to the Committee that once the document was finalized and made public that there would be another opportunity for Public Comment.
3. It was also explained that this document was not the only process/effort in place; that they had other avenues in which to provide feedback on various mandates/initiatives, e.g. procurement processes are not included in this Plan, specifics on indicators/quantifications.
4. The Committee will also have an opportunity to review parts of the Block Grant but that this document was merely a summary of what Maryland is already doing, so any recommendations would have no significant effect on change for this FY.
5. A few acronyms needed to be spelled out (HBBI, DBM, and HR).
6. BHA offered a distinction between Dashboard tools and DLA-20 Data Mart to Committee members.
7. Evaluation criteria is still needed for Strategies 5.2, 5.3 and 5.4

The next step is to make changes in the document according to today's recommendations, when appropriate, and then to disseminate a final draft to the entire Council.

Meeting was adjourned.



State of Maryland Behavioral Health Advisory Council

Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor – Dennis R. Schrader, Secretary, MDH

Maryland's Behavioral Health Advisory Council's Planning Committee Plan Review Meeting- Minutes for the FY2017 Draft Behavioral Health Plan

July 19, 2017
11:00am – 1:00pm

Attendees: Dennis McDowell and Dori Bishop, Co-Chairs; Julie Jerscheid; Lisa Lowe; Virginia Spence; Cynthia Petion; Hilary Phillips; and Robin Poponne

The Committee meeting was called to order to provide an overview of the FY 2018 Annual Behavioral Health Plan format, goals and elements. Hilary Phillips provided this to the members. The Plan's goals fall within four domains based on the Balanced Scorecard strategic framework. These goals include:

- Customer Needs
- Internal Business Processes
- Learning Innovations
- Finances

One of the major goals of the Plan will be to continue improving communications with staff and our internal and external customers. The Committee appreciated hearing a detailed explanation of the differences between internal and external customers. As a result of this meeting, in addition to a few editorial/typographical errors, which were noted for correction, the following recommendations were made to improve the plan:

- There are many areas in the plan that do not mention Peers as involved participants yet are appropriate avenues for peer engagement – planning processes, development of campaigns, etc.
- SBIRT screening should be available in all schools
- Specific terminology and abbreviated names (emergent or non-emergent, 8-507, etc.) should be briefly explained. Special initiatives or grants that are named should be briefly described within the text of the strategy.
- Administration could increase outreach efforts with universities to establish a standard of study in every medical department/school of addiction as a required course of study.
- BHA could expand recognition and support of additional grassroots, non-profit advocacy organizations, beyond the ones mentioned in the Plan. Make available on state and local Web sites a listing of peer organizations representing consumers of behavioral health services.

c/o Behavioral Health Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473
TTY: (800) 735-2258

- Use of generic rather than specific names of the various medically assisted therapies (MATs) or of the pharmaceutical company in the document.
- Would be beneficial to cite the legislation or the task force behind specific strategies.
- Strategies would be enhanced by clarifying what population they serve if not serving the system in general.

Members who were present as well as those who were not, were given one week to send additional comments for this review to Greta Carter.

A final review of the draft plan will take place in August. Members will be notified of that date.

Meeting was adjourned

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email(if available)
Makeitha Abdulbarr	Others (Not State employees or providers)	MD County Behavioral Health Advisory Councils	11604 Capstan Drive Upper Marlboro MD, 20772 PH: 301-343-7765	ABDULBARR@COMCAST.NET
Barbara Allen	Others (Not State employees or providers)	Community Advocate	8325 Fall Chill Court Ellicott City MD, 21043-6048 PH: 410-491-4149	BARBARA@JAMESPLACEINC.ORG
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Dori Bishop	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Advocate	4204 Greenway Baltimore MD, 21218-1134 PH: 410-913-8614	DORIBISHOP@AOL.COM
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Kenneth Collins	State Employees	MD County Behavioral Health Advisory Councils	401 Bow Street Elkton MD, 21921 PH: 443-245-3772	KEN.COLLINS@MARYLAND.GOV
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Jan Desper Peters	Others (Not State employees or providers)	Black Mental Health Alliance, Inc.	200 E. Lexington Street Baltimore MD, 21202 PH: 410-338-2642	JANDESPER@BLACKMENTALHEALTH.COM
Allysa Dittmar	State Employees	Governor's Office of Deaf and Hard of Hearing	100 Community Place Crownsville MD, 21032 PH: 443-453-5871	ALLYSA.DITTMAR@MARYLAND.GOV
			2301 Argonne Drive	

Catherine Drake	State Employees	Maryland Division of Rehabilitation Services	Baltimore MD, 21218 PH: 410-554-9440	CATHERINE.DRAKE@MARYLAND.GOV
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Kate Farinholt	Family Members of Individuals in Recovery (to include family members of adults with SMI)	National Alliance on Mental Illness-Maryland	10630 Little Patuxent Pkwy. Columbia MD, 21044 PH: 410-884-8691	ED@NAMIMD.ORG
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Antonio Hayes	State Employees	Maryland House of Delegates	6 Bladen Street Annapolis MD, 21401 PH: 410-841-3545	ANTONIO.HAYES@HOUSE.STATE.MD.US
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James Hedrick	State Employees	Maryland - Governor's Office of Crime Control and Prevention	100 Community Place Crownsville MD, 21032-2066 PH: 410-697-9311	JHEDRICK@GOCCP.STATE.MD.US
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Susan Lichtfus	Others (Not State employees or providers)	MD County Behavioral Health Advisory Councils	119 Deaver Street Havre de Grace MD, 21078 PH: 410-638-5248	slichtfuss@sheppardpratt.org
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Theresa Lord	Parents of children with SED	Advocate	221 Laysan Teal Court Church Hill MD, 21623-1424 PH: 443-875-7948	ALORD4U2@GMAIL.COM
Dan Martin	Others (Not State employees or providers)	Mental Health Association of Maryland, Inc.	Suite 505 Lutherville MD, 21093 PH: 410-235-1178	DMARTIN@MHAMD.ORG
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			300 East Joppa	

Stephen Moyer	State Employees	MD Depart of Public Safety and Correctional Svcs	Road Towson MD, 21286 PH: 410-339-5032	STEPHEN.MOYER@MARYLAND.GOV
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Kathleen O'Brien	Providers	Maryland Addictions Director's Council (Behavioral Health) MADC	41161 Knight Road Leonardtwn MD, 20650 PH: 301-904-1489	KATHLEEN@WALDENSIERRA.ORG
Luciene Parsley	Others (Not State employees or providers)	Disability Rights Maryland	Suite 2000 Baltimore MD, 21211 PH: 410-727-6352 FX: 410-727-6389	LUCIENEP@DISABILITYRIGHTSMD.ORG
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			382 Homeland	

Anita Wells	Others (Not State employees or providers)	Academic/Research Professional	Southway, 1B Baltimore MD, 21212 PH: 443-885-3495	AMWELLS991@GMAIL.COM
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Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	54	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	13	
Total Individuals in Recovery, Family Members & Others	27	
State Employees	25	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	27	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	7	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
 - a) Public meetings or hearings? Yes No
 - b) Posting of the plan on the web for public comment? Yes No
 - c) Other (e.g. public service announcements, print media) Yes No

If yes, provide URL:

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BEHAVIORAL HEALTH ADMINISTRATION

Subject: Availability of Behavioral Health Plan for Citizen Review

Date/time: June through August 1, 2017, Monday through Friday, 8:30 a.m. – 4:30 p.m.

Place: Spring Grove Hospital Center, Mitchell Bldg., 55 Wade Avenue, Catonsville, MD, 21228

Additional Information: The Behavioral Health Administration (BHA) is in the process of developing the FY 2018 Behavioral Health Plan as part of its application for the FY 2018 – 2019 Federal Mental Health (MHBG) and Substance Abuse (SABG) Block Grant funds. Final submission of the FY 2018-2019 MHBG and SABG applications to the federal Substance Abuse and Mental Health Services Administration, Centers for Mental Health Services, Substance Abuse Prevention and Treatment will occur by September 1, 2017. Drafts of the FY 2018 Behavioral Health Plan can be reviewed in June 2017 at the above address. Any general comments regarding the Behavioral Health Plan or specific comments regarding drafts to the finalization of the MHBG/SABG applications will be considered and incorporated as appropriate. The documents will be available after their due dates, and will be posted on the BHA website: <http://bha.dhmdh.maryland.gov>. Comments on the plan may also be made after submission of the plan to the Federal Government.

Contact: Greta Carter – 410-402-8473

<http://www.dsd.state.md.us/MDR/mdregister>

Footnotes: