



***FY 2014 ANNUAL STATE
MENTAL HEALTH PLAN
IMPLEMENTATION REPORT***

A CONSUMER – ORIENTED SYSTEM

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November 2014

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“The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.”

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ACKNOWLEDGEMENTS

As in the past, the FY 2014 State Mental Health Plan is the result of the hard work of many people, particularly the Mental Hygiene Administration (MHA) staff, consumers, providers, mental health advocacy groups, the Planning Committee of the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council and representatives of the Core Service Agencies. However, during the past four years the participation in the development of this annual plan was much increased through additional organizational and community stakeholders who gave their time to review and offer input into this document through all day Mental Health Plan Development Meetings held in the spring. Again on April 26, 2013 the gathering included representatives of:

Consumer, child and family advocacy organizations

Wellness and Recovery Centers/Recovery and Wellness Centers

Mental health providers and provider organizations

Local Mental Health Advisory Committees

Local Drug and Alcohol Abuse Councils

Maryland Association of Core Service Agencies

Core Service Agencies' Boards of Directors

Protection and Advocacy Agencies

The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Maryland Blueprint Committee

Alcohol and Drug Abuse Administration (ADAA) and other Maryland Department of Health and

Mental Hygiene (DHMH) state agencies

University of Maryland's System Evaluation Center (UMD SEC), Evidence Based Practice

Center (UMD EBPC) and the Institute of Innovation and Implementation

Other interested stakeholders and citizens of Maryland

The use of break-out groups, as well as the availability of and interaction among key MHA staff and stakeholders, allowed much to be accomplished in a limited period of time. The groups identified recommendations to support planning efforts in developing a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues. While not all suggestions/recommendations were able to be included in the final document, many of the concepts prioritized by the break-out groups are expressed, at least in part, in a number of strategies. The input of the participants, through the group discussions and interactive process, has been invaluable. We at MHA thank all of you who contributed to the development of this plan and look forward to continued collaboration as we proceed with our goals and future endeavors in a behavioral health system of care.

STATE OF MARYLAND MENTAL HYGIENE ADMINISTRATION

MISSION

The Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will 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 and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

THE VISION

The Vision of our behavioral health system of care is drawn from fundamental core commitments:

- Coordinated, quality system of care that is supportive of individual rights and preferences
- Availability of a full range of services
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring conditions are common
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers across the life span

VALUES

The values underpinning this system are:

(1) SUPPORTIVE OF HUMAN RIGHTS

Persons with psychiatric disabilities have the same rights and obligations as other citizens of the state. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.

(2) RESPONSIVE SYSTEM

The behavioral health system of care must be responsive to the people it serves, coherently organized, and accessible to those individuals needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner. The hospitals are one part of the community-based mental health system. The behavioral health system of care must collaborate with other public and private human health service systems in order to allow for continuity of care and facilitate support with all activities of life.

(3) EMPOWERMENT

Consumers, families, and advocates will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operational aspects of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

- (4) ***COMMUNITY EDUCATION***
Promote wellness through early identification and prevention activities for risk groups of all ages. Public education and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services come from increased awareness and understanding of psychiatric disorders and treatment options.
- (5) ***FAMILY AND COMMUNITY SUPPORT***
We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports.
- (6) ***LEAST RESTRICTIVE SETTING***
An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.
- (7) ***WORKING COLLABORATIVELY***
Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently appropriate level of mental health services.
- (8) ***EFFECTIVE MANAGEMENT AND ACCOUNTABILITY***
Accountability is essential to consistently provide an adequate level of mental health services. Essential management functions include monitoring and self-evaluation, rapid response to identified weaknesses in the system, adaptation to changing needs, and improved technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.
- (9) ***LOCAL GOVERNANCE***
Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources with needs, and increase economic efficiency due to the closer proximity of the service delivery level.
- (10) ***STAFF RESOURCES***
The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

List of Acronyms

ACA	Affordable Care Act
ACT	Assertive Community Treatment
ADAA	Alcohol and Drug Abuse Administration
ASAM	American Society for Addiction Medicine
ASO	Administrative Services Organization-ValueOptions®Maryland
BHA	Behavioral Health Administration
BHI	Behavioral Health Integration
B-HIPP	Behavioral Health Integration in Pediatric Primary care
BI	Brain Injury
BIP	Balancing Incentive Payments Program
BRSS TACS	Bringing Recovery Supports to Scale Technical Assistance Strategy
CBH	Community Behavioral Health Association of Maryland
CCAC	Cultural and Linguistic Competence Advisory Committee
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CLCTI	Cultural Linguistic Competence Training Initiative
CME	Care Management Entities
CMS	Center for Medicare/Medicaid Services
CoC	Continuum of Care (formerly Shelter Plus Care)
CPRS	Certified Peer Recovery Specialist
CSA	Core Service Agency
CQT	Consumer Quality Team
DDA	Developmental Disabilities Administration
DDC	Dual Diagnosis Capability

DHCD	Department of Housing and Community Development
DHMH	Maryland Department of Health and Mental Hygiene
DHR	Maryland Department of Human Resources
DJS	Maryland Department of Juvenile Services
DORS	Division of Rehabilitation Services
DPSCS	Department of Public Safety and Correctional Services
DSS	Department of Social Services
EBP	Evidence-Based Practice
FLI	Family Leadership Institute
FPE	Family Psycho-Education
GOC	Governor's Office for Children
HTI	Healthy Transitions Initiative
HUD	Department of Housing and Urban Development
HUI	Housing Unlimited, Inc.
IFSC	Interagency Forensic Services Committee
IIMR	Integrated Illness Management and Recovery
LAUNCH	Linking Actions for Unmet Needs in Children's Health
LEAP	Leadership Empowerment and Advocacy Project
LGBT	Lesbian, Gay, Bi-sexual, Transgender
LMHAC	Local Mental Health Advisory Committee
LIFT	Launching Individuals Futures Together
MA	Medical Assistance or Medicaid
MABPCB	Maryland Addiction and Behavioral Health Professionals Certification Board
MAP	Maryland Access Point

MARFY	Maryland Association of Resources for Families and Youth
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCF	Maryland Coalition of Families for Children’s Mental Health
MCO	Managed Care Organization
MDoA	Maryland Department of Aging
MDOD	Maryland Department of Disabilities
MFP	Money Follows the Person
MHA	Mental Hygiene Administration
MHAMD	Mental Health Association of Maryland, Inc.
MHBG	Federal Mental Health Block Grant
MHFA	Mental Health First Aid
MIS	Management Information Systems
MMHEN	Maryland Mental Health Employment Network
MPAH	Maryland Partnership for Affordable Housing
MSDE	Maryland State Department of Education
NAMI MD	National Alliance on Mental Illness-Maryland
OCA	Office of Consumer Affairs
ODHH	Governor’s Office of the Deaf and Hard of Hearing
OFS	Office of Forensic Services
OHCQ	Office of Health Care Quality
OMS	Outcome Measurement System
OOOMD	On Our Own of Maryland, Inc.
PASRR	Preadmission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness

PCCP	Person Centered Care Planning
PDMP	Prescription Drug Monitoring Program
PRP	Psychiatric Rehabilitation Program
QuIP	Quality Improvement Incentive Program
RAISE	Recovery after an Initial Schizophrenia Episode
RFP	Request for Proposal
RICA	Regional Institutes for Children and Adolescents
RRP	Residential Rehabilitation Program
RWC	Recovery Wellness Centers
SAMHSA	Substance Abuse and Mental Health Services Administration
SE	Supported Employment
SED	Serious Emotional Disorders
SMI	Serious Mental Illness
SOAR	SSI/SSDI, Outreach, Access, and Recovery
SOC	System of Care
SPA	State Plan Amendment
SPMI	Serious and Persistent Mental Illness
SSA	Social Security Administration
SSI/SSDI	Supplemental Security Income/ Social Security Disability Insurance
SUD	Substance Use Disorder
TAY	Transition-Age Youth
TBI	Traumatic Brain Injury [also referred to as Brain injury (BI)]
TCM	Targeted Case Management
TTW	Ticket to Work
UMBC	University of Maryland – Baltimore County

UMD EBPC	University of Maryland Evidence-Based Practice Center
UMD SEC	University of Maryland Systems Evaluation Center
WRAP	Wellness Recovery Action Plan
WRC	Wellness and Recovery Center

**SYSTEM GOALS
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Many of the Mental Hygiene Administration (MHA) goals, objectives, and strategies in this State Mental Health Plan for children, adolescents, and adults are a result of existing interagency cooperation, as well as public and private partnerships. This operational plan has been updated annually to address critical issues, current activities, and ongoing efforts related to the coordination of care and improvement of service systems; particularly in the areas of: public education; awareness; training of consumer, families, and mental health professionals; promotion of wellness, prevention, recovery, and diversion activities; evidence-based and promising practices; cultural competency; and development of affordable housing options.

This is the last documentation of activities of the Mental Hygiene Administration (MHA), as well as the collaborative efforts with the Alcohol and Drug Administration (ADAA). As of July 1, 2014, these two administrations have merged becoming the Behavioral Health Administration. You can read more about this project under strategy 2-1B on pages 32-33 of this document. Because this is a document giving the end of fiscal year status for FY 2014 strategies, MHA, ADAA, and former job titles will be referenced throughout. As we discuss efforts that are ongoing or initiatives that will begin in FY 2015, it would be most appropriate for us to reference the Behavioral Health Administration (BHA). We hope this is not too confusing to the reader.

In this document, we continued to focus on efforts toward improvement in the delivery of prevention, treatment, and recovery support services at the same time focusing on the Administration’s efforts toward promoting expansion of behavioral health with the goal of improving and impacting care across behavioral health and somatic domains. MHA continued to organize its FY 2014 plan activities based on the Substance Abuse and Mental Health Services Administration (SAMHSA’s) Eight Strategic Initiatives (Listed in Appendix B).

We have worked together with consumers, families, providers, advocacy organizations, professionals, and interested citizens to complete this process and we are very grateful to all of you who participated in these efforts.

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GOAL I. INCREASE PUBLIC AWARENESS AND SUPPORT FOR IMPROVED HEALTH AND WELLNESS.

Objective 1.1. The Mental Hygiene Administration (MHA), in collaboration with the Core Service Agencies (CSAs), will continue to work with the behavioral health community to initiate educational activities and disseminate, to the general public, current information related to psychiatric disorders, prevention mechanisms, treatment services, and supports.

(1-1A) **Federal Mental Health Block Grant Strategy*
MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Missouri Department of Health, the National Council for Community Behavioral Health, and the Mental Health Association of Maryland, Inc. (MHAMD) will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland and throughout the United States.

Indicators:

- Continued publication, distribution, and promotion of Mental Health First Aid Participant Manual, Teaching Notes, and other materials
- Implementation of Youth Mental Health First Aid education and training program
- Continued research, development and piloting of curriculum supplements for specialized audiences
- Number of people trained
- Continued partnership with MHAMD and Core Service Agency (CSAs) to deliver additional training to local communities such as Area Offices on Aging, Department of Social Services, law enforcement, parole and probation, judges, public health, emergency medical services personnel, shelter workers, higher education, and state employees
- Program sustained through course fees and other funding sources

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Cynthia Petion and Carole Frank, MHA Office of Planning; DHMH; CSAs; Mental Health Association of Maryland (MHAMD); Maryland Coalition of Families for Children's Mental Health (MCF); On Our Own of Maryland (OOOMD); Missouri Department of Mental Health; the National Council for Community Behavioral Health; Mental Health and Criminal Justice Partnership; Maryland Police and Correctional Training Commission; other behavioral health advocacy groups

MHA Monitor(s): Brian Hepburn, BHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

Mental Health First Aid (MHFA) is the initial help given to someone developing a mental health problem or in a mental health crisis before appropriate professional or other assistance, including peer and family support, can be engaged. The eight-hour course teaches people how to give first aid to individuals and to learn the signs and symptoms of the most common mental health problems.

Mental Health First Aid can serve as a cross-training program as mental health and substance use treatment integrates in the state of Maryland. Several Core Service Agencies, including those that have begun to integrate their bureaus, have trained staff in the core program as well as instructors. Key participants for the core program training include individuals from a wide gamut of areas such as veterans, aging and assisted living, law enforcement, judges, public safety, higher education, faith communities, family members/caregivers, nursing home staff, and state employees among many others.

Additionally, to further increase the impact of MHFA, the Governor's state budget included \$300,000 for the FY 2014 expansion of MHFA. As a result, training opportunities have increased. In FY 2014, 224 MHFA trainings were conducted, certifying 2,579 people in the core and/or youth program to be MHFA responders bringing the total number of trained responders in Maryland to more than 7,884 as of June 31, 2014. In addition, more than 400 instructors are now certified in Maryland across both curricula with nearly half of those (190), being certified in FY 2014.

Since the official launch of the program in late 2009, almost 292,782 core participant manuals and over 4,600 core instructor kits have been distributed nationally. In FY 2014, MHAMD piloted and released curriculum modules supplementing the Adult program which include: Military, Veterans and Families, Public Safety, and Higher Education. Full transition from the 12-hour to the 8-hour program was completed in December 2013. There is also a Spanish Language Program. The Core Adult Program, includes teaching notes, a slide deck, and a participant manual. Many of the films/DVDs now contain Spanish subtitles. MHAMD is the statewide organization charged with producing and distributing the materials nationally as well as managing the training program in Maryland.

Since the formal launch of the Youth Program in October 2013, more than 104,000 Youth manuals and 1,667 Youth instructor kits have been sold. Youth Mental Health First Aid courses in the US now include filmed interviews. Key audiences for the youth program include teachers/school administrators, school nurses and health techs, guidance counselors and crisis workers, school security staff, bus drivers, and other school personnel. Also coaches and recreation league staff, faith and youth group leaders, scout leaders, mentors and volunteers, parents and PTAs, law enforcement/first responders, juvenile justice, pediatricians, pediatric nurses, and medical staff.

Strategy Accomplishment:

This strategy was achieved.

(1-1B)

MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

Indicators: Continued support for:

- Maryland Coalition of Families for Children's Mental Health's (MCF) and Mental Health Association of Maryland's (MHAMD's) Children's Mental Health Awareness Campaign – "Children's Mental Health Matters"; number of public service announcements aired, volume of literature disseminated, and other outreach activities implemented
- National Alliance on Mental Illness (NAMI MD) – NAMI WALK, Family to Family, and other education programs
- On Our Own Maryland, Inc. (OOOMD) – Anti-Stigma Project workshops
- Network of Care – promotion and usage
- MHAMD – outreach campaign for older adults
- CSA – outreach/media campaigns
- Wellness and Recovery Centers (WRC) and Recovery Wellness Centers (RWC) – outreach efforts to further integrate consumer run support services, training and programs
- The Substance Use and Mental Health Services Administration (SAMHSA) *Bringing Recovery Supports to Scale Technical Assistance Strategy* (BRSS TACS) Policy Academy Award (a funding source to support coordinated efforts to adopt recovery-oriented systems of care on a broad scale to develop a peer credentialing model that will be inclusive of MHA and ADAA specializations
- Two day peer conference with a focus on workforce development and collaborations.

Involved Parties: Cynthia Petion and Robin Poponne, MHA Office of Planning; Al Zachik, MHA Office of Child and Adolescent Services; Marian Bland and Steve Reeder, MHA Office of Adult Services; MHA Office of Forensic Services; MHA Office of Consumer Affairs; appropriate MHA staff; CSAs; MCF; MHAMD; NAMI MD; OOOMD; Wellness and Recovery Centers (WRC); community providers

MHA Monitor: Robin Poponne, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

Children's Mental Health Matters

In FY 2014, MCF and MHAMD, with continued support of MHA, continued the partnership with a number of community organizations and stakeholders including the System of Care grants (MD CARES, Rural Cares, and Launching Individuals Futures Together [LIFT]), to promote the successfully received *Children's Mental Health Matters* awareness campaign. This social marketing effort is designed to build a network of information and support for families across Maryland and raise awareness of children's mental health. First Lady of Maryland, Katie O'Malley, served as Honorary Campaign Chairperson for the sixth year, and Maryland State Superintendent Dr. Lillian Lowery endorsed the school partnership program for the second year in a row. The FY 2014 Campaign was the largest and most successful effort, thus far, reaching more

Marylanders and engaging more school/community partners to raise awareness about children's mental health.

During May 4–10, 2014, Children's Mental Health Awareness Week in Maryland, 111 local and state agencies/nonprofits/providers pledged to be Campaign Partners and 150 public schools pledged to be School Champions, committing to spread the word and hold at least one awareness raising event within their community or school. Events scheduled across the state included a Campaign Poster reception at *Open Eyes, Open Minds: Raising Mental Health Awareness Through Art* at the American Visionary Art Museum. Other events included: a flash mob and youth panel at the University of Maryland Baltimore County; baseball awareness nights; and essay and art contests on mental health-related topics in schools.

This year the Campaign has focused its effort on resilience. The Campaign offered a Webinar for families and a Resiliency Calendar for the month of May to give parents and caregivers tips on boosting resilience in the youth they care for. The Web site also features resources such as additional Webinars, fact sheets about children's mental health, and guidance on how to get help. The campaign's Web site is www.childrensmentalhealthmatters.org.

The campaign continued its partnership with local broadcast affiliates in radio and television. In addition to traditional print and broadcast media, social media tools such as the Web site, Google Calendar, and Facebook page were used to disseminate information. The Campaign distributed 260 free Awareness kits, which included green wristbands, the 2014 poster, other promotional items, and a new Crisis Services fact sheet. Thousands of additional items were distributed to schools and partners across the state.

NAMIWALKS

MHA continued to support the National Alliance on Mental Illness-Maryland (NAMI MD) and other stakeholders participating in NAMIWALKS, a kick-off event for successfully promoting *MAY MENTAL HEALTH MONTH*. In 2014, NAMIWALKS took place on May 31, 2014 at 1:30 in the afternoon, outside the Baltimore Science Center. More than 2,000 people attended the Walk. The Downtown Inner Harbor Partnership continues to collaborate with NAMI MD toward the success of this event. Food and health vendors were on site as a convenience to the participants. The awareness walk is designed to highlight the importance of education, advocacy, and support for persons diagnosed with a serious mental illness and their families. This annual event also helps reduce stigma often associated with mental illness by providing an opportunity for positive interactions and networking.

The NAMI MD peer and family support education programs offer unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. Below are a few of the various support education groups taught, facilitated and/or presented by peers in FY 2014 that receive funding support from the state and the proceeds from the NAMIWALKS:

- Family-to-Family - a free 12-session education and skills course for families, taught by thoroughly trained relatives, which this year incorporated information on supported employment opportunities. At least 27 Family-to-Family courses were held enrolling more than 460 individuals.
- The Peer-to-Peer classes, which includes education on individual empowerment, family and peer support, relapse prevention, and enhancement of personal activity and communication skills - nearly 100 individuals living with mental illness were enrolled in seven courses throughout FY 2014.
- In Our Own Voice – a presentation about living with mental illness facilitated by individuals who effectively use their personal experience in a structured workshop to educate the community, providers, and others living with mental illness. In FY 2014 one hundred and fifty-four presentations occurred, reaching more than 2,900 individuals.

The Walk and other fund raising activities support some of the costs of many other NAMI programs as well.

On Our Own of Maryland, Inc. - The Anti-Stigma Project

On Our Own of Maryland, Inc. (OOOMD) is a statewide mental health consumer education and advocacy group that promotes equality in all aspects of society for people who receive mental health services and develops alternative, recovery-based initiatives. In collaboration with MHA, OOOMD leads the development and implementation of many projects that promote outreach, education and recovery. One of the oldest projects is the Anti-Stigma Project (ASP). In 2014, OOOMD, celebrates the 20th year of the ASP, as they continue to collaborate efforts to fight stigma within the mental health system. Since the inception, ASP has trained more than 20,000 people directly and impacted countless others indirectly. During this fiscal year, the ASP presented 53 workshops throughout the state, which trained 940 people in the full program and reached a wide audience through tangentially related organizations which included: colleges/universities, a forensic hospital, a halfway home, a program for individuals with developmental disabilities, a senior service center, and a hospital for veterans. ASP workshops may be designed and tailored to address specific populations and situations. Each workshop is team-facilitated by experienced trainers with extensive and varied experience in mental health, addictions, recovery, education and communications. Workshops currently offered included: *Stigma...in Our Work, in Our Lives; An Inside Look at Stigma; Stigma: Language Matters; and Stigma: It Doesn't Discriminate.*

Network of Care

The Maryland Network of Care (NOC) for Behavioral Health continues to enhance Maryland residents' ability to access consumer-driven, recovery-oriented and community-specific information regarding available mental health services in all of Maryland's 24 jurisdictions. Specialized service information is provided for Maryland's Youth, as well as a special portal for Veterans and families to help service men and women returning from Iraq and Afghanistan with behavioral issues, to obtain access to services. Core Service Agencies (CSAs) have been encouraged to support, at the county

level, the expansion and promotion efforts of NOC. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers (WRCs), as well as other community settings, and plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC. Many consumers have received on-site training in the utilization of personal health record features and in the use of individual advance directives.

Outreach Campaign for Older Adults

Through the Mental Health Association of Maryland's (MHAMD) "Coalition on Mental Health and Aging," representatives of MHA, Maryland Department of Human Resources (DHR), Maryland Department of Aging (MDoA) work hand-in-hand to jointly plan opportunities, cross-trainings, client sharing responsibilities, and opportunities for additional partnerships. *Mental Health in Later Life: a Guidebook for Older Marylanders and the People Who Care for Them* is produced and distributed by the MHAMD to bring education and resources regarding important issues of mental health and aging. In FY 2014, the Director of the Coalition gave a workshop at the MHA Annual Conference on substance use disorders among older adults.

Several CSAs also provide training, outreach, and consultation on issues related to the needs of older adults to various community settings that serve this population.

Core Service Agencies

CSAs plan, develop and manage a full range of treatment and rehabilitation services for adults with serious mental illnesses (SMI) and for children and adolescents with serious emotional disorders (SED). There are 19 CSAs in Maryland which are often the gateway to public health services. CSAs are the local face of the public health services and work collaboratively with other human services agencies to promote comprehensive services, wellness, evidence based practices, and integrated care. Outreach efforts are also implemented through community activities and partnerships. Included among the FY 2014 outreach activities were: trainings for community members on available services and supports; Mental Health First Aid; availability of community resources; behavioral health presentations; town hall meetings on behavioral health services; and outreach supports and services to older adults and homeless individuals. The CSAs, overall, average more than 300 sponsored trainings and public education events each year.

Wellness and Recovery Centers

Throughout Maryland there are 26 local Wellness & Recovery Centers (WRCs) that are established as places of ongoing peer support and training opportunities. There is an increased focus on the involvement of the WRCs in surrounding community organizations and activities to allow the centers and their members to become active participants in the greater community. In FY 2014, each of the 26 WRCs provided education forums internally and outreach sessions on mental health topics to consumers in hospitals, outpatient mental health clinics, and other sites that provide mental health services. Additionally, sessions were dedicated to educating the community at large with the goal of reducing stigma and promoting wellness activities such as smoking cessation, nutrition, healthy living and education and awareness on substance use. The WRCs also produced newsletters and/or calendars containing announcements and write-ups of special events.

The ADAA and MHA collaborated to further develop peer-based recovery services and systems to enhance efforts towards behavioral health integration. In FY 2012, Maryland applied for and received a SAMHSA, *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy Award. This effort was designed to build workforce capacity and create infrastructure to ensure collaboration and sustainability for Peer Recovery Support Services. As a result of this and other efforts to expand and strengthen the role of Peer Support Specialists and Recovery Support Specialists, a peer recovery certification process is in place. SAMHSA has contributed funding toward training available through August of 2014. Meanwhile, in March, currently eligible peer support and recovery support specialists were “grandfathered” into certification through the Maryland Addiction and Behavioral Health Professionals Certification Board (MABPCB).

Strategy Accomplishment:

This strategy was achieved.

(1-1C)

In collaboration with the University of Maryland Systems Evaluation Center (UMD SEC), increase public awareness and support for improved health and wellness through the use of Data Shorts publications to provide concise behavioral health data, analysis, and public health information that can be used by various stakeholders.

Indicators:

- Promote public mental health awareness and improved communication among MHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, release eight Data Shorts pertaining to: public, mental and behavioral health data; information; and behavioral health efforts in the State of Maryland as well as nationwide
- Continue to build electronic distribution list serve as well as avenues of dissemination and distribution of Data Shorts

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems (MIS) and Data Analysis; UMD SEC; University of Maryland Evidence-based Practice Center (UMD EBPC); ADAA

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2014 activities and status as of 6/30/2014 (end-year report):

Data Shorts provides concise behavioral health data and analysis that can be used by the various stakeholders. This is a Behavioral Health Administration (BHA) project in collaboration with the University of Maryland, Systems Evaluation Center (UMD SEC) that has scheduled distribution throughout the fiscal year.

Data Shorts topics range from a comparison of consumers receiving mental health services with and without substance use disorders, functioning scales related to recovery both in adults and youth, mental illness stigma, and challenges to continuity of care for adults receiving behavioral health services. It is anticipated that there will be more individuals that will utilize services as Maryland moves forward with conducting more screenings and early interventions.

There were a total of 12 Data Shorts released within FY 2014. The Data Shorts are distributed via Twitter and published electronically on the BHA Web site. More than 70 copies of recent Data Shorts were distributed to both Senate and House representatives during the Legislative Hearing sessions. The Data Shorts were well promoted and received praise and valuable feedback from stakeholders.

In FY 2014, the Data Shorts committee was integrated with ADAA staff and a good number of the topics produced involved Behavioral Health Integration. The distribution list was expanded to include ADAA staff, now part of the BHA, and various substance use providers and other stakeholders. The Data Shorts electronic distribution list has grown to over 231 mental health advocates, providers, and administrative contacts.

Additionally, MHA, through DHMH departmental-wide efforts, maintained established social media outlets through Facebook and Twitter as a means of disseminating mental health data and news among MHA, CSAs, providers, advocates, consumers, family members, and the public at large.

Strategy Accomplishment:

This strategy was achieved.

(1-1D)

MHA, in collaboration with the Core Service Agencies (CSAs) will continue to facilitate an all-hazards approach to emergency preparedness and response for MHA as an Administration and for the mental health community at large.

Indicators:

- All-Hazards Disaster Mental Health Plans from the CSAs updated
- Multi-state Consortium and Brain Tree Solution utilized as resources

Involved Parties: Marian Bland, MHA Office of Special Needs Populations; Facilities CEOs; Facilities Emergency Managers; CSAs Region III Disaster Behavioral Health Coordinators; consultants

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

FY 2014 activities and status as of 12/31/14(end-of-year report):

MHA's Office of Special Needs Populations reviews, facilitates updates to, and assists in the revision of, the All-Hazards Mental Health Disaster Plans for MHA (now the BHA) and all the CSAs.

Statewide and locally, CSA All-Hazards Plans are partially updated in selected areas of the plan such as essential contact information. CSAs are also using current plans and preparations to develop joint Behavioral Health Disaster plans. Local Health Departments continue to identify needs whether unmet or resolved and inform the State Emergency Operation Center (SEOC) and the Office of Preparedness and Response (OP&R) which maintains this information and situation reports. BHA, in collaboration with the CSAs, will continue to facilitate an all-hazards approach to emergency preparedness and response for BHA as an Administration and for the behavioral health community at large.

On a State-National level, MHA has been working with the Federal Emergency Management Agency (FEMA) and Brain Tree Solutions consultants to provide input toward the development of the FEMA Region III Operational Response and Responder Training Plan. This document is being designed to enhance regional disaster Behavioral Mental Health preparedness among the Region III States – Maryland, Virginia, Delaware, Pennsylvania, West Virginia, as well as the District of Columbia. Additionally, meetings are ongoing with Brain Tree Solutions to identify the best practices disaster behavioral mental health training curriculum and other training solutions on the state and national levels.

Strategy Accomplishment:

This strategy was achieved.

Objective 1.2. MHA will continue efforts that facilitate recovery, build resiliency, and develop mechanisms to promote health and wellness across the lifespan.

(1-2A)

**Federal Mental Health Block Grant Strategy*

MHA, in collaboration with Alcohol and Drug Abuse Administration (ADAA), On Our Own of Maryland (OOOMD), and other key staff will continue to support statewide activities to further enhance peer recovery supports, utilizing best practices within the consumer movement.

Indicators:

- Promotion of MHA and ADAA kick-off celebration for National Recovery Month (September) in concert with development of a Peer Conference through the Substance Abuse and Mental Health Services Administration (SAMHSA) *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy
- Increased collaboration with MHA Office of Consumer Affairs (OCA) and ADAA Recovery Managers to enhance the integration of Wellness and Recovery Centers (WRCs) and Recovery and Wellness Centers (RWCs)
- A 1-2 day retreat held to address the strengths, similarities and fears surrounding the integration of these peer run recovery centers put forth by the OCA and in collaboration with key ADAA staff members.
- Training and consultation for WRC/RWC implemented for co-occurring support groups and peer run centers.
- Increased consumer and family participation on policy and planning committees across the state, to include No Wrong Door and health home initiatives

Involved Parties: MHA Office of Consumer Affairs; Marian Bland, MHA Office of Special Needs Populations; Laura Burns-Heffner, ADAA; OOOMD; CSAs; WRCs; RWCs

MHA Monitor: MHA Office of Consumer Affairs

FY 2014 activities and status as of 6/30/2014 (end-year report):

The National Recovery Month event is promoted each year in September by SAMHSA. Recovery Month promotes the societal benefits of prevention, treatment, and recovery for mental health and substance use disorders. ADAA, in collaboration with MHA, recognized SAMHSA's 24th Annual "National Recovery Month" with a kick-off event on September 11, 2013. Featured speakers included Kathleen Rebbert-Franklin, Acting Director, ADAA; Brian Hepburn, Executive Director, MHA; Pat Taylor, Faces and Voices of Recovery; and Leah Harris, National Empowerment Center. The event was attended by 121 people.

Another major event that promoted peer recovery was Maryland's first Peer Recovery Specialist Networking Conference. This was a two-day conference held on May 29-30, 2014 in collaboration with ADAA, MHA, the University of Maryland Training Center, the Danya Institute, and the Central East Addiction Technology Transfer Center (ATTC). One hundred seventy (170) peers registered and nine (9) CEUs were issued for submission towards the Maryland Addiction and Behavioral Health Professionals Certification Board [MABPCB (formerly MAPCB)], Certified Peer Recovery Specialist (CPRS) credential.

Additionally, peer support network efforts are fostered through Maryland's statewide network of peer-run Wellness and Recovery Centers (mental health) and Recovery Community Centers (substance use). Participants have discussed implementing initiatives that support integration of behavioral health within their organizations. These initiatives include trainings on co-occurring disorders – mental health and substance use disorders – and data on the behavioral health system. A one (1) day retreat was held on July 17, 2014 at Bon Secours to further address behavioral health integration and the role of peers in policy and planning.

Strategy Accomplishment:

This strategy was achieved.

(1-2B)

**Federal Mental Health Block Grant Strategy*

MHA, in collaboration with ADAA, the MDQuit Center of the University of Maryland/Baltimore County (UMBC), consumers, providers, the CSAs, and other stakeholders, will continue to promote and implement behavioral health and wellness initiatives regarding smoking cessation and related activities toward the reduction of early mortality rates in Maryland.

Indicators:

- A report and data analysis submitted to the DHMH Deputy Secretary of Behavioral Health and Disabilities, based on the recently completed survey of Maryland Behavioral Health Clinical & Staff Providers Smoking/Tobacco Behaviors and Attitudes of Providers About Consumer/Client Smoking/Tobacco Behaviors (Fall 2012); support enlisted of DHMH leadership for the next phase of smoking cessation and wellness activities
- Development of effective interventions, tools, best and promising practices, and education strategies for clinical & staff providers to assist consumers/clients in smoking/tobacco cessation efforts
- Through consultation with staff of the Smoking Cessation Leadership Center (of the University of San Francisco) remain informed of the latest research in the field to enhance Maryland's development of an integrated behavioral health approach to smoking/tobacco use reduction that includes: outreach, public education, and consumer/client participation

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; MHA Office of Adult Services; MHA Office of Child and Adolescent Services; other MHA staff; MHA Consultants; UMD SEC; Alcohol and Drug Abuse Administration (ADAA); DHMH Tobacco Prevention and Control; Managed Care Organizations (MCOs); Maryland Medicaid; CSAs; UMBC MDQuit Center; Community Behavioral Health Association (CBH); On Our Own of Maryland (OOOMD); MHAMD; MCF

MHA Monitor(s): Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

FY 2014 activities and status as of 12/31/14(end-of-year report):

The leadership of the DHMH/Maryland Smoking Cessation Leadership Team, led by representatives from ADAA and MHA, completed the update of the State's work plan

which had been developed at the Wellness and Smoking Cessation Policy Academy in 2010. The updated work plan reflects lessons learned and new goals based on the 2012 Survey of Clinical and Staff at Behavioral Health Provider Agencies as well as the experience of consumer leaders in smoking cessation efforts over the past four years.

The findings of the 2012-13 Survey of Behavioral Health Providers on Clinical/Staff Smoking Behaviors were presented to the Deputy Secretary, Behavioral Health and Disabilities during a meeting with the Leadership Team in late July 2013. By that point the findings from the survey were already in use by the MDQuit center in the development of educational resource and training materials for behavioral health agencies.

MHA continued to work with ADAA and DHMH's Center for Health Promotion, Education & Tobacco Use Prevention, to utilize a co-developed metrics system and submit data monthly to StateStat to measure: the number of adults and youth with behavioral health issues who are smoking; number of calls to the Maryland Tobacco Quitline; and the number of nicotine replacement therapy materials distributed. These measures have been refined and sharpened.

Through participation in a survey conducted by the Smoking Cessation Leadership Center (SCLC) of the University of California at San Francisco in March/April of 2014, members of Maryland's SCLC provided information that was utilized by the SCLC and SAMHSA in the development of new policy academies on Wellness and Smoking Cessation for other states building on the experience of Maryland and the other pioneer states which participated in policy academies and have implemented integrated behavioral health strategies for consumers. Maryland was invited by SAMHSA to present at a policy academy and a summer conference focusing on Tobacco Behavioral Health and Cancer. Through ongoing communication with the SCLC and linkages with community partners in Maryland, the Maryland team has kept stakeholders updated on the latest research and strategies on multiple issues pertaining to smoking cessation and prevention. Information has been regularly disseminated across the Maryland network on issues pertaining to trainings, best practices, outreach strategies, public education, models of consumer leadership, and e-cigarettes.

In FY 2014, the ADAA and MDQuit entered into a three year agreement to provide onsite training to behavioral health treatment agency staff to enable them to provide smoking cessation services in their treatment programs for patients and staff. The smoking cessation training and implementation oversight will be done at approximately 110-150 behavioral health treatment agencies statewide at administration and clinical levels for outpatient and residential services. There is no cost for training and staff are provided with continuing education credits. Ninety-nine providers have been trained in the first year of this initiative.

The continued collaboration of MHA and ADAA, and their partnerships with the MDQuit Center of UMBC and key community agencies has helped to maintain a high priority for the issue of tobacco use and need for smoking cessation services for behavioral health populations within behavioral health and somatic care environments.

Strategy Accomplishment:

This strategy was achieved.

(1-2C)

Continue to implement, evaluate, and refine the Self-Directed Care project in Washington County and throughout the state.

Indicators:

- Self-directed care (SDC) plans developed and approved with peer support workers assisting consumers with the process
- Continued Wellness Recovery Action Plan (WRAP) training of consumer advocates and consumer participants with an emphasis on stress reduction and wellness
- Person Centered Care Planning (PCCP) training introduced to consumer advocates and consumer participants for goal directed, person centered recovery initiatives
- Implementation of SDC explored in other jurisdictions as funding is available
- Increased Internet utilization – Network of Care and use of advance directives for mental health treatment

Involved Parties: MHA Office of Consumer Affairs; MHA staff; Washington County CSA and providers; ADAA Regional Services Manager; Wellness and Recovery Centers (WRC); OOOMD; consumers and family members

MHA Monitor: MHA Office of Consumer Affairs

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA in collaboration with the Washington County CSA and the local Wellness and Recovery Center, Office of Consumer Advocates, implemented a consumer self-directed care pilot program. The Self-Directed Care (SDC) program assisted 87 or more individuals with the development and implementation of their personal “recovery” plans. At any one time, 40-45 individuals are active within the program. Staffing consists of Peer Advocates (two full-time and one part-time) who assist consumers with the process. Though the process includes development of plans, advocates do much more than that. Quarterly, participants complete a self-assessment matrix that tracks their progress (and challenges) in a number of domains on their lives, including housing, income, education, employment interests, natural supports, etc. SDC also implemented the use of a stress scale that is done quarterly to determine the severity of difficulties that participants face in their lives. Many SDC participants have low incomes that contribute to housing and other difficulties. SDC also began developing regularly scheduled group activities in which participants support each other’s efforts in recovery, learn more about community information, socialize, and develop plans to address additional group needs.

Peer Advocates continue to help consumers develop and implement their recovery plans, which include directing the use of their benefits to access both public mental health services and non-traditional support services such as driver education, obtaining one's driver's permit and license, gym memberships, and continuing education classes. If needed, SDC consumer funds pay for non-traditional resources such as classes, project-related clothing, textbooks, etc. Several consumers are in college and on the Dean's list. Person Center Care training continues to be introduced to consumer advocates and program participants to facilitate the development of goal directed, person centered recovery initiatives. Additionally, individuals in the SDC program learn to independently manage their personal finances and are in various stages of developing or applying a plan for financial stability. SDC conducted Social Security work incentive workshops for SDC individuals and staff to advise them of how work incentives operate and how they can make use of them. One focus of the workshops was to dispel myths such as: one cannot work and apply for benefits at the same time or that there are few resources for individuals who do not have higher education.

As part of the Office of Consumer Advocates, Inc. (OCA, Inc.), an affiliate of On Our Own of Maryland that operates in Washington, Allegany, and Garrett counties, SDC has Peer Advocates who offer WRAP classes, as part of the contract deliverables, to the individuals who utilize OCA, Inc. services. WRAP training and other activities offered to SDC participants assist them in identifying triggers, managing stress, etc. so that they can remain active in school/college/GED classes, physical health activities, etc. Additionally, training has been offered to staff to implement additional support when stressors occur.

Strategy Accomplishment:

This strategy was achieved.

(1-2D)

Expand on the efforts to embed a resilience-focused, strength-based approach to the provision and evaluation of child and adolescent mental health services through specific training on the core concepts of resilience, which promotes improved treatment outcomes and family engagement.

Indicators:

- Expand collaboration with the University of Maryland for resilience-based curriculum development
- Develop criteria and strategies for promoting resilience at system, organizational, community, family, and individual levels
- Resilience Committee meetings held to develop planned outcomes
- Number of Resilience Trainings requested and provided
- Efforts of the Resilience Committee expanded to include a wellness and prevention focus across the lifespan

Involved Parties: Joan Smith, MHA Office of Child and Adolescent Services; University of Maryland School of Medicine, Department of Psychiatry; MHA Resilience Sub-Committee of the Maryland Blueprint Committee; CSAs; family members, advocates, and providers

MHA Monitor(s): Albert Zachik, and Joan Smith, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Resilience Committee, made up of representatives of the BHA, CSAs, families, providers, other state agencies, and the University of Maryland (School of Medicine), continues to: meet on a monthly basis to develop and promote training for: organizational resilience, community resilience, and resilience for individuals across the lifespan. In FY 2014 the Committee began to gather information toward developing on-line modules which, based on hands-on-theory, would include elements of the core concepts of resilience:

- Increased sense of competency
- Caring and respect for others
- Hope and optimism
- Ability to reframe stress
- Increased coping and problem-solving skills
- Sense of purpose and meaning

Additionally, MHA chairs a Wellness and Prevention Committee, which is representative of all child serving agencies and meets to develop common language and goals across state agencies. This Committee has shared information on a resilience and strength-based model of engagement, which in part is offering feedback based on the Adverse Childhood Experiences (ACE) assessment tool, that promotes the use of attachment-based programming to assist young children to feel safe and secure within their environments. In concert with the Resilience Committee, this Committee also focuses on promoting child well-being, and reducing the behavioral health concerns related to trauma. Through the efforts of both committees, five workshops/conferences have been provided in FY 2014, based on the core concepts and the reduction of the impact of trauma, to approximately 300 (unduplicated) people.

In addition a resilience training and resource manual was developed in conjunction with the University of Maryland, which includes: an overview and historical perspective of resilience and resilience training in Maryland; power points on various topics such as organizational resilience, developing treatment plans and assessments from the perspective of resilience; issues of trauma; suggestions for caretakers and families; results of the change over time (COT) matrix from a study by the Resilience Breakthrough Collaborative (a University of Maryland grant-funded group that explored the process of moving from resilience theory to practice and supported six child and adolescent providers making a commitment to embed resilience-focused efforts into their organizations and service delivery); and contacts and resources. The manual is a work in progress and is expected to become the basis of the on-line resilience modules for FY 2015-16 implementation.

MHA through collaborative efforts, has accomplished a lot, without many resources, in the area of mental health promotion of resilience, wellness, and prevention through provider trainings and public awareness events over the years. The Resilience work has been ongoing since 2006, and continues to expand its efforts through a committed group of individuals. In FY 2014, the Resilience and the Wellness and Prevention Committees began to plan an Emotional Wellness Campaign to reach more people in the state of Maryland. The goals of the Campaign are two-pronged, desiring to impact the general public across the lifespan and to impact those individuals engaging in treatment/recovery, also across the lifespan. There is an increased recognition of the need to help all people to be emotionally healthy.

Strategy Accomplishment:

This strategy was achieved.

(1-2E)

MHA, in collaboration with Core Service Agencies (CSAs) and other entities, will continue to implement activities to promote outreach and linkage to services for older adults.

Indicators:

- Continue to support the CSAs and provider system to include older adults in all health, wellness, recovery initiatives and activities
- Promote education of service providers, health care workers, older adults, caregivers and the public to inform them about the special needs and considerations of older adults
- Encourage partnerships with local Areas on Aging regarding participation in the chronic disease self-management programs

Involved Parties: MHA Office of Adult Services; MHAMD's Coalition on Mental Health and Aging; CSAs; Local Areas of Aging

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

Efforts are continuous to encourage the CSAs and provider system to include older adults in all health, wellness, recovery initiatives and activities. MHA Office of Adult Services reviewed CSA plans to ensure older adults issues are addressed. Currently there are psycho-geriatric coordinators employed or contracted within three CSAs (Howard and

Montgomery counties and Baltimore City). Four counties have special conditions of awards (COAs) within their Plans related to older adults: Garrett and Frederick counties and Baltimore City have elderly outreach through in-home services. Prince George's County has specialized assisted living and nursing supports.

MHA continues to support the activities of MHAMD's Mental Health and Aging Coalition. This Coalition provides training and outreach related to older adults' behavioral health to include trainings at senior centers and state and local conferences such as the Maryland Suicide Prevention Conference. MHA's Offices of Adult Services and Special Needs Populations collaborated to convene a conference in spring 2014, which included a workshop on older adults and substance use.

Through the federal Mental Health Block Grant, MHA requested and was awarded funds to hire a consultant in FY 2015 who, under the auspices of the University of Maryland Behavioral Health Systems Improvement Collaborative, will identify and implement evidence-based practices for older adults, such as chronic disease self-management, and help the Behavioral Health Administration (BHA) to modify and improve the Preadmission Screening and Resident Review (PASRR) contract which serves to reduce the number of unnecessary nursing home placements.

Strategy Accomplishment:

This strategy was achieved.

Objective 1.3. MHA will increase opportunities for consumer, youth, family and advocacy organizational input into the planning, policy, quality assurance, evaluation, and decision-making processes.

(1-3A)

Participate in oversight of the Consumer Quality Team (CQT) project for statewide expansion.

Indicators:

- Continued statewide implementation, covering all of Maryland's regions and outlying jurisdictions
- Psychosocial programs and inpatient facilities in Maryland visited
- Feedback meetings held, identified issues resolved, and annual report submitted
- CQT team established for Child/ Adolescent programs and to include consumer and family involvement.

Involved Parties: MHA Office of Consumer Affairs; Cynthia Petion, MHA Office of Planning; Marian Bland and Steve Reeder, MHA Office of Adult Services; MHA Office of Child and Adolescent Services; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; State facility representatives; CSAs; MHAMD; NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH)

MHA Monitor(s): Cynthia Petion, MHA Office of Planning and MHA Office of Consumer Affairs

FY 2014 activities and status as of 6/30/2014 (end-year report):

The CQT is a consumer-run organization, staffed by consumers and family members, which, in FY 2014, entered its eighth year of operation. It is a program of the Mental Health Association of Maryland (MHAMD) and supported by funding from BHA through State funds and the federal mental health block grant. CQT is authorized by BHA to conduct site visits, announced and unannounced, to programs in the public mental health system. During the site visits, consumers who volunteer are confidentially interviewed and share their concerns and satisfaction with CQT. In FY 2014, CQT interviewed a total of 1,305 consumers on 322 site visits to psychiatric rehabilitation programs (PRPs) and inpatient facilities. Feedback meetings were held to review issues, concerns and discuss resolutions with the facility/program directors, consumers, the CSAs, and BHA leadership. The project continues to protect and enhance rights by obtaining first-hand information from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. Both consumers and program staff have reported significant program changes made as a result of the reports.

At the request of BHA, CQT has also been asking consumers in psychiatric rehabilitation programs (PRPs) about their satisfaction with their housing. Many people have indicated a desire to live on their own rather than in program housing. Staff have indicated that deficiencies in readiness of consumers to live on their own and a lack of available, affordable housing, as barriers to this goal.

CQT received funding to expand its focus to include child and adolescent services beginning with site visits to eight private residential treatment centers (RTCs) and two Regional Institutes for Children and Adolescents (RICAs), as a part of the “RTC Retooling Project”. A full-time Program Coordinator (Deputy Director of CQT) was hired to lead the activities for the development and implementation of the youth and family visits. Young interviewers were hired to conduct these, in addition to the adult visits. All CQT staff were trained for a better understanding of youth behavioral challenges. Older interviewers will conduct the parent interviews and the interviews with very young children. A RTC Steering Committee was formed with representatives from the Maryland Coalition of Families for Children’s Mental Health (MCF), the Maryland Association of Resources for Families and Youth (MARFY), the University of Maryland School Mental Health Center, OOOMD, RTC Coalition, BHA and MHAMD. A business associate’s agreement was signed between BHA and CQT, allowing CQT to conduct youth interviews without requiring further consent. All of CQT protocols were reviewed for The Health Insurance Portability and Accountability Act (HIPAA) compliance. Procedures for interviews with youth and families were developed, addressing areas such as reports of abuse and neglect. As funding becomes available, the ultimate goal is to offer this initiative in all 24 jurisdictions and the remaining state-operated facilities.

Strategy Accomplishment:

This strategy was achieved.

(1-3B)

Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children’s Mental Health (MCF) Family Leadership Institute for parents of children with behavioral disorders; youth leadership programs; and the Leadership Empowerment and Advocacy Project (LEAP).

Indicators:

- Annual MCF Family Leadership Institute (FLI) convened, training activities for families implemented, number of graduates
- Increased youth leadership participation in state and local policy committees and public awareness events
- LEAP redefined and expanded to include increased collaboration with deaf and /or hard of hearing adult leadership and participation at statewide trainings
- Explore opportunities to enhance Transition-Age Youth (TAY) participation in leadership activities and public services opportunities through schools, social media and other outlets.
- Increased consumer and family participation in state and local policy planning for behavioral health system of care ongoing

Involved Parties: Al Zachik and Tom Merrick, MHA Office of Child and Adolescent Services; Susan Kadis, MHA Office of Consumer Affairs; Marian Bland, MHA Office of Special Needs Populations; MCF; CSAs; OOOMD

MHA Monitor(s): Al Zachik, MHA Office of Child and Adolescent Services and Susan Kadis, MHA Office of Consumer Affairs

FY 2014 activities and status as of 6/30/2014 (end-year report):

Family Leadership Institute (FLI)

The Maryland Coalition of Families for Children's Mental Health (MCF) held its eleventh Family Leadership Institute (FLI) in FY 2014 to prepare caregivers to be better advocates for their child and all children and youth who have behavioral health challenges in their communities and across the state. In the ten years since FLI began, over 340 family members from all 24 Maryland jurisdictions have graduated from the program.

In 2014 twenty-one participants attended the six weekend (60 hour) program, representing twelve different counties and one from Washington, DC. The participants brought a rich diversity of economic and social backgrounds, and included forty percent African-American and five percent Hispanic individuals. The participants learned about children's mental health, how to support their own child and family more effectively through the school and other agencies, as well as how to incorporate a framework for parent leadership and other advocacy work in the community. Components included Navigating the Maryland System of Care, Diagnosis and Treatment, Legislative Process and Advocacy, Substance Abuse, and other relevant topics. Families met with agency administrators and policymakers, medical directors, psychiatrists, and other experts in children's behavioral health in Maryland.

The Family Empowerment Scale was used as a pre and post-training assessment tool, to measure increases in levels of knowledge, leadership, advocacy, and empowerment. In all areas there were significant increases. At the conclusion of the session, participants built an action plan to connect the knowledge and skills to their home, school, and community situations. Some of the activities in which graduates from this class are now involved include: participating on the Statewide Child and Adolescent Board, taking an active advocacy role in areas such as Substance Abuse and Fetal Alcohol Syndrome (FAS), speaking at workshops and conferences such as Connections and Montgomery County Transition Fair, and helping other families navigate the Individualized Education Program (IEP) process in their community schools.

Youth and Young Adult Involvement

MHA, in partnership with other federal grants, has supported *Taking Flight*, a joint program of the MCF and the OOOMD for youth and young adult leadership development. It is a youth council comprised of youth advocates ranging in ages from late teens to early twenties. Members are a diverse group of individuals with different backgrounds (mental health, foster care, lesbian, gay, bi-sexual, transgender [LGBT], etc.). A goal is to draw upon experiences to advocate toward making positive system changes. A peer-developed and facilitated Young Adult Leadership Retreat was held in May 2014 with 35 participants from five different youth organizations across the state including the Healthy Transitions Initiative and the OOOMD Transition-Age Youth Project. *Taking Flight* members have been promoting its anthology, *I Thought I Was the Only One*, through book events and coffee houses across the state.

The Launching Individuals Futures Together (LIFT) youth program, also led by MCF, convened a meeting of youth stakeholders on February 12th, 2014 to discuss the job description for the LIFT youth engagement specialist. New partners that participated included Active Minds, Towson University, OOOMD, Youth MOVE National, and the Local Management Board. MCF and LIFT project staff conducted interviews during the first week of June 2014. MCF has since hired a Youth Engagement Specialist who will focus on engaging and empowering youth in Baltimore County and developing programming with the LIFT target population and/or a similar population of youth who are involved with behavioral health services.

Leadership Empowerment Advocacy Project (LEAP)

The Consumer Affairs Liaison within the MHA Office of Consumer Affairs (OCA) is involved in coordinating and implementing LEAP which has been funded by the MHA since 1990. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates while playing a prominent role within state and local policy-making bodies. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state.

In FY 2014, LEAP training continued in the following areas: recovery and wellness, assertiveness training, leadership skills, cross-disability advocacy, and the future of services under Medicaid. Involved participants from across the state graduated from the program. Additionally, efforts and resources were available to include participation from individuals who are deaf or hard of hearing. LEAP graduates continue to serve on committees, federal and state advisory boards; as well as participate in the state planning process for the public mental health system.

Strategy Accomplishment:

This strategy was achieved.

GOAL II. PROMOTE A SYSTEM OF INTEGRATED CARE WHERE PREVENTION OF SUBSTANCE ABUSE AND MENTAL ILLNESS IS COMMON PRACTICE ACROSS THE LIFE SPAN.

Objective 2.1. MHA, in collaboration with Core Service Agencies (CSAs), the administrative services organization (ASO), managed care organizations (MCOs), behavioral health and health care providers, and other administrations and agencies, will continue to develop mechanisms to promote integrated health care.

(2-1A)

Continue to facilitate coordination of care activities throughout the behavioral health system of care and study data to determine impact of wellness activities and coordination of care in the provision of community behavioral health services.

Indicators:

- Utilization of existing interagency data to facilitate coordination of care i.e. Outcome Measurement System (OMS) data, pharmacy data (PharmaConnect), and other data, as appropriate
- Collaboration with Medicaid Pharmacy regarding prescribing practices of anti-psychotic medicine in children
- Support the provision of outreach, training, and technical assistance to providers participating in Health Home implementation to further integrate somatic and behavioral health services
- Utilization of the Coordination of Care Committee to coordinate care of complex dual diagnosis cases
- Integration of elements of coordination of care in behavioral health system of care through the Community Mental Health Medical Directors Consortium

Involved Parties: Lisa Hadley, and Jean Smith, MHA/ADAA Office of the Clinical Director; MHA-MCO Coordination of Care Committee; UMD SEC; Community Mental Health Medical Directors Consortium; Alcohol and Drug Abuse Administration (ADAA); MCOs; Medical Assistance - Office of Health Services; ValueOptions@Maryland

MHA Monitor: Lisa Hadley, MHA/ADAA Office of the Clinical Director

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA, now BHA, continues to monitor data, develop wellness activities, and facilitate coordination of care throughout the system. Using the PharmaConnect system, pharmacy data has been downloaded on a regular basis from the administrative services organization (ASO) to the managed care organization (MCO) that provides somatic and substance abuse care to clients who are also receiving mental health services. Also, DataLink, which enables the sharing of public mental health system treatment information with detention centers, has expanded to multiple jurisdictions through coordination among DPSCS, ASO, and CSAs. The Outcome Measurement System (OMS) public Web-based datamart site also continues to guide coordination of care efforts for individuals who utilize outpatient and other services within the system.

DHMH's Deputy Secretaries of Behavioral Health and Disabilities and of Health Care Financing continued to lead the ongoing efforts to integrate services for mental health and substance use disorders. In FY 2014, the third and final phase of this Behavioral Health Integration process included the RFP process to select an ASO to facilitate integrated care across the healthcare service delivery system and the merger of the mental health and substance use administrations.

Maryland's Medicaid Health Homes Initiative aims to further the integration of behavioral and somatic care through improved coordination. The health home provision authorized by the Affordable Care Act (ACA) provides an opportunity to build a person-centered system of care whereby medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan. A workgroup on chronic health homes was convened to make a recommendation on a new "Health Home" service under the ACA, and make a recommendation on how the new service could be developed to support any integration model. MHA collaborated with Maryland Medicaid on the implementation of a Chronic Health Home State Plan Amendment (SPA) which took effect on October 1, 2013. MHA provided outreach and technical assistance to providers who wished to participate in this program. At the start of Calendar Year (CY) 2014, 70 health home applications had been received and 45 were approved.

In FY 2014, MHA continued to collaborate with the MHA-MCO Coordination of Care Committee, through bi-monthly meetings, to coordinate complex cases, especially dual diagnosis cases, and to determine barriers and identify strategies for integrated care. Some of the coordination of care activities included: review of medication; making recommendation for changes; and identification of additional services that can be helpful to individuals with complex case histories. This committee collaborated with the ASO (ValueOptions@Maryland) to enhance integration of care for patients who were high utilizers of both MCO services and mental health services. The Committee also collaborated with the "No Wrong Door Project" for HIV Prevention Services of the DHMH Prevention and Health Promotion Administration to integrate HIV prevention into behavioral health services treatment programs. This collaboration included the introduction of the "No Wrong Door Integrative Screen" which is a tool for integrating care and facilitating appropriate referrals.

In FY 2014 the Community Mental Health Medical Directors consortium continued to monitor the Quality Incentive Program (QuIP) for outpatient mental health centers. QuIP is a comprehensive plan for monitoring provider utilization, expenditures, and quality of care including integrative aspects of care. In addition the consortium also: provided physician feedback to MHA on the community services impact of the planned integration of mental health and substance abuse treatment services; provided information to community physicians on resources and services for developmentally disabled clients; trained medical directors on the Peer Review Program for Antipsychotic Medication in Children for the purpose of increasing clinically appropriate use of medications and reducing side effects in the child population; cross trained members on the uses of the Prescription Drug Monitoring Program (PDMP) for the purpose of improving coordination of care with fellow physicians who may be prescribing narcotic-based medications; and trained physicians on the use of the new Evaluation and Management Codes, which document enhanced coordination of somatic and psychiatric care.

Strategy Accomplishment:

This strategy was achieved.

(2-1B)

Participate in DHMH's Behavioral Health Integration Steering Committee and workgroups to support the implementation of the behavioral health financing and systems integration model.

Indicators:

- MHA represented on DHMH's Committee and Requests for Proposals workgroup meetings
- Input provided toward implementation of model of care
- Information disseminated to appropriate stakeholders

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Lisa Hadley, MHA/ADAA Office of the Clinical Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Rachael Faulkner, MHA/ADAA Office of Governmental Affairs and Communications; ADAA; MHA and ADAA staff as appropriate

MHA Monitor(s): Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

DHMH's Deputy Secretaries of Behavioral Health and Disabilities and of Health Care Financing continued to lead the ongoing efforts to integrate services for mental health and substance use disorders. November 1, 2012, the Steering Committee issued a report recommending a specialty behavioral health carve-out as the model for financing behavioral health care in Maryland. The Steering Committee recommended that the carve-out operate using an administrative services organization (ASO), with significant and meaningful performance risk at the ASO and behavioral health provider levels. In FY 2014, the third and final phase of this Behavioral Health Integration process included the development of the Request for Proposal (RFP) to select an ASO to administer the new MA financing model, as well as collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards, and a financing approach that complements emerging clinical models of integration.

Additionally, DHMH held stakeholders meetings to allow members of the public to provide input into the RFP process. The RFP was released in April 2014 and an ASO selection was announced in the fall 2014.

Additionally, the next steps included the combining of the mental health and the substance abuse administrations into a behavioral health administration. This process was overseen by the DHMH Deputy Secretary of Behavioral Health and Disabilities. The behavioral health administration organizational process was well underway in FY 2014 with the appointment of a clinical director for mental health and substance abuse and the merger of the forensic services of three administrations (MHA, ADAA, and Developmental Disabilities Administration [DDA]). A new BHA organizational chart was released in September 2013. Legislation was introduced in December, under SB 84, changing the name of the Joint Committee on Access to Mental Health Services to the

Joint Committee on Access to Behavioral Health Services. Additional legislation was introduced during the 2014 Maryland Legislative Session under HB 1510 to formally merge MHA and ADAA into the Behavioral Health Administration (BHA). The merger took effect July 1, 2014. A Behavioral Health Integration Stakeholder workgroup has been formed as part of the passage of HB 1510. The first meeting was held on June 13 with monthly meetings to be convened through October 2014. A report to the Legislature will be issued by December 2014. Additionally, a committee has been formed to review statutory and regulatory changes and make recommendations.

MHA (now BHA) staff attended all workgroup meetings as well as all stakeholder meetings and will continue to do so in FY 2015. Meeting information and minutes were disseminated to stakeholders via the Behavioral Health Integration (BHI) Web site and electronic mailings.

These activities are key to the behavioral health integration process and Health Care Reform implementation. All activities will lead to a more robust service delivery system that will increase Marylanders access to coordinated health care.

Strategy Accomplishment:

This strategy was achieved.

(2-1C)

In collaboration with the University of Maryland's Schools of Medicine and Pharmacy, implement practice guidelines to ensure appropriate pharmacological utilization for adolescents and children with serious emotional disorders with focus on youth in Baltimore foster care system and for Medicaid recipients under age eighteen (18) across the state.

Indicator:

- Pharmacological practice guidelines implemented for ages 9-17
- Number of cases reviewed

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHA Medicaid Policy Analyst; other MHA staff; Maryland Medical Programs (DHMH); the University of Maryland Department of Child and Adolescent Psychiatry; University of Maryland School of Pharmacy; Department of Human Resources (DHR); CSAs; Maryland Department of Juvenile Services (DJS); the Maryland State Department of Education (MSDE); UMD SEC; MCF; Community Behavioral Health Association of Maryland (CBH); and other interested parties

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

In order to address the concerns that an increasing number of children are being prescribed antipsychotic medicines without sufficient monitoring, the Maryland's Medicaid Pharmacy Program (MPP) implemented a peer-review authorization process to ensure safe and effective use of antipsychotic medication. The goal of the program is to ensure that children and adolescents receive optimal treatment in conjunction with appropriate non-pharmacological measures in the safest manner possible. The program works in partnership with University of Maryland School of Pharmacy and the Division of Child and Adolescent Psychiatry.

The MPP's Board-Certified child psychiatrist oversees the project. This program, which began in October, 2011, initially addressed the use of antipsychotics in Medicaid (MA) patients under five years of age. In July 2012, it expanded to encompass children under ten years of age. By FY 2014, pharmacological practice guidelines for youth, ages 9 to 17, were developed and the program began to include all children under the age of 18.

In FY 2014, the Peer Review served 4,392 youth (13,581 requests). The number of requests are greater than the number of youth due to factors such as multiple requests for medications, medication changes, renewals, and missing data submitted by the prescriber.

In addition, contracts have been established with the University of Maryland at Baltimore, for implementation through its School of Pharmacy, to review Baltimore City child welfare caseload for their pharmacological utilization; linking psychotropic medication usage with the Department of Social Services (DSS) Chessie data and Maryland public health and pharmacy claims data for youth in the Baltimore City DSS out-of-home placements.

Strategy Accomplishment:

This strategy was achieved.

(2-1D)

Continue to interface and maintain liaison efforts and partnerships with other agencies and administrations to support a comprehensive system of behavioral and somatic health services and community supports.

Indicators:

- Collaborations established and implemented with state entities

FY 2014 activities and status as of 6/30/2014 (end-year report):

- **Maryland Department of Disabilities (MDOD)**, Brian Hepburn, Liaison – MHA continues to collaborate 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. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Maryland Department of Aging (MDoA)**, Stefani O'Dea, Liaison - The Maryland Mental Health Association's "Coalition on Mental Health and Aging" serves as the vehicle through which representatives of various state agencies, CSAs with geriatric staff specialists, and other key stakeholders meet regularly to confer regarding older adults

with mental illness, collaborate for access to long term support services for Older Adults, and to consult on various issues of aging.

- **DHMH Developmental Disabilities Administration (DDA)**, Stefani O’Dea, Liaison - BHA and DDA continue to serve on the following boards and committees related to needs of consumers with traumatic brain injury (TBI) and or co-occurring (mental illness/developmental disability): Maryland TBI Advisory Board; TBI Waiver Advisory Committee; Community Pathways Advisory Committee; Balancing Incentive Payments Program /Money Follows the Person (BIP/MFP); and TBI Waiver Provider Meetings. Also, in FY 2013, the forensic offices of MHA, ADAA, and DDA were combined into one office overseen by the DHMH Director of Forensic Services. DDA is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Public Safety and Correctional Services (DPSCS)**, Marian Bland, Liaison - The Office of Forensic Services (OFS) interfaces and works collaboratively with DPSCS. OFS and DPSCS staff serve on the Criminal Justice Information and Advisory Board and continue to collaborate with DPSCS on Criminal Justice Information System (CJIS) standards and measures. The administration collaborated with DPSCS for the implementation/expansion of DataLink and implementation and oversight of the Co-occurring Release Program (Second Chance grant), which provides assessment of community needs and develops case management plans to prepare for a successful transition to the community. MHA also partners with the DPSCS for Chrysalis House Healthy Start Program which gives services and supports to women in the correctional system who are dually diagnosed and have trauma issues and who are pregnant or mothers of infants. The Director of the OFS co-chairs the meetings of the Interagency Forensic Services Committee of the Maryland Advisory Council on Mental Hygiene/Planning Council.
- **Judiciary of Maryland**, The Office of Forensic Services (OFS) continues to interface and participate on joint projects with the Maryland Judiciary. OFS provides training to the judiciary on various forensic issues. OFS and members of the Judiciary collaboratively work on the Interagency Forensic Services Committee-Maryland Advisory Council/Planning Council. OFS continues to work with the Judiciary on issues affecting the Mental Health Courts.
- **Department of Juvenile Services (DJS)**, OFS collaborates with DJS on juvenile cases that are forensically involved and monitors competency evaluations for children conducted in Jessup. Meetings are held every 90 days to review protocols. The OFS Chief of Juvenile Pre-Trial Services participates in identified joint meetings, symposiums, etc. with DJS and provides training to DJS and judges, on issues affecting forensically involved juveniles. MHA routinely met every two weeks with multi-agency review teams (DSS, MSDE, and DJS) and also routinely collaborated with DJS's interdepartmental workgroups to develop recommendations for the behavioral health needs of Maryland youth served by DJS. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **DHMH Office of Health Care Quality (OHCQ)**, Audrey Chase and Sharon Ohlhaber, Liaisons –MHA’s Offices of Compliance and Community Program Evaluation continued to offer consultation to the Office of Health Care Quality (OHCQ) as needed to address issues related to compliance, regulatory interpretation, and provider/program approval. OHCQ staff participated in MHA’s monthly Compliance Committee meetings and the two Provider Applicant Interest meetings that were held during FY 2014.

- **Governor’s Office of the Deaf and Hard of Hearing (ODHH)**, Marian Bland, Liaison - The Administration continued to participate on the Behavioral Health Subcommittee (now Human Services Subcommittee) of the Maryland Advisory Council on Deaf and Hard of Hearing. MHA provides assistance with review of proposals as well as technical assistance on mental health and other behavioral health issues. The Administration also participated on the Deaf-blind subcommittee of the Maryland Advisory Council on Deaf and Hard of Hearing.
- **Department of Veterans Affairs (MDVA)**, MHA Office of Special Needs Populations, Liaison - MHA collaborates with the Department of Veterans Affairs through its participation on DHMH’s Veterans Advisory Committee and with the Supplemental Social Security, Outreach, Access, and Recovery (SOAR) initiative. Through the Homeless ID Project, a case manager is funded to work with the Baltimore Veterans Affairs (VA) to complete SOAR application for homeless veterans who have mental illnesses or co-occurring substance use disorders. DHMH also administers the Maryland Commitment to Veterans Initiative, which partners with the VA to address the behavioral health needs of veterans.
- **Department of Human Resources (DHR)**, Marian Bland, and Albert Zachik, Liaisons – MHA collaborated with DHR to provide training to Adult Protective Services staff on Adult Services and Special Needs Populations. Also worked with DHR as a state partner on Maryland’s SOAR Initiative and the pre-planning for the re-establishment of the State Interagency Council on Homelessness. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Housing and Community Development (DHCD)**, Russell Springham and Marian Bland, Liaisons - MHA collaborated with DHCD on the Homeless Management Information System Data warehouse. MOUs were drafted with DHCD to provide technical assistance to Projects for Assistance in Transition from Homelessness (PATH) and Continuum of Care (CoC) programs (formerly Shelter Plus Care) funded through MHA. MHA worked collaboratively with DHCD as a part of the Maryland Partnership for Affordable Housing (MPAH) for the implementation of new HUD Section 811 and Weinberg units. DHCD will oversee the development of 150 project-based rental assisted (PRAs) HUD section 811 units in the next fiscal year (2015) and BHA will make referrals from State facilities and residential rehabilitation programs to fill the units. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Governor’s Office for Children (GOC)/Children’s Cabinet**, Tom Merrick, Liaison – GOC and MHA are active partners in implementing the Wraparound through care management entities (CMEs). As an active participant of the Children’s Cabinet, MHA meets regularly with senior staff from the participating child-serving agencies to plan services across agencies for children, youth, and families. The Children’s Cabinet Interagency Plan is monitored each year and intersects with MHA’s ongoing planning processes.
- **Division of Rehabilitation Services (DORS)**, Steve Reeder, Liaison – Joint efforts included implementation of the evidence-based practice model of supported employment (SE) and the dissemination of shared data and outcomes. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland State Department of Education (MSDE)**, Albert Zachik and Cyntrice Bellamy, Liaisons – MHA meets with the Assistant Superintendent for Special Education at MSDE to collaborate on mutual concerns involving the mental health needs of children in school and early childhood settings. This department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Family Health Administration (FHA) DHMH Prevention and Health Promotion Administration [formerly Family Health Administration and Environmental Health and Infectious Disease Administration]**, - Al Zachik, Marian Bland and Darren McGregor, Liaisons – MHA 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), Project Maryland LAUNCH (which increases the use of early screenings, assessments, and mental health consultations; increases integration of behavioral health and primary care; enhances home visiting; and provides family strengthening and parent skills training), and works closely with the administration on the Early Childhood Mental Health. MHA participates on the HIV Planning Group along with Prevention and Health Promotion and ADAA to develop strategies to reduce risk of HIV infection.
- **Maryland Emergency Management Agency (MEMA)**, Brian Hepburn, Liaison – MHA continues its partnership with MEMA (the state agency responsible for mass care and shelter), DHMH’s Office of Preparedness and Response, MDOD, and DHR. Ongoing trainings and presentations are offered to state facilities and involved state agencies.
- **DHMH Office of Capital Planning, Budgeting, and Engineering Services**, Cynthia Petion and Robin Poponne, Liaisons – MHA, in collaboration with this Office, processes requests for the DHMH Administration-Sponsored Capital Program (Community Bond) which provides capital grant funds for prioritized community-based services such as the development of affordable housing for individuals with serious mental illnesses.
- **Maryland Health Care Commission (MHCC)**, Brian Hepburn, Liaison – MHA 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)**, Brian Hepburn, Liaison – MHA and HSCRC meet periodically to update the rate-setting process for hospital rates for inpatient services.
- **DHMH Alcohol and Drug Abuse Administration (ADAA)**, Carole Frank, Liaison - MHA collaborated, under the auspices of DHMH’s Behavioral Health and Disabilities, with ADAA in the ongoing efforts of Behavioral Health Integration. Partnerships were enhanced in MHA’s Annual Conference planning and the state Mental Health Plan Development meeting. ADAA and MHA merged to become the Behavioral Health Administration as of July 1, 2014. This agency was represented on the Maryland Advisory Council/P.L. 102-321 Planning Council and representatives/staff support from the BHA will participate in the behavioral health advisory council as it becomes established in FY 2016.
- **DHMH Medical Care Programs**, Brian Hepburn, Lisa Hadley, and Daryl Plevy, Liaisons – MHA participates in the Maryland Medicaid (MA) Advisory Committee and in the Medical Care Organizations’ (MCOs) monthly directors’ meetings. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council. MHA works with Maryland’s Medical Assistance program on issues and state plan amendments such as Money Follows the Person, the 1915 (i) State Plan Amendment for Children,

Youth and Families, telemental health services, implementation of Health Homes, the Balancing Incentive Program, and the Medicaid Emergency Psychiatric Demonstration. MHA continues to review provider billings and refers providers of concern to Maryland Medicaid Fraud Control Unit. With the merger of MHA and the Alcohol and Drug Abuse Administration on July 1, 2014, the new Behavioral Health Administration will continue to work closely with Medicaid to oversee the provision of public behavioral health services. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.2. MHA will work with the CSAs and other stakeholders to develop, implement, and evaluate screening, prevention, and early intervention services across the life span for individuals with psychiatric disorders or individuals who are at risk for psychiatric disorders.

(2-2A)

**Federal Mental Health Block Grant Strategy*

In collaboration with the Maryland State Department of Education (MSDE), the Maternal and Child Health Bureau, the Maryland Early Childhood Mental Health Steering Committee, the University of Maryland, and other stakeholders continue to build infrastructure and workforce development initiatives to support the delivery of high quality mental health promotion, prevention, early intervention, and treatment services for young children and their families.

Indicators:

- Support the implementation of Maryland *Linking Actions for Unmet Needs in Children's Health* (LAUNCH) and utilize implementation data to modify and sustain strategies as well as support policy reform, workforce development initiatives, and public awareness initiatives
- Review summary of the Social and Emotional Foundations for Early Learning (SEFEL) implementation data provided by MSDE
- Review summary of Early Childhood Mental Health Consultation implementation data provided by MSDE

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; MSDE; Maternal and Child Health Bureau; University of Maryland; the Maryland Early Childhood Mental Health Steering Committee

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Early Childhood Mental Health Consultation Committee continues to meet quarterly and oversees the implementation data for Linking Actions for Unmet Needs in Children's Health (LAUNCH) and the Social and Emotional Foundations for Early Learning (SEFEL).

SAMHSA's Project LAUNCH continued in its second year to serve children and to generate data. The project is designed to support states development of an early childhood system of care for young children and their families and focuses on implementing strategies that promote young child wellness and support a coordinated system of care for young children. Prince George's County was identified and contracted as the local community in which to implement specific strategies in the following five areas:

1. Developmental Screening and Assessment
2. Enhancement of Home Visiting Services
3. Early Childhood Mental Health Consultation – four mental health consultants hired to serve 10 Prince George's County schools, the Prince George's County Child Care Resource Center is on call for TA
4. Behavioral Health Integration into Primary Care
5. Family Support and Parent Education

A local coordinator and support staff were hired to initiate the start of direct services in targeted communities within Prince George's County. Also, the Center for Infant Study (CIS) gave a series of workforce development workshops for providers who do home visits. Forty-seven home visit providers from seven agencies participated in the seven half-day training sessions.

The SEFEL initiative is an approach toward building a consistent, evidence-based professional development framework for the early care and education workforce through the provision of training and technical assistance to state teams, demonstration sites, trainers, coaches, etc. MSDE and the University of Maryland School of Social Work's Institute for Innovation and Implementation have made several improvements and updates to the new SEFEL Web site. The Web site has had 2,633 unique hits from July 1 to September 30, 2014. Additionally, four preschool training modules became available via the Web site as of November 2013. Infant and toddler modules became available in December 2013. In the last quarter (July 1-September 30th) 483 unique individuals have taken at least one module of SEFEL training. Future plans include adding a data collection Web site aimed at assisting sites in implementing SEFEL to fidelity in their programs.

Strategy Accomplishment:

This strategy was achieved.

(2-2B)

**Federal Mental Health Block Grant Strategy*

MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

Indicators:

- Annual MHA Suicide Prevention conference conducted with inclusion of training sessions on issues/needs of special needs populations such as veterans and lesbian, gay, bi-sexual, transgender (LGBT)
- Education and outreach activities implemented to promote awareness and resource development
- Recommendations implemented from the Governor's Commission on Suicide Prevention final report

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Al Zachik Cyntrice Bellamy, MHA Office of Child and Adolescent Services; Cynthia Petion, MHA Office of Planning; Marian Bland and Steve Reeder, MHA Office of Adult Services; Maryland Department on Aging; The Maryland Crisis Hotline Network; The Maryland Committee on Youth Suicide Prevention; WRCs; MSDE; CSAs; Johns Hopkins University; University of Maryland; local school systems; other key stakeholders

MHA Monitor(s): Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Annual MHA Suicide Prevention conference was convened in October 2013, celebrating its 25th year with the theme "Twenty-five Years of Saving Lives" with inclusion of training sessions on issues/needs of special needs populations such as veterans and individuals who are LGBT, older adults, African American youth, counseling on lethal means, and the survivors' panel. Populations across the lifespan were covered in workshops throughout the conference. In FY 2014, meetings were held for the planning of the 26th Annual Suicide Prevention Conference for the fall 2014.

The Governor's Commission on Suicide Prevention submitted its Plan and final report in October 2012. The Commission's work provided clear priorities and achievable strategies for the organization, delivery, and funding of suicide prevention, intervention and post-vention services, across the state for years to come. The three primary goals were:

1. Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern
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 a suicide attempt or completion

MHA's FY 2014 activities continued efforts toward these goals, as follows:

- Promotion of public awareness and education on suicide prevention through training on suicide prevention and the availability of resources provided to community-based human service organizations, faith-based organizations, CSAs, and state hospital staff

- Support of the work of the Maryland Hotlines, as well as their efforts to provide ongoing outreach to providers, schools, and other persons within their communities.
- Delivery of Mental Health First Aid (MHFA) training across the state, which includes a suicide prevention segment.
- Promotion of Kognito, an on-line, interactive program using virtual role-play to help high school faculty, staff, and administrators learn common signs of psychological distress and ways to approach at-risk students.
- The implementation of social media resources – Facebook and Twitter – which reach individuals across the lifespan. The promotion of the theme, “Life Matters, Reach out, We’re Here”, a new informational card, emergency numbers, and other resources are featured.
- A social marketing campaign for the continued rebranding of suicide prevention for efforts across the lifespan is in the planning stages. This will include video techniques and chat-lines that will appeal to various age groups.

The Web addresses for the Social Media sites are:

Facebook: <https://www.facebook.com/MDSuicidePrevention>

Twitter: <https://twitter.com/MDSuicidePrev>

In fall 2014, SAMHSA awarded the Garrett Lee Smith Suicide Prevention Grant to BHA. This grant will provide a continuum of suicide prevention training, resources, and technical assistance (TA) to advance the development of a comprehensive suicide prevention and early intervention service system for youth and young adults in Maryland.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.3. MHA, in collaboration with the CSAs and other stakeholders, will continue to facilitate the development, implementation, and evaluation of services that address the needs of children, adolescents, transition-age youth with psychiatric disorders, and their families.

(2-3A)

MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop a plan to sustain integrated home and community-based services and supports for youth and young adults in transition following the conclusion of the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties.

Indicators:

- Strategic and operational plans developed
- Involved systems and services identified and eligibility criteria reviewed
- Fifty (50) youth and young adults in transition served during the fiscal year

Involved Parties: Tom Merrick, MHA Office of Child and Adolescent Services; Steve Reeder, MHA Office of Adult Services; MDOD; MSDE; CSAs; DHR; MCF; Governor's Interagency Transition Council for Youth with Disabilities; the University of Maryland; NAMI MD; OOOMD; local school systems; parents; students; advocates; other key stakeholders

MHA Monitor(s): Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Healthy Transitions Initiative (HTI) demonstration project develops and provides integrated home and community-based services and supports for Transition-Age Youth (TAY) through the pilot program in Washington and Frederick counties. During FY 2014, the program served 68 youth and young adults. The contracted provider of services, Way Station Inc., collaborates with MHA, HTI leadership, and community organizations to provide integrated home and community-based services to youth, young adults, and parents/caregivers in both counties.

The project has completed its final year of the five-year funding period and funding sources continue to be sought. An immediate sustainability plan has been operationalized with a proposal submitted to SAMHSA to add additional sites, such as Mid-Shore region, Baltimore City, and Anne Arundel County.

The project director has operationalized a plan to put standards in place that will make the eligibility criteria, training, services, and operational procedures consistent across all HTI sites.

Training and technical assistance (TA) in evidence informed practices for TAY are provided to grant-funded providers of services to emerging adults. Also, monthly training and TA continues to be provided to staff at current HTI sites to include TIP (Transition to Independence) practice guidelines and fidelity assessment tools.

Strategy Accomplishment:

This strategy was achieved.

(2-3B)

**Federal Mental Health Block Grant Strategy*

Implement the provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches.

Indicator:

- Continued development of a consistent model for family peer support
- Financing approach identified for populations served by CMEs
- A crisis response and stabilization model identified
- Coordination of CME service recipients' somatic and oral health improved consistent with wellness and Early and Periodic Screening Diagnosis and Training (EPSDT) standards of care
- Timely submission of data to Center for Health Care Strategies (CHCS)

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; the Maryland Child and Adolescent Mental Health Institute; the University of Maryland; Department of Juvenile Services (DJS); DHR; Center for Medicare/Medicaid Services (CMS); MCF; CHCS; State of Georgia; State of Wyoming

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

Maryland's CHIPRA Quality Demonstration Grant, awarded by the federal Center for Medicare/Medicaid Services (CMS), focuses on the implementation, expansion, and sustainability of Care Management Entities (CMEs) with continuing exploration of growth of the CME structure for home and community-based services. This is a five year grant, which entered its final year of implementation in FY 2014. The sixth progress report was submitted to CMS on time on January 31, 2014 and all data with regard to CHIPRA deliverables have been submitted to CMS and the Center for Health Care Strategies (CHCS). The grant is scheduled to end in February 2015. Maryland is requesting a 12-month no-cost extension to maximize and leverage remaining funds toward completing all aspects of the final operational plan.

The 1915 (i) State Plan for Home and Community-based Services (HCBS), also referenced as a Medicaid State Plan Amendment (SPA), has been approved. 1915(i) SPA establishes a specialized behavioral health delivery system for children with complex behavioral health care needs and their families. As part of this effort, through an additional SPA, Maryland has redefined Targeted Case Management (TCM) to include multi-level care coordination utilizing fidelity Wraparound for children and adolescents. The 1915 (i) SPA includes family peer-to-peer support as a Medicaid-billable service.

Maryland continues to put significant effort into sustaining Wraparound service delivery using the Care Management Entity (CME) model for populations of youth currently served through the public child serving agencies. Children served through current SAMHSA-funded Children's Mental Health Initiative Cooperative Agreements, commonly referred to as System of Care (SOC) grants are included within these populations.

The coordination of somatic and oral health services, to increase the consistent compliance with the EPSDT standards of care, is being addressed through a process that will encourage CMEs to include these services in care plans developed for CME service recipients. The Oral Health curriculum is complete and posted online and training available as of February 2014. The Health Care curriculum is in draft form and targeted for completion in fall 2014.

During this reporting period, in-depth face-to-face interviews with providers of crisis response and stabilization services across the state were scheduled to learn about the variety and variability of the services available, the funding mechanisms used to support the services, the policies and procedures of the providers, and how the services are accessed. The information gathered from the interviews will be analyzed and used to develop a “best practice” model and potential rate structure for crisis response and stabilization services for children. Also, national crisis response data and systems are being tracked to learn from other successful programs and systems.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.4. MHA will collaborate with CSAs and stakeholders to promote screening for mental health disorders, improve access and quality of services in a behavioral health system of care for individuals with co-occurring disorders, and provide linkages to appropriate treatment and supports across the life span.

(2-4A)

**Federal Mental Health Block Grant Strategy*

In collaboration with DHMH and ADAA, continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.

Indicators:

- Technical assistance (TA) provided to Core Service Agencies requesting assistance in promoting DDC within their jurisdictions
- Training and consultation for agencies requesting assistance in implementing practice changes which promote agency-wide DDC
- Continued TA to the substance abuse specialists and team leaders on Assertive Community Treatment (ACT) teams to enhance DDC of those teams
- Ongoing training for behavioral health providers on the use of scientifically-validated screening and assessment instruments in support of screening for and assessment of co-occurring disorders
- Provision of training and TA on Person Centered Care Planning (PCCP) principles and practices, within the context of county and agency substance abuse and mental health services integration projects

Involved parties: Carole Frank and Cynthia Petion, MHA Office of Planning; Marian Bland and Steve Reeder, MHA Office of Adult Services; Eileen Hansen and Tom Godwin, the University of Maryland Evidence Based Practice Center (UMD EBPC); ACT teams; mental health providers

MHA Monitor: Carole Frank, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA was exemplary in providing leadership, vision and a strategic focus in supporting CSA jurisdictions, providers and clinicians toward Dual Diagnosis Capability (DDC) in the public mental health system.

MHA has provided ongoing leadership in support of increasing DDC on many levels. Collaborative efforts have been encouraged with other agencies outside of and within DHMH, particularly with ADAA. Ongoing training consultation and TA for agencies requesting assistance in implementing practice changes which promote agency-wide DDC was provided across the state by the UMD EBPC consultant and trainer for co-occurring disorders (CODC/T).

A number of existing mental health treatment and rehabilitation programs, as well as programs/addictions services providers established or identified through ADAA, have developed co-occurring capability and are able to improve service delivery to individuals with complex needs. Mental health and addictions providers in Westminster and the Lower Shore areas have requested and received additional TA.

In FY 2014, throughout Maryland, support was provided to several CSAs upon request (Behavioral Health Systems Baltimore; Anne Arundel, Carroll, Mid-Shore, Frederick, Prince George's and Washington counties) to promote program assessment through utilization of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capabilities in Mental Health Treatment (DDCMHT) instruments.

Regional screening and assessment trainings took place for 52 provider agency participants in Western and Southern Maryland and on the Eastern Shore to promote program assessment through utilization of the DDCAT and DDCMHT instruments. The CODC/T assisted agencies with analysis of aggregate data collected through the multiple assessments completed.

Trainings in January and April of 2014 also included Person Centered Care Planning (an approach designed to enable people to direct their own plan for services and supports). Approximately 29 providers in Anne Arundel County and 50 Child Welfare conference participants in Washington County attended these workshops.

Additionally, ongoing help and support has been provided to Assertive Community Treatment (ACT) Teams throughout the state. In FY 2014, there were 48 participants (including ACT Team leaders and Substance Use Disorders [SUD] Specialists) attending four trainings on the American Society for Addiction Medicine (ASAM) six dimension assessment format.

All of the activities were developed in support of the integration process at the system, program, and workforce levels.

Strategy Accomplishment:

This strategy was achieved.

(2-4B)

MHA and the University of Maryland Systems Evaluation Center (UMD SEC) will analyze data relating to utilization of services in a behavioral health system of care by individuals with co-occurring disorders to further inform system and service planning and identify areas for quality improvement activities.

Indicators:

- Analysis conducted of consistency between diagnosis and self or provider report upon initial authorization of services in the Outcomes Measurement System (OMS) population

Involved parties: Cynthia Petion, MHA Office of Planning; Susan Bradley, MHA Office of Management Information System (MIS) and Data Analysis; ADAA; UMD SEC; UMD EBPC; ValueOptions@Maryland

MHA Monitor(s): Cynthia Petion, MHA Office of Planning and Susan Bradley, MHA Office of MIS and Data Analysis

FY 2014 activities and status as of 6/30/2014 (end-year report):

Outcome Measurement System (OMS) data, based on self-reports of individuals utilizing outpatient services in the Public Mental Health System, is captured and reported monthly on public web-based datamart. UMD SEC has utilized OMS data as it relates to those with co-occurring substance abuse and mental health disorder. The UMD SEC has continued to refine the OMS datamart, and focus on comparing and contrasting the OMS change-over-time data results for those consumers who have a co-occurring substance abuse disorder with those consumers who do not have a co-occurring substance abuse diagnosis. Collaboration among parties produced a data set used to track shared population's characteristics and outcomes.

Additionally UMD SEC staff, under guidance by MHA, combined ADAA data to identify a group of individuals served by both administrations. The data was analyzed to understand demographics, diagnosis, and outcomes of the group. Some of this information was shared in a joint presentation of mental health, substance use, and co-occurring data, "Exploring Behavioral Health Integration Through Data", at the Annual MHA Conference. Also, in collaboration with UMD SEC, a series of related Data Shorts (a periodically-released sheet of graphs and a short accompanying narrative, each focusing on a different aspect of behavioral health integration) has been generated and shared through the MHA/BHA and ADAA/BHA Web sites.

As the MHA and ADAA are in the process of merging and service modalities for the state are being combined, it is vital that MHA and ADAA explore and understand the data for those with co-occurring diagnosis.

Strategy Accomplishment:

This strategy was achieved.

(2-4C)

**Federal Mental Health Block Grant Strategy*

Plan a system of integrated behavioral health promotion, prevention, and treatment services for children, youth, and young adults who are at risk for, or have mental health and/or substance abuse disorders.

Indicators:

- Summary of Maryland *Launching Individual Futures Together* (Project LIFT) implementation data
- As part of DHMH's behavioral health integration process, utilize the Maryland Behavioral Health Collaborative (MBHC) strategic plan to identify recommended strategies to support an integrated behavioral health system of care for children and adolescents
- Utilize the support of the SAMHSA-funded System of Care expansion grant to accomplish the planning process

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; MHA Staff; MBHC; ADAA; CSAs; Health Departments; providers; youth and young adults; consumers; families; advocates

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

As behavioral health integration (BHI) moved forward, Project LIFT (Launching Individual Futures Together), a SAMHSA System of Care (SOC) expansion grant, was instrumental in identifying and recommending appropriate strategies to assist children and adolescents. The LIFT plan laid out a broad set of guidelines and was, in effect, a "plan to plan" as the DHMH BHI took place. The Plan has eight major goals which include: wellness; screening and assessment; adequate service package; quality improvement; workforce development; policy planning; and social marketing.

The LIFT grant is intended to work with emerging Transition-Age Youth (TAY) and families with co-occurring disorders who are below a residential level of care. The care coordination components for this process are designed for youth who require a level of care more intense than the current Targeted Case Management (TCM) model provides. Current TCM services are provided at two levels of care: general and intensive. The grant is in the process of developing a third, most intensive level of care coordination using a Wraparound service delivery model infused with SOC values to engage youth and families in community-based care. This would have the impact of making a third level of intensive care coordination available to youth who are ineligible for the 1915(i) due to family income. The redesign means that additional Medicaid youth who are at or below the residential treatment level of care can be served in the community with the Wraparound Model (those with family income of 150%-300% federal poverty) with access to the full public behavioral health service array.

The grant also included training and coaching TCM providers in Wraparound (including emerging TAY adaptation) SOC core competencies, WrapTMS, and PracticeWise to use with evidence-based practices (EBPs). Alliance was contracted as the TCM provider. LIFT has been training and coaching Alliance in Wraparound over the course of the first year of direct services implementation. MCF leads family involvement efforts for the LIFT project. A family navigator has been identified to work directly with Alliance and LIFT families. LIFT will continue to expand this effort through statewide replication of the model. LIFT will also train the children's behavioral health workforce in SOC including specific training on co-occurring practice, cultural and linguistic competency, trauma-informed care, and evidenced-based services.

The Institute is in the process of revamping the current Wraparound Practitioner Certification Program specifically to meet the needs of the statewide implementation of the 1915(i). The proposal includes a shift to an organizational accreditation for Maryland Wraparound providers. At the staff level, the proposed program will certify care coordinator supervisors in the Wraparound service delivery model. The Institute is working closely with colleagues at DHMH and local Core Service Agencies to redesign a training curriculum that will meet the needs of the evolving system.

The Wraparound service delivery model began enrolling youth and families in July 2013. Children who have Serious Emotional Disorders (SED), mental health and/or substance use disorders are beginning to be served and outcome measures are being reviewed. In FY 2014, 12 males and 18 females were served.

A statewide stakeholder meeting was held in mid-September 2013 to solicit stakeholder input related to the guidelines of the final plan. The Maryland Behavioral Health Collaborative submitted a final Behavioral Health Strategic Plan for BHI for children and adolescents, a deliverable of the LIFT grant, to SAMHSA as required, in July 2014.

The work for this grant was completed.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.5. MHA will closely monitor the activities of national and state health reform and prepare and plan appropriate coordination and collaboration.

(2-5A)

Improve communication and efforts that support activities that lead to implementation of behavioral health integration and coordination of care in the delivery of services to individuals with mental illnesses.

Indicators:

- Network of providers educated about Health Care Reform, through DHMH and MHA Web sites, MHA conference, Webinars, and Community Mental Health Directors meetings
- Participation on DHMH behavioral health integration workgroups
- Activities of community mental health providers who are integrating somatic care into their services monitored and supported

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Cynthia Petion, MHA Office of Planning; MHA Medicaid Policy Analyst; CSAs, Center for Medicare/Medicaid Services (CMS); Maryland Medicaid (MA); other mental health consumer and family advocacy groups; CBH; other stakeholders

MHA Monitor(s): Brian Hepburn, MHA Office of the Executive Director and Lisa Hadley, MHA/ADAA Office of the Clinical Director

FY 2014 activities and status as of 6/30/2014 (end-year report):

The process of selecting an integration model for Medicaid (MA) financed behavioral health services entered its final phase with the merger of the Mental Health and the Alcohol and Drug Abuse administrations, as of July 2014, and the issuance of a Request for Proposal for an administrative services organization to administer the new MA financing model, as well as collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards, and a financing approach that complements emerging clinical models of integration.

In light of the passage of the Affordable Care Act (ACA), multiple trainings on Healthcare reform as well as stakeholder input into the behavioral health integration process, have been provided through utilization of meeting announcements, distribution of materials and resource information, Webinars of the meetings, and other discussions/presentations around the state.

DHMH and the mental health and substance use administrations facilitated ongoing efforts that fostered an inclusive process. The Maryland Advisory Council on Mental Hygiene/P.L. 102-324 Planning Council and the State Drug and Alcohol Abuse Council have been informed throughout the ACA implementation and the behavioral health integration (BHI) process by the leadership of both MHA and ADAA and other pertinent staff. Also, the Annual MHA Conference theme was “Proactive Approaches to Care in Times of Change”. Conference workshops, attended by many providers and advocates across the state, aimed to educate and share information that would help providers prepare for system changes that affected them and impacted consumers directly.

In addition to the Behavioral Health Stakeholders’ meetings, DHMH convened the Continuity of Care Advisory Panel and the Outpatient Services Programs to, respectively,

enhance continuity of care for individuals with serious mental illness, examine barriers and make recommendations to strengthen the public behavioral health service delivery system as well as address deficiencies that lead to interruptions of care; and examine the development and implementation of assisted outpatient treatment programs, Assertive Community Treatment (ACT) programs, and outpatient service programs. This process is ongoing into FY 2015 with recommendations to be shared in a report in December 2014.

Communication between system staff, stakeholders, and providers has increased as efforts to implement and monitor behavioral health integration services are ongoing. MHA (now BHA) continues to participate in integration efforts and support integration of behavioral health and somatic health care at the provider level.

Other models of primary care and behavioral health integration promoted and supported by the state system of behavioral health care include:

- Behavioral Health Integration Program in Primary Care (B-HIPP) – a program which supports the efforts of pediatric primary care providers to assess and manage mental health concerns. Assistance is available to primary care providers without charge and without regard to a patient’s insurance status.
- Maryland’s Medicaid Health Homes Initiative - Health Homes aim to further the integration of behavioral and somatic care through improved coordination. MHA collaborated with Maryland Medicaid on the implementation of a Chronic Health Home State Plan Amendment (SPA) which took effect on October 1, 2013. At the start of CY 2014, 70 health home applications had been received and 45 approved.

Strategy Accomplishment:

This strategy was achieved.

(2-5B)

In collaboration with the DHMH Office of Medical Care Programs, identify specified programmatic changes needed to increase Maryland's eligibility for Medicaid's Balancing Incentive Payments Program (BIP) to increase shifts in state Medicaid spending towards community-based care.

Indicators:

- Development of a core standardized assessment instrument for all Mental Health services
- Participation on Maryland Access Point (MAP) Advisory Board and Money Follows the Person (MFP)/BIP workgroup meetings
- Analysis of programs, contracts, and regulations to identify conflicts in case management systems
- Addition of a statewide toll-free phone number and Web site to its MAP system of Aging and Disability Resource Centers (ADRC)

Involved Parties: MHA Medicaid Policy Analyst; MHA Office of Adult Services; DHMH Medical Care Programs (Medicaid); CSAs; MAP ADRCs; Traumatic Brain Injury (TBI) Resource Coordinators

MHA Monitor: Stefani O'Dea, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

This program is a multi-year project and much of the analysis of programs, contracts, and tools are in process.

BHA has been working with Medicaid to identify a uniform assessment tool that can be used with the behavioral health population. This tool is scheduled to be implemented, as required, prior to the end of BIP (September 2015). The BHA system of care is expected to utilize this tool a great deal.

BHA continues to participate in the bi-monthly MFP/BIP stakeholder meetings and Mental Health and Aging Coalition meetings and other ad hoc workgroups to implement the structural changes to enhance community-based care funding process as required through BIP. Additionally, the MHA Office of Adult Services also instituted regular (at least bi-monthly) meetings between the Office of Adult Services, the MHA Office of Special Needs Populations, Medicaid/Office of Health services, and MFP/BIP staff to work towards implementation of the BIP required structural changes. Some of these changes include: conflict free case management; core standardized assessments; and no wrong door approach to services. MHA submitted all required documents to Medicaid related to case management (no changes recommended) and provided feedback on MFP operation protocol revisions.

MHA and the Maryland Department of Disabilities (MDOD) have created a training plan for Maryland Access Point (MAP) to include Mental Health First Aid and brain injury trainings. MHFA trainings to MAP sites have begun in FY 2014.

The establishment of a toll-free number for Aging and Disability Resource Centers (ADRC) is not under the purview of BHA. However, BHA has hired a consultant to research evidenced based practices geared towards older adults with behavioral health issues

Strategy Accomplishment:

This strategy was achieved.

GOAL III. WORK COLLABORATIVELY TO REDUCE THE IMPACT OF VIOLENCE AND TRAUMA FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND OTHER SPECIAL NEEDS.

Objective 3.1. The DHMH Office of Forensic Services (OFS) will provide technical assistance and training to providers of forensic services to individuals residing in the community who are court involved.

(3-1A)

**Federal Mental Health Block Grant Strategy*

The OFS will provide training and consultative services to providers of forensic services who work with individuals residing in the community on conditional release from the Mental Hygiene Administration (MHA) and, the Developmental Disabilities Administration (DDA) facilities. The training is designed to educate providers on psychiatric diagnoses “triggers/symptoms of relapse, departmental policies and procedures and strategies to reduce the recidivism of individuals residing in the community to MHA and/or DDA facilities.

Indicators:

- Provider linkages established
- Structured training and orientation to providers
- Assess and analyze data on the percentage of individuals returned to MHA/DDA facilities
- Schedule individual meetings with providers requiring additional technical assistance

Involved Parties: Richard Ortega, Lori Mannino, Michelle Fleming, Tiwana Rice, DHMH/MHA Office of Forensic Services (OFS); Community Forensic Aftercare Program; Leslie McMillan, Developmental Disabilities Administration; the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Monitor(s): Lori Mannino, DHMH Office of Forensic Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The DHMH – Behavioral Health Administration’s Office of Forensic Services (OFS) oversees services provided for individuals who are court involved and have a mental illness, substance use disorder, or developmental disability. These services include court-ordered evaluations of individuals whose competency to stand trial or criminal responsibility are at issue in a criminal case; inpatient services for individuals committed as incompetent to stand trial or not criminally responsible; and monitoring of individuals found not criminally responsible and court-ordered to conditional release in the community. In December 2013, the number of individuals on conditional release was 730. The OFS collects data on the behavioral health forensic services system. Training and technical assistance is provided to DHMH forensic evaluators and community providers on forensic issues.

The Community Forensic Aftercare Program (CFAP) works with various community providers in a number of ways. In FY 2014 CFAP mailed out 193 letters notifying providers of the conditional release requirements of the consumers they had agreed to

serve. In addition to providing written material, conditional release monitors provide valuable linkages to community providers, judiciary, and state facilities through regular phone consultation and by reviewing every conditional release plan proposed by DHMH. In addition to community linkages, the monitors and staff of OFS have continued to provide structured training to all those interacting with forensic consumers. Trainings topic areas have included, but was not limited to:

- Mental Health First Aid
- Public Safety and Mental Health
- Discharge planning/initiatives and reporting requirements; and
- Management of forensic consumers

Trainings have also been provided to mental health probation agents to educate them on sex offense registry requirements, emergency petition, and how to recognize a mental health crisis.

The OFS/CFAP is involved in numerous meetings with forensic coordinators, community providers, key representatives from the criminal justice systems, judiciary, and DHMH state hospitals to address discharge and treatment planning, and other issues as needed. OFS staff collaborate with community providers on a daily basis about managing forensic consumers in the community. Collaboration has been through email, phone calls, and site visits, depending on the needs of the situation.

Strategy Accomplishment:

This strategy was achieved.

Objective 3-2. The DHMH Office of Forensic Services in consultation with clinical staff will develop a Peer Review Program that randomly reviews court mandated evaluations prepared by Qualified Community Evaluators (QCEs).

(3-2A)

The DHMH Office of Forensic Services will develop a Peer Review Program that randomly reviews court mandated evaluations prepared by QCEs. The Peer Review Program will assist the QCEs to identify complex clinical issues involving competency and criminal responsibility of court involved individuals.

Indicators:

- Work group formed to develop protocols
- Identification of the number of evaluations to be reviewed annually
- Presentation by work group to senior management staff

Involved Parties: Richard Ortega and Erik Roskes, DHMH/MHA Office of Forensic Services; Lisa Hovermale and Mike Rehak, DDA; the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Monitor: Richard Ortega, MHA Office of Forensic Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

A Task Force was convened and the Work Plan to develop protocols was completed in April, 2013. The Work Plan was presented to senior management staff in June, 2013. The plan identified that a senior clinician (Clinical Director of Forensics) would direct and manage the Peer Review process. A candidate for this position was selected in February, 2014. The Clinical Director began his duties in May, 2014. However, the review of evaluations has not commenced.

Strategy Accomplishment:

This strategy is partially achieved.

(3-2B)

Facilitate community placements, ensure access to somatic and mental health services, and monitor plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.

Indicators:

- Plans of care developed and monitored for approximately 60 TBI waiver participants
- Increased utilization of enhanced transitional case management to support program's expansion and increased enrollment
- Financial incentives identified to expand provider capacity
- Additional providers enrolled
- Eligible participants enrolled in Money Follows the Person (MFP) Project, enhanced federal match spent on initiatives that increase community capacity

Involved Parties: Stefani O'Dea and Nikisha Marion, MHA Office of Adult Services; Medical Assistance Division of Waiver Programs; Coordinators for Special Needs Populations in MHA facilities; CSAs; TBI Advisory Board; community providers

MHA Monitor: Stefani O'Dea, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA is the lead agency in Maryland for current Brain Injury (BI) initiatives, which include a Home and Community-Based Services (HCBS) Waiver for individuals with BI. There are two full time administrative case managers. In FY 2014, 72 people were enrolled in the BI waiver and 73 plans of care developed. Additionally, an enhanced federal match was obtained for the 11 individuals who enrolled through Money Follows the Person (MFP).

Two provider incentives were made available in FY 2014 via a competitive bid process to increase provider capacity. However, no additional providers were enrolled. Outreach and provider recruitment efforts continue.

In FY 2014, Charlotte Hall Veterans Home was recognized a BI waiver point of entry to increase accessibility to the veteran population. However, no one has yet been referred from that facility.

The biggest change in FY 2014 affected the BI waiver's technical eligibility. The brain injury definition used for the purposes of establishing eligibility was modified from a traumatic brain injury definition to a broader acquired brain injury definition. These changes were reflected in state regulations (COMAR 10.09.46).

BHA continues to contract with the Brain Injury Association of Maryland (BIAM) to provide program education, application assistance, and transitional case management for the BI waiver.

Strategy Accomplishment:

This strategy was achieved.

(3-2C)

MHA's Office of Special Needs Populations, in collaboration with Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), CSAs, advocates, and other involved parties will redesign the process for providing interpreting services, data collection, and the delivery of services using integrated, statewide, and regional approaches.

Indicators:

- Identification of uniform data tool to be utilized by CSAs in local jurisdictions
- Use of appropriate data tools by the administrative services organization- ValueOptions@Maryland (ASO) to track specific services rendered to individuals who are deaf or hard of hearing
- In collaboration with ADAA, an interpreting contract developed and utilized across populations and with individuals with co-occurring disorders
- Resources identified to develop regional teams to manage needs/services for individuals who are deaf or hard of hearing across the life span, on the local level

Involved Parties: Marian Bland, MHA's Office of Special Needs Populations; DHMH's Office of Behavioral Health and Disabilities; Iris Reeves, MHA Office of Planning; MHA Office of Child and Adolescent Services; CSAs; Governor's Office of the Deaf and Hard of Hearing (ODHH); ADAA, DDA, consumers; advocacy organizations and family groups; state and local agencies, colleges and universities; local service providers

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA's Office of Special Needs Populations developed a uniform quarterly reporting form in FY 2013 to collect information from providers on: the number of consumers receiving interpreting services to access public mental health system services; the type of interpreting; and type of service being rendered. The CSAs began using this tool in 2014 to report data on the number of consumers served and the type of services received.

MHA participated in the review and selection of vendors for the state's visual language contracts which was launched through the Department of Budget Management on January 1, 2014. Visual communication services are now available in every region statewide.

A regional integrated process for providing services has not been established. This strategy will be explored further as MHA and ADAA integrate. However, resources have been identified to develop an Assertive Community Treatment (ACT) Team of vendors who meet the criteria for ACT. Further exploration of additional resources is needed. The behavioral health subcommittee for deaf and hard of hearing was re-established in September 2013. MHA serves as interim chair of this subcommittee. Mechanism to fund regional teams will be explored through this subcommittee.

Strategy Accomplishment:

This strategy was achieved.

(3-2D)

Increase sensitivity to trauma experiences and incorporate trauma-informed care principles and practices in treatment in MHA state psychiatric facilities.

Indicators:

- Risk assessments completed on each admission to the state facilities
- Trauma-informed education included in mandatory annual trainings
- Education in the areas of sexual abuse and sexual harassment provided to patients
- Trauma specific language incorporated in hospital policies
- Peer Support Specialists available as consultants to staff and patients
- Selected environmental changes made to support positive on-unit experiences

Involved Parties: Mary Sheperd, MHA Deputy Director Hospitals and Adolescent Residential Treatment; Lisa Hadley, MHA/ADAA Office of the Clinical Director; Susan Kadis, MHA Office of Consumer Affairs; Peer Support Specialists

MHA Monitor: Mary Sheperd, MHA Deputy Director Hospitals and Adolescent Residential Treatment

FY 2014 activities and status as of 6/30/2014 (end-year report):

Assessment of patients has always included mental health screening and substance use. However, including a trauma assessment allows for a comprehensive picture of the presenting problems. Therefore, all new admissions are given a trauma assessment which helps to drive treatment and provide patient feedback on alternative strategies when a patient requires intervention for aggressive behaviors.

In FY 2011, an advisory committee was formed to implement SB 556/HB 1150 written to develop and implement strategies to promote the principles of trauma-informed care. One strategy included providing training in trauma-informed care principles, as well as trauma specific services for staff and consumers within state-operated psychiatric hospitals. All facilities have incorporated trauma-informed care (TIC) practices and principles in mandatory orientation training and updates throughout the year. All new employees are required to attend the training within the first week of employment. Each employee at the facility is taught TIC. This includes clinical, support, dietary, housekeeping, maintenance, and contractual. It is the philosophy that anyone that could possibly have any interaction with a patient should receive the training. Attendance records and sign off for supervisor are required. An attendance list of annual trainings is kept on file and used when completing the annual Performance Evaluation Program (PEP). Regulations have propelled this mandate forward but the BHA facilities embraced this requirement as part of excellent patient care.

Mental Health First Aid training continues to be promoted for the para-professionals in the facilities. The facilities now have certified trainers on staff who work collaboratively with administration certified trainers. The nursing education departments are taking the lead on this initiative.

Selective environmental changes to enhance the on-unit experience have been made such as comfort rooms, which continue to be upgraded and expanded in all the BHA facilities. Murals have been painted in the comfort rooms at Eastern Shore Hospital Center (ESHC). At Springfield Hospital Center, relaxation CDs are played throughout the unit when the milieu begins to escalate. All facilities are exploring sensory integration in designing the comfort rooms.

Additionally, Peer Support Specialists are available as consultants to staff and patients in the facilities. Currently, Eastern Shore, Thomas Finan, and Springfield Hospital Centers employ Peer Support Specialists who are funded partially or fully through OOOMD/Main Street Housing. Peer supports help to lead groups and participate in patient activities. They meet individually with patients to lend individual support and listen to their needs. They advocate for the patients and often serve as a go-between for the patient and staff. The facilities are in agreement that they would like to expand the program to include additional personnel in the peer support program.

Strategy Accomplishment:

This strategy was achieved.

Objective 3.3. MHA, in collaboration with CSAs, consumer and family organizations, governmental agencies, the administrative services organization (ASO), and other stakeholders, will address issues concerning improvement in integration of community services.

(3-3A)

**Federal Mental Health Block Grant Strategy*

Expand crisis response systems to increase utilization of intensive services to allow individuals with mental health and substance use issues to be served in the least restrictive setting.

Indicators:

- Expansion of crisis response services throughout the state
- Implementation of Center of Excellence For Early Intervention
- Community education and outreach activities implemented i.e. Mental Health First Aid (MHFA) and Crisis Intervention Systems Management (CISM)

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Lisa Hadley, MHA/ADAA Office of the Clinical Director; Marian Bland and Steve Reeder, MHA Office of Adult Services; MHA Facility CEOs; MHA Office of Forensic Services; MHA Office of CSA Liaison; Maryland Medicaid; CSA directors in involved jurisdictions; UMD EBPC, Mental Health Association of Maryland (MHAMD), other stakeholders

MHA Monitor(s): Brian Hepburn, MHA Office of the Executive Director and Lisa Hadley, MHA/ADAA Office of the Clinical Director

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA, in collaboration with CSAs, providers, and other stakeholders, has developed and implemented diversion activities and initiatives throughout Maryland for individuals with mental illnesses and co-occurring disorders. These efforts included support of crisis response systems, mobile crisis programs, hospital diversion, crisis beds, and assertive community treatment (ACT) services. MHA and the CSAs in various jurisdictions partnered with law enforcement agencies to offer training for officers, other public safety officials, and community providers regarding the management of crises involving persons who appear to have a mental health disorder and who may or may not have committed an offense.

Crisis response services are expanding throughout state and the utilization of Crisis Intervention teams is increasing. In FY 2014, the total number of calls made to crisis response systems was 84,383; the number of mobile crisis team face to face visits was 4,587; the number of individuals receiving in-home intervention was 989; and the number of individuals seen for urgent care visits was 9,081. All of these numbers show an increase over FY 2013 numbers.

The Maryland Center of Excellence: Early Intervention Program (EIP) is currently under development in Maryland. This is a specialized program with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with psychotic disorders. The program will be comprised of three components: 1) Outreach and Education Services, 2) Clinical Services, and 3) Regional Early Intervention Learning Collaborative Teams. The Team roles include:

- Team Leader – overall coordination of services, individual therapy, case management, crisis intervention, information gathering, safety planning, outreach/education.
- Recovery Coach – Social Skills training, weekly participation group, monthly family group, school coordination, outreach/education.
- Employment/Education Specialist – Job development, addressing work and school-related goals/problems, outreach/education.
- Psychiatrist – Prescribing, shared decision making, education.

Research will be integrated into each of these components and will focus on using existing/new objective methods for early detection and prediction of disease emergence, progress or recovery. These tools will then be used to guide intervention refinement to enhance efficacy and effectiveness.

Also, in FY 2014, SAMHSA provided additional funds to states to support ‘evidence-based programs that address the needs of individuals with early serious mental illness (SMI), including psychotic disorders’. States are required to set-aside five percent of their Mental Health Block Grant (MHBG) allocation to support this activity and will have to submit an addendum to their current MHBG application that outlines a proposal to implement the set-aside. Maryland will expand the existing early psychosis intervention program, which was established in 2009, entitled Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program. RAISE Connection is an intensive outpatient treatment with weekly sessions designed to provide community-based, recovery oriented individualized services to persons who are within the first one to two years of developing psychosis and schizophrenia. The MHBG set-aside will primarily address RAISE as part of the second component of EIP, Clinical Services. The funding will support

infrastructure and management, as well as data collection/evaluation, of two new RAISE Connection-like Early Intervention Teams under the EIP, serving the same population.

Additionally, MHFA trainings are expanding, including recently implemented training on Youth MHFA. MHA is working to coordinate trainings statewide. Several MHA staff members have become certified to conduct trainings on Adult and/or Youth MHFA.

Strategy Accomplishment:

This strategy was achieved.

(3-3B)

In collaboration with Maryland Medicaid and the ADAA, review and revise the financing mechanisms to improve the delivery of integrated behavioral health care.

Indicators:

- Regular and routine agency participation in statewide discussions
- Regular and routine collaboration with stakeholders to ensure diverse viewpoints are represented
- Review and refine state regulations to foster integrated care delivery
- Where appropriate, draft amendments to the Medicaid State Plan

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHA Medicaid Policy Analyst; Marian Bland and Steve Reeder, MHA Office of Adult Services; MHA Office of CSA Liaison; Marion Katsereles, MHA Office of Administration and Finance; Maryland Medicaid-Office of Health Services

MHA Monitor: Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Department of Health and Mental Hygiene implemented Phase 3 of the behavioral health integration process and moved forward with the decision to implement a performance-based carve out of mental health and substance abuse services as well as merge the Mental Hygiene and the Alcohol and Drug Abuse administrations. The two administrations reorganized into a single Behavioral Health Administration (BHA) on July 1, 2014.

The Department convened seven meetings for the Behavioral Health Stakeholder Process for stakeholder input to inform decisions relating to the integration. The topics of these meetings included: a kick-off of the Phase 3 process; discussion of the ASO RFP elements, both for Medicaid and non-Medicaid; a focus on elements in the Joint Chairmans' Report (JCR) for the Behavioral Health Integration that included an outline of how services for the uninsured, and MA ineligible services will be provided; a discussion of the role of existing local entities; evaluation of the impact of the model; rate setting methodologies; and current outcome measures. The last meeting was dedicated to review and discussion of the draft JCR report for comments before submission on December 1, 2013. After a two-year process, the State of Maryland released a Joint Chairmans' Report on Behavioral Health Integration. Substance use disorder services will be "carved out", alongside mental health services, beginning early 2015.

In July, 2011 the Deputy Secretary for Behavioral Health and Disabilities appointed a Behavioral Health Integrated Regulations Workgroup to develop integrated regulations governing providers of behavioral health, which includes both mental health and substance use disorder services. The Workgroup consisted of representatives from the Mental Hygiene and Alcohol and Drug Abuse Administrations, the Office of the Attorney General, the Office of Health Care Quality, the Office of Health Care Financing, as well as providers of behavioral health services.

The Workgroup has been guided by these principles:

- Reflect and encourage both system and service integration
- Promote administrative simplicity
- Facilitate and support the use of evidence-based interventions
- Support a person-centered approach

There will be new integrated behavioral health regulations inclusive of an accreditation process to replace prior regulations which “approved” providers and programs through the Office of Health Care Quality (OHCQ).

Additionally, the Mental Hygiene Administration, the state Medicaid office, and the Alcohol and Drug Abuse Administration worked to develop a Request for Proposal (RFP) for a new ASO that will manage the delivery of integrated behavioral health systems. In September, 2014, it was announced that ValueOptions@Maryland won the RFP bid to manage the BHA benefits for Medicaid recipients and uninsured, effective January 1, 2015.

Strategy Accomplishment:

This strategy was achieved.

(3-3C)

In collaboration with Maryland Medicaid and ADAA, respond to funding opportunities included in the Patient Protection and Affordable Care Act.

Indicators:

- Respond to the Medicaid Emergency Psychiatric Demonstration (MEPD) call for proposals (awarded March 13, 2012)
- Complete the development of a health home model to serve people with serious and persistent mental illness (SPMI), substance abuse disorders, and/or co-occurring chronic somatic health conditions

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHA Medicaid Policy Analyst; Marian Bland and Steve Reeder, MHA Office of Adult Services; MHA Office of CSA Liaison; Marion Katsereles, MHA Office of Administration and Finance; Maryland Medicaid-Office of Health Services

MHA Monitor: Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

Medicaid Emergency Psychiatric Demonstration (MEPD) - The MHA continued to monitor the admission of consumers aged 21-64 with emergency psychiatric conditions for inclusion in the Medicaid Emergency Psychiatric Demonstration (MEPD). Maryland was one of 11 states selected to participate in the MEPD, which provides reimbursement for certain services delivered by private psychiatric hospitals, for which Medicaid reimbursement has historically been unavailable. During the last quarter (April-June 2013), Maryland admitted 278 individuals to private psychiatric hospitals for treatment of an emergency psychiatric condition. The initial report to Congress was released Dec. 1, 2013. http://innovation.cms.gov/Files/reports/MEPD_RTC.pdf

Maryland's Medicaid Health Homes Initiative – The health home provision authorized by the Affordable Care Act (ACA) provides an 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.

MHA, in collaboration with ADAA and Maryland Medicaid, developed a plan for the implementation of a Chronic Health Home State Plan Amendment (SPA). Maryland's implementation model, in combination with meeting medical necessity criteria for psychiatric rehabilitation programs (PRPs) or mobile treatment (MT) services, will 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); individuals with an opioid substance use disorder that is being treated with methadone; and individuals 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 were implemented. The program went live October 1, 2013. As of September 2014, 60 providers were approved as Health Home providers (46 psychiatric rehabilitation programs; 10 mobile treatment programs; 4 opioid treatment programs).

Strategy Accomplishment:

This strategy was achieved.

(3-3D)

MHA, in collaboration with the MHA facility CEOs, CSAs, and providers, will continue to identify the needs of patients ready for discharge and community integration.

Indicators:

- Recommendations for a service continuum plan developed and implemented

Involved Parties: Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Marian Bland and Steve Reeder, MHA Office of Adult Services; CSAs; facility CEOs; Alcohol and Drug Treatment Coalition; Health Officers; Community Partners; providers; other stakeholders

MHA Monitor: Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations

FY 2014 activities and status as of 6/30/2014 (end-year report):

The CEO's and/or Clinical Staff of Finan Center, Eastern Shore Hospital Center, Springfield Hospital Center, and Spring Grove Hospital Center personally meet with the CSAs that service their catchment area at regularly occurring monthly meetings. The Regional Institutes for Children and Adolescents (RICAs) meet regularly with the Residential Treatment Coalition. Minutes are kept at all meetings.

Based on decisions made, discharge readiness and aftercare plans are forwarded to service providers for consideration for inclusion in their respective programs. Once potential candidates for community reintegration are selected, the hospital and the community provider set up interviews, schedule daily visits to the program, culminating in overnight stays and then provisional discharge. The patient has a 28 day trial at the program before officially discharged from the hospital. Working with the health care providers on a continuum of care discharge protocol allows for services to be tailored to meet the needs of patients about to be discharged from state psychiatric facilities.

Strategy Accomplishment:

This strategy was achieved.

GOAL IV. PROVIDE A COORDINATED APPROACH TO INCREASE EMPLOYMENT AND PROMOTE INTEGRATION OF SERVICES AND TRAINING TO DEVELOP AND SUSTAIN AN EFFECTIVE BEHAVIORAL HEALTH WORKFORCE.

Objective 4.1. MHA, in collaboration with CSAs and state agencies, will develop employment options and supports to increase the number of consumers employed.

(4-1A)

Continue to implement the Maryland Mental Health Employment Network (MMHEN), a consortium of Maryland mental health supported employment providers and CSAs, to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration (SSA) incentives such as Ticket-to-Work.

Indicators:

- Data reported on number of programs participating and consumers receiving training in these programs and number of consumers receiving individual benefits counseling in the Ticket-to-Work Program
- Continue implementation of a curriculum for in-service training and continue provision of training to statewide employment specialists
- Develop a manual to document procedures, reporting data, wages trends, and outcomes

Involved Parties: Steve Reeder, MHA Office of Adult Services; Maryland Department of Disabilities (MDOD); Harford County Office on Mental Health; UMD EBPC; UMD SEC; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions@Maryland; SSA; consumers

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

MMHEN was developed as an employment network with an administrative model, to help the Social Security Administration (SSA) disability beneficiaries with serious mental illness to obtain and retain employment, while developing a career path that would lead to economic and personal self-sufficiency. MHA, in collaboration with SSA, Maryland State Department of Education-Division of Rehabilitation Services (MSDE-DORS), the Harford County Core Service Agency (CSA), and the evidenced-based supported employment providers, continued this demonstration project into its fifth year of implementation, under the auspices of SSA's Ticket-to-Work (TTW) regulations.

The participating providers are Alliance (Belcamp), Goodwill STEP (Baltimore and Westminster), Mosaic (Timonium), Humanim (Columbia), and Cornerstone Montgomery (formerly St. Luke's House) with two providers, Upper Bay Counseling and Behavioral Health Services, added this year. Services received included job placement, benefit counseling, wage tracking, job coaching, and technical and administrative assistance to participating providers as needed.

In FY 2014, 360 individuals participated in the TTW program through this employment network and MMHEN collected \$115,929 in Ticket payments, and distributed \$88,407 to providers. This represents a 31% increase in income over FY 2013. MMHEN has also

expanded its ability to provide personalized benefits counseling to ticket holders who are not affiliated with supported employment programs. MMHEN is receiving payments on 23 non-affiliated individuals.

MMHEN maintains a database and performs daily data collection in order to assign tickets, request payments from SSA and to make payments to providers as agreed. The Program Administrator gathers data each month and quarterly reports are supplied to MHA. MMHEN Program Administrator and MHA representatives spent considerable time this year working to bring a Ticket Tracker system online.

In FY 2014, MMHEN provided eight pre-employment consultations and ten Benefits Summary Analyses. MMHEN works in collaboration with On Our Own of Maryland (OOOMD) to ensure that practices, language, and service delivery are consistent with consumer-focused supports. Additionally, MMHEN partners with OOOMD to provide peer supports to consumers involved with evidence-based supported employment providers.

MMHEN provided eight daylong intensive training sessions to 250 professionals and family members, in various locations around the state entitled, “*Social Security Benefits Advocacy: Using Work Incentives to Make Employment Work for Consumers with Mental Illness.*” There were also training sessions designed specifically for: a housing agency, Alliance Psychiatric Rehabilitation Program, NAMI Harford County, Harford County Transitioning Fair, Upper Bay Counseling, Behavioral Health Services, and My Sister’s Place. MMHEN hired a business liaison who promotes employment for individuals with mental illness among the business community. This will increase the ability to serve individuals who need only job placement assistance and ongoing benefits counseling for employment eligibility. The consultant has also partnered with OOOMD and is assisting in setting up Anti-Stigma Workshops at various business sites.

MMHEN developed a manual and printed outreach materials, also available in electronic format, which outline policies and procedures for issues such as ticket assignment, benefits counseling service delivery, community presentations, payment requests and other related issues. There have been continuing improvements made to MMHEN Web site with the addition of information about work incentives and the business liaison supports. Also, MMHEN now operates a toll-free number four hours per week where consumers, professionals and families can call in reference to work incentives. This number has been the source of several new referrals.

In April, 2014, MMHEN staff provided support to MHA in writing a SAMHSA grant application to establish additional supported employment programs in Prince George’s County and Baltimore City, expand TTW services, and facilitate efforts toward developing a peer-operated supported employment service.

Strategy Accomplishment:

This strategy was achieved.

(4-1B)

MHA, in collaboration with NAMI MD and the University of Maryland Evidence-Based Practice Center (UMD EBPC), will educate consumers and family members as to the availability of benefits counseling and supported employment (SE) and their role in facilitating consumer recovery and economic self-sufficiency.

Indicators:

- Increased understanding of MHA's supported employment program by consumers, transition-age youth, and families
- Continue implementation of the Johnson & Johnson - Dartmouth Community Mental Health Program Family Advocacy Project to educate family members as to the role of supported employment in consumer recovery
- Trained SE resource person available at selected local NAMI affiliates – Metro Baltimore, Frederick, Howard, and Montgomery county organizations
- Incorporation of supported employment content for Family-to-Family classes available to selected NAMI affiliates

Involved Parties: Steve Reeder, MHA Office of Adult Services; MHA Office of Consumer Affairs; MDOD; UMD EBPC; Dartmouth Psychiatric Research Center; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions@Maryland

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Family Advocacy Team is a special project within the Johnson & Johnson-Dartmouth Community Mental Health Program whose mission is to develop a collaborative working relationship between a state's mental health authority and the state's NAMI chapter to educate families about the important connection between employment and recovery. The education, training, and resource sharing is being delivered through a viable family organization in ways that have proved successful historically. The Family Advocacy Project is not funded at this time but is being sustained through interest and involvement of family members who are actively involved in securing grant funding. State-to-state team calls with the Dartmouth Psychiatric Research Center continue.

Eight trainings were provided with 250 attendees including NAMI members and provider agencies. MHA provided oral and written materials to all participants. The Johnson & Johnson-Dartmouth Community Mental Health Program Family Advocacy Project Team Leader, NAMI MD and Mental Hygiene Administration worked collaboratively to elicit interest in the Benefits Workshops and to emphasize the role employment plays in recovery.

Four NAMI affiliates each have a resource person - Metro Baltimore, and Frederick, Howard, and Montgomery counties. These Resource Persons field information and referral calls at the NAMI affiliates with the goal of encouraging individuals with mental illness and their family members to consider the employment-recovery link.

Supported employment content has been incorporated in Family-to-Family classes at selected NAMI affiliates and also on the national level. NAMI National's edition of its Family-to-Family curricula (a support education program that offers unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery), which all states must follow, includes information developed by Maryland's Family Advocacy Team, in conjunction with CBH's Vocational Committee, on what families need to know about evidence-based supported employment.

Strategy Accomplishment:

This strategy was achieved.

Objective 4.2. MHA will develop and implement collaborative training initiatives involving other agencies and stakeholders serving individuals with psychiatric and co-occurring disorders in the behavioral health system of care.

(4-2A) **Federal Mental Health Block Grant Strategy*
MHA, in collaboration with ADAA, will continue to enhance workforce development by expanding the involvement of Peer Support Specialists in behavioral health integration.

Indicators:

- Development of a Peer Credentialing Model in Maryland through utilization of the SAMHSA *Bringing Recovery Supports to Scale Technical Assistance (BRSS TACS)* Policy Academy Award (a funding source to support coordinated efforts to adopt recovery-oriented systems of care on a broad scale)
- Define Medicaid reimbursable services that are inclusive of areas of mental health, substance use, and co-occurring and define which Peer Specialist responsibilities are best suited for reimbursement.

Involved parties: MHA Office of Consumer Affairs; MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; OOOMD; CBH; WRCs; ADAA Regional Services Manager; mental health advocacy groups; peer organizations

MHA Monitor(s): Susan Kadis, MHA Office of Consumer Affairs

FY 2014 activities and status as of 6/30/2014 (end-year report):

In January, 2013, a workgroup on peer certification was convened in order to evaluate any existing addiction and/or mental health core curricula that might potentially be used towards a Peer Recovery Support Specialist certification. Additionally, MHA established a linkage with ADAA to have full representation from all consumers and staff with interest in mental health and substance abuse concerns. The final recommendations for curriculum and standards was presented to MHA leadership in FY 2014. Additionally, SAMHSA convened, with Maryland participation, the *Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)* Policy Academy, designed to build workforce capacity and create infrastructure to ensure collaboration and sustainability for Peer Recovery Support Services. A certification was developed by the Academy for implementation by the Maryland Addiction and Behavioral Health Professionals Certification Board (MABPCB) and approved by the International Certification and Reciprocity Consortium in late September 2013. Final instructions and application were posted on MABPCB Web site as of November 1, 2013.

Currently-eligible peer support and recovery support specialists were “grandfathered” in beginning on March 1, 2014 and continued for 90 days. The remaining outcome for this strategy is for 100 peers to become certified by March 1, 2015. To date, 90 peers have been certified through the grandfathering process with the remainder of 10 to be certified by March 1 2015. Currently, more than 160 approved supervisors have been registered and continued training is underway. MABPCB is also developing ongoing training for current certified peers to continue forth with the renewal process of certification.

The exploration and preliminary documents regarding MA reimbursement have been prepared. Efforts are underway to reconvene workgroup activity. Due to other immediate priorities around Behavioral Health Integration, the process to continue efforts to define Medicaid reimbursable services that are inclusive of areas of mental health, substance use, and co-occurring and determine which Peer Specialist responsibilities are best suited for reimbursement has been delayed. However, upon hiring of a new Director of the Behavioral Health Administration’s Office of Consumer Affairs, the workgroup will reconvene to address these issues. These efforts will roll over and continue forth into FY 2015.

Strategy Accomplishment:

This strategy was achieved.

(4-2B) **Federal Mental Health Block Grant Strategy*
MHA, in collaboration with ADAA and DDA, will act as the lead DHMH Behavioral Health Workforce Consortium and the central repository of workforce development training and information.

Indicators:

- Updates made to and utilization of the document for the Mapping of the DHMH Behavioral Health Workforce Development Activities
- Needs of Behavioral Workforce Consortium identified and recommendations developed and submitted to DHMH as appropriate
- Development explored of a work plan to guide workforce development efforts in the Behavioral Health Integration process

Involved Parties: Carole Frank, MHA Office of Planning; MHA staff; ADAA; DDA; DHMH; CSAs; Maryland Addictions Director’s Council (MADC) Higher Education Collaborative; behavioral health providers; consumers; family members; mental health and substance use local entities; other stakeholders

MHA Monitor: Carole Frank, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

During FY 2014, the Workforce Development Committee held quarterly meetings to discuss the mission and goals of the Committee. The Committee is comprised of representatives from: the Mental Hygiene and the Alcohol and Drug Abuse Administrations, now merged and referred to as the Behavioral Health Administration; Maryland Association of Core Service Agencies (MACSA); CBH; MADC; Maryland Association of Resources for Families and Youth (MARFY); UMD EBPC and UMD Innovations Institute; OOOMD; and other mental health and substance use disorder providers.

One of the key purposes of the Committee was to function as the central repository of workforce development resources and information. This effort was accomplished through “Roundtable” updates of the Workforce Development representatives and information on the Mapping Tool. Information provided from this resource included collaborative efforts with the National Council Learning Community. This was a partnership with MADC and the National Council for Community Behavioral Health to promote integration of substance use, mental health, and primary care. There were regular meetings and TA/coaching for participating providers. MADC also began another partnering effort with colleges and universities around the state to address the schools’ expectations when students are placed in internships as well as targeting what is needed in the field. Updates were also provided on efforts to rework the scopes of practice and certification requirements for different credential and license level substance use counselors in COMAR 10.58.07. The Committee shared information on providers’ efforts to implement dual diagnosis capability assessments. The Co-Occurring Disorder Workgroup (ADAA, MHA, DDA and the UMD EBPC) have met to discuss current activities throughout the state that included the development of Evidence-Based Practice (EBP) toolkits for co-occurring disorders, lessons learned from the Supervisors’ Academy for Co-occurring Disorders, and further promotion of training opportunities with Addiction Technology Transfer Center (ATTC), the American Society for Addiction Medicine (ASAM), and UMD EBPC’s Co-Occurring Trainer/Consultant.

Other workforce development efforts included the BRSS TACS Policy Academy that promoted the roll out of the Peer Recovery Specialist Credential and Training and the Child and Adolescent Behavioral Health Integration activities on training providers on youth co-occurring screening and assessment.

Additional resources included The Annapolis Coalition on the Behavioral Health Workforce – Innovative Practices in Behavioral Health Workforce Development and Cultural Competency and Workforce Development for Mental Health Professionals.

Next steps for the Workforce Development Committee may include working with the BHA and DHMH to develop a framework to guide workforce structures for behavioral health integration. This may include strategies identified in the “Modern Behavioral Health System”, such as the creation of learning models/core competencies to ensure training is available; licensure and certification requirements, and addressing the existing workforce to include trained family/peer supports as part of the paid workforce. Additionally, the Committee will review SAMHSA’s recent Strategic Initiatives to support strategies that further enhance workforce development and training.

Strategy Accomplishment:

This strategy was achieved.

Objective 4.3. Develop initiatives that promote the delivery of culturally competent and linguistically appropriate behavioral health services.

(4-3A)

MHA, in collaboration with key stakeholders, will refine the development and implementation of cultural competence training activities for consumers, providers, staff, and individuals in an integrated behavioral health system.

Indicators:

- Continuation of Behavioral Health Dialogue: “A Cultural Overview – The MHA & the ADAA” with increased administrative and programmatic leadership involvement to integrate cultural competency throughout the behavioral health system
- Increased utilization of the cultural competence assessment tool to enhance further development of the Cultural Linguistic Competence Training Initiative (CLCTI) curricula
- Incorporation of cultural competence training efforts in state, federal, and local planning activities
- Incorporation of cultural sensitivity awareness in training activities for special needs populations i.e. deaf and hard of hearing; Traumatic Brain Injury (TBI); older adults; lesbian, gay, bi-sexual, transgender (LGBT); individuals who are homeless; and individuals with co-occurring disorders
- Exploration of expansion of 3-hour CLCTI training to additional behavioral health providers and programs

Involved Parties: Iris Reeves, MHA Office of Planning; MHA Office of Consumer Affairs; Marian Bland, MHA Office of Special Needs Populations; other MHA staff; ADAA; CSAs; Maryland Advisory Council on Mental Hygiene/ Cultural and Linguistic Competence Advisory Committee (CCAC); OOOMD; consumers; family members; advocacy groups

MHA Monitor: Iris Reeves, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

Efforts to promote cultural competence and meet the needs of an increasingly diverse population continue to be important components of Maryland’s behavioral health system of care.

In March 2014, with the purpose of broadening the understanding of the nuances of culture/cultural awareness/cultural sensitivity as movement takes place toward behavioral health integration, a second *Behavioral Health Dialogue* took place. The emphasis was on “Stigma Reduction/Language Matters. Thirty-five to forty participants, including representation from ADAA/MHA staff, providers, consumers, CSAs and advocacy organizations, participated in the all-day Dialogue. In early June 2014, the training proposal for FY 2015 was submitted for the next Dialogue in the series: “Expanding/Understanding Regional Worldview within the Behavioral Health System” to be presented in March 2015.

Utilizing lessons learned from the Cultural and Linguistic Competency Training Initiative (CLCTI) training and consultation have been provided to adult programs and providers to promote program changes that would increase the cultural competency of the program and its recovery-orientation. Trainings reflect regional/geographic needs, as appropriate. The cultural competence assessment tool (CCAT) was utilized to inform adjustments/modifications, where appropriate, in CLCTI curricula. Collaborative training partnerships in the areas of CLCTI curricula have been formed and made available, upon request. In FY 2012, a modified training model was developed to be utilized with small regional groups, special needs populations and geographically different groups. Following the inception of the CLCTI, more than 550 individuals received, at a minimum, this modified 2-3 hour CLCTI training. MHA maintains a collaborative relationship with the Governor's Office of Deaf or Hard of Hearing (ODHH) for resources to address consumer and/or system related issues.

Also, in FY 2014, CSA FY 2016 Plans for all jurisdictions were reviewed as they planned and managed efforts in the local mental health communities. Comments and technical assistance were offered on cultural competence activities upon request. Mental Hygiene Administration promoted local planning efforts by the CSAs to include the development of increased awareness of activities related to behavioral health integration and the need to incorporate strategies/activities on cultural competency in local annual plans. Additionally, the MHA Coordinator of Multi-Cultural Issues participated in MHA/ADAA Annual Conference planning and gave input to state planning documents.

Strategy Accomplishment:

This strategy was achieved.

GOAL V. BUILD PARTNERSHIPS TO INCREASE THE PROVISION OF AFFORDABLE HOUSING AND REDUCE BARRIERS TO ACCESS IN ORDER TO PREVENT HOMELESSNESS FOR INDIVIDUALS WITH MENTAL ILLNESS.

Objective 5.1. Evaluate and develop opportunities to maximize current resources to promote affordable safe housing for individuals with serious mental illness.

(5-1A)

Continue to work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funding to support an array of affordable and integrated housing choices for individuals with serious mental illness (SMI).

Indicators:

- Community bond housing applications approved to increase funding for supported and independent housing units
- Pre-application meetings held, as appropriate, to inform perspective applicants about the Community Bond Program and to encourage partnerships within the state and local areas to pursue development efforts
- Continued support of DHMH partnership with the Maryland Department of Housing and Community Development (DHCD), other state and local agencies, and funding entities to encourage participation in annual community bond proposal
- Program monitored, data collected and reviewed on number of units developed and persons served through the Community Bond Program
- Documentation of annual progress and barriers in the development and completion of housing projects

Involved Parties: Cynthia Petion and Robin Poponne, MHA Office of Planning; Marian Bland, MHA Office of Special Needs Populations; MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; DHCD; Maryland Department of Disabilities (MDOD); Developmental Disabilities Administration (DDA); local housing authorities; housing developers

MHA Monitor: Robin Poponne, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA's priority for Administration-Sponsored Capital Program grant (Community Bond) financing is the development of affordable housing projects. To date, more than 555 housing units have been developed through Community Bond funding in partnership with community housing development organizations, mental health provider organizations, and other entities such as: Main Street Housing, Prologue, Humanim, Housing Unlimited, Way Station, Supported Housing Developers, Community Housing Associates, Key Point, Alliance, Family Services Foundation, Mosaic, Crossroads, People Encouraging People, Project PLASE, etc. Additionally, other supported housing providers, as well as a few developers, have applied for tax credits through DHCD and are working on

blended funding projects to serve individuals coming out of the state hospitals or stepping down from residential rehabilitation programs (RRPs).

A pre-application meeting was held at the end of January 2014 and well attended by more than 50 providers to explain the application process and inform them about the benefits of community bond funding as a way to increase affordable housing options. Attendees represented mental health, substance use, and developmental disabilities. Subsequent meetings with providers were held, as needed, to provide technical assistance, address changes, and to delineate the inclusion of appropriate special needs populations. The number of applicants for FY 2016 awards (application due in 2014) totaled seven for affordable housing for individuals with a mental illness. In FY 2013 and 2014, in addition to funds awarded to develop affordable housing, some mental health community bond funds were awarded to develop or expand capacity to behavioral health/health home services. These projects were in concert with the Department/Administration's behavioral health integration efforts. However, even though MHA has merged with ADAA, to become the Behavioral Health Administration, it is expected that affordable housing for individuals with behavioral health disorders will remain a priority.

MHA is committed to diverting individuals from admissions and/or discharging individuals from the hospitals to assist in further reducing the hospital census and giving individuals access to the most appropriate level of care. This includes individuals transitioning from RRP to Supported Housing so that individuals in state hospitals may access the vacant RRP beds. In 2011, through a collaborative effort among Springfield Hospital Center (SHC), Housing Unlimited, Inc. (HUI), and the Montgomery County CSA, community bond funding to purchase homes was leveraged. As a result, 20 RRP residents, over two years, moved into affordable housing in the community creating vacancies for 20 SHC patients to move into RRP. As the two year agreement ended, the CSA took on the role of administering annual state funds toward rental subsidy for the individuals placed in HUI housing under this initiative. Also, HUI has made a commitment to fill vacancies in two new Community Bond funded homes (10 units, altogether), acquired in FY 2014 and 2015, with individuals from RRP.

MHA continues partnering with DHCD and Maryland Partnership for Affordable Housing (MPAH) to determine waiting list for Weinberg Foundation units to finance affordable, quality, independent, integrated housing opportunities for persons with disabilities who have very low incomes and meet certain eligibility criteria. Also, the federal Department of Housing and Urban Development (HUD) 811 initiatives are widely used to supplement rental costs for individuals with limited income.

In an effort to enhance the internal process of tracking funded units that have been completed, as well as follow the progress of recent awardees, the MHA Office of Planning and the MHA Housing Coordinator are completing the development of a Community Bond Projects monitoring mechanism with plans to review, in FY 2015, programs previously awarded funds.

Strategy Accomplishment:

This strategy was achieved.

Objective 5.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for individuals who are homeless.

(5-2A)

Enhance efforts to increase housing opportunities through utilization of available federal subsidies and grants

Indicators:

- Realign the Projects for Assistance in Transition from Homelessness (PATH) funding to focus services on the delivery of outreach, case management, integrated services, and recovery for individuals who are homeless or at imminent risk of becoming homeless.
- Maximize use of the Shelter Plus Care Housing funding and other support systems to provide rental assistance to individuals with mental illness who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding
- Collaborate with MDOD, Kennedy Krieger, and DHMH to access the Housing Choice Voucher Program through the new HUD grant

Involved Parties: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; MHA Office of Adult Services; ADAA; CSAs; MHA facilities; Continuum of Care Homeless Boards; local detention centers; HUD; Chrysalis House Healthy Start Program; local service providers; consumers; case management agencies; housing authorities; other nonprofit agencies; other MHA staff; PATH service providers

MHA Monitor(s): Marian Bland, MHA Office of Special Needs Populations and Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

PATH

The PATH program provides services to individuals who became homeless or are at imminent risk of becoming homeless. In FY 2014, the PATH program continued to provide funding to all 23 counties and Baltimore City. The total federal funding was \$1,203,000 for FY 2014. There was a decrease in funding by \$78,000. Overall, PATH served 6,271 individuals in FY 2014 and enrolled 2,411.

Quarterly reports provide a snapshot of services provided during the year for people who are homeless. Additionally, an Annual Progress Report is submitted to SAMHSA to provide statewide data on individuals who are homeless and were assisted through PATH for the year, as well as the services and linkage to housing provided. Many people were outreached, enrolled, received case management, linked to services in the community,

and provided housing assistance. The services were provided to all four geographic jurisdictions - Central, Eastern, Southern and Western Maryland. In addition, they were five counties approved to provide one-time-only funds to prevent evictions; this year 25 individuals were assisted.

State PATH contacts provide on-going technical assistance to providers and CSAs to ensure they are meeting funding priorities that are aligned with SAMHSA's Recovery model initiative.

This program was successful because 19 out of the 25 PATH providers in the state of Maryland provide outreach services and case management which is SAMHSA's goal to link individuals to community mental health and other services as needed.

CoC Program

In FY 2014, HUD funded MHA's Continuum of Care (CoC) Program (formerly called Shelter Plus Care Housing) in the amount of \$4.8 million for a total of 317 units. MHA submits an Annual Performance Report to HUD every year when each grant expires to ensure that funding is renewed for the coming year. In addition, MHA participates in the Continuum of Care competition to provide housing in the counties. Also, every county that provides CoC Housing inputs information into the Homeless Management Information System on all individuals and families to generate an annual report to verify the actual count of people being served in the rental assistance program.

Housing Choice Vouchers

The cooperative agreement was signed by HUD in June of 2014 delineating the timeline for new construction and rehab of 150 awarded Section 811 units to continue through FY 2015. The upcoming HUD 811 units however will be developed in the greater Baltimore and Metro regions of Maryland only. Thus, the HUD 811 housing will be for those who live in the 12 designated jurisdictions or those willing to move and live there. RRP and Targeted Case Management (TCM) providers and CSA staff were informed at meetings and through email about the forthcoming affordable housing opportunity. TCM providers were trained in June 2014 about the referral process and eligibility standards required of all who access the HUD 811 housing in FY 2015 and 2016. Details regarding the online site Social Serve were discussed with providers, but further trainings will be held in the next fiscal year.

Additionally, MHA has secured state funding to develop a Housing First Pilot in Baltimore City, Montgomery and Prince George's counties. The Housing First Pilot will provide rental subsidies to homeless individuals assisted with SSI/SSDI, Outreach, Access, and Recovery (SOAR) and individuals transitioning from state hospitals or residential rehabilitation programs.

MHA participated with MDOD on the Maryland Partnership for Affordable Housing (MPAH) Advisory Council and the interagency and training subcommittees to ensure individuals who have a serious mental illness are able to access the Section 811 vouchers and Weinberg units. MHA has also extended outreach to mental health providers to inform them about the availability of funding. Additionally, MHA allocates federal HUD funding to CSAs to provide rental assistance to individuals who are homeless or were formerly homeless.

Strategy Accomplishment:

This strategy was achieved.

(5-2B)

**Federal Mental Health Block Grant Strategy*

Continue to expand the Supplemental Security Income/ Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) program statewide to further develop an integrated behavioral health model to improve access to services.

Indicators:

- Additional SOAR sites developed, including the Eastern Shore, new partners trained in SOAR, and workgroups formed
- Expand the pilot certification program to include all counties currently participating in SOAR
- Work with the State Hospitals and SSA to develop a process to expedite the reinstatements of benefits to patients as a part of the discharge planning
- Data collated and submitted to State Stat on a monthly basis

Involved Parties: Marian Bland, Caroline Bolas, and Keenan Jones – MHA Office of Special Needs Populations; Susan Bradley, MHA Office of Management Information System (MIS) and Data Analysis; Policy Research Associates; Social Security Administration – Disability Determination Services; Conference Planning Committee; SOAR team; case managers; colleges and universities; ADA; Department of Public Safety and Correctional Services (DPSCS); DHR; Veterans Administration; PATH-funded providers; other community and facility-based providers

MHA Monitor(s): Marian Bland and Caroline Bolas, MHA Office of Special Needs Populations

FY 2014 activities and status as of 6/30/2014 (end-year report):

The ongoing SOAR Initiative within Maryland continues to grow and become ever more successful. This is in part due to the many effective partnerships that have been developed since MHA took over the project in 2008.

A number of new sites and many more community providers became involved in SOAR in FY 2014. Providers in Allegany County and Charles counties have undergone SOAR training and are now participating in the initiative.

The SOAR TA team has provided trainings and ongoing support to the local SOAR Leads, Work Groups, and dedicated SOAR case managers. Five 2-day Stepping Stones to Recovery SOAR trainings were held in FY 2014, training more than 135 case managers, mental health professionals and social workers. Completed evaluation forms

indicated that over 90% of all participants were either very satisfied or satisfied with the information provided and with the way in which the training was organized and presented. MHA, in conjunction with representatives from community providers and Disability Determination Services, gave presentations about SOAR at four conferences in FY 2014. MHA in conjunction with Maryland Mental Health Employment Network presented its first SOAR Webinar for SOAR providers.

On June 20, 2014 MHA, in collaboration with the University of Maryland Training Center, held its Inaugural SOAR Conference. Seventy-five people attended from across the state. The conference included presentations on housing and employment, as well as a number of other SOAR related topics. This event gave SOAR-trained providers the opportunity to expand their knowledge of the SOAR process while sharing ideas among each other. Due to the very positive feedback received, requests have been made to make the conference an annual event.

Following a comprehensive evaluation, the SOAR certification process was revised and expanded across all established SOAR sites. As of June 2014, 13 people hold full SOAR Certification Status.

Work is ongoing with the state hospitals and SSA to develop a process to expedite the reinstatements of benefits to patients as a part of the discharge planning. Trainings and meetings have highlighted a number of potential barriers and all concerned are currently exploring how best to overcome these to ensure that benefits can be reinstated or obtained in the most efficient manner.

Data on numbers of approvals, SOAR processes, and processing times is collected monthly from all SOAR sites. Data is submitted to StateStat on a monthly basis and annually to the National TA Center.

Approved SOAR applications numbered 180 with the average processing time of 72 days (2 ½ months) for initial cases. The total number of decisional SOAR cases in FY 2014 was 216. Maryland has one of the highest state approval rates for SOAR claims within the country. Although the National TA center has yet to publish the national approval rate for initial SOAR cases for FY 2014, in 2013 the national approval rate for initial claims was 65%. In FY 2014, Maryland's approval rate for initial cases is 87%. Due in part to this ongoing success and high approval rates, MHA was asked to submit a journal article about the Maryland SOAR program to the World Medical and Health Policy journal.

Strategy Accomplishment:

This strategy was achieved.

GOAL VI. UTILIZE DATA AND HEALTH INFORMATION TECHNOLOGY TO EVALUATE, MONITOR, AND IMPROVE THE QUALITY OF BEHAVIORAL HEALTH SYSTEM OF CARE SERVICES AND OUTCOMES

Objective 6.1. MHA, in collaboration with Core Service Agencies (CSAs); consumer, family, and provider organizations; and state facilities will identify and promote the implementation of models of evidence-based, effective, promising, and best practices for mental health services in community programs and facilities.

(6-1A) **Federal Mental Health Block Grant Strategy*
Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education; also explore pilot implementation of Integrated Illness Management and Recovery (IIMR) program.

Indicators:

- Programs evaluated annually to determine eligibility for EBP reimbursement rates
- Ongoing data collection on EBPs receiving training, meeting fidelity, and providing consumer services
- Increased number of programs meeting fidelity standards for EBP programs
- Number of new programs established
- Continue to monitor IIMR pilot project through curriculum development and fidelity assessment at three sites (Frederick, Washington, and Howard counties)

Involved Parties: Steve Reeder, MHA Office of Adult Services; Brian Hepburn, MHA Office of the Executive Director; Lisa Hadley, MHA/ADAA Office of the Clinical Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Carole Frank, MHA Office of Planning; ValueOptions@Maryland; Dartmouth Psychiatric Research Center; UMD EBPC; UMD SEC; CSAs; community mental health providers

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

EBP Programs continue to be evaluated annually. Non-EBP and new programs continue to receive consultation, training, and technical assistance from the UMD EBPC Trainer/Consultants. Providers continue to request fidelity assessments to determine eligibility for EBP reimbursement rates. Fidelity assessments, for programs offering the EBPs of assertive community treatment (ACT), family psycho-education (FPE), and supported employment (SE), are conducted annually by MHA Fidelity Monitors to determine each program's eligibility to receive the enhanced EBP reimbursement rate.

There are 59 approved Mental Health Vocational Programs, 21 of which are assessed to meet evidence-based fidelity. The number of consumers received EBP SE services in FY 2014 was 2,508.

There are 29 approved Mobile Treatment programs, 13 of which are assessed to meet evidence-based fidelity. EBP ACT services provide integrated services by a multi-disciplinary team to include substance abuse and employment specialists, as well as nursing professionals. All ACT teams have received training in providing evidence-based FPE and SE from University of Maryland consultants and are linked to DORS

counselors as an important component of service delivery. ACT fidelity assessments were conducted using the *Tool for Measurement of Assertive Community Treatment* (TMACT). This tool has improved the evaluation of the quality of services. The ACT Trainer/Consultant has provided ongoing consultation and training to eight programs in FY 2014. As of July 1, 2012 ACT teams have been submitting monthly outcomes data to MHA and the Baltimore City CSA. The number of consumers receiving EBP ACT services in FY 2014 was 2,060.

There were no new Family Psycho-education (FPE) providers in FY 2014, but the existing providers continued the practice by starting new FPE groups. Three programs are providing EBP-FPE. A total of 19 individuals and eight family members attended FPE groups in FY 2014.

Data collection is ongoing. Data Sources include the EBP Center Semi-annual report and Fidelity Evaluator Tracking Tool. Annual reports are submitted to the MHA Office of Adult Services as component of an annual evaluation to determine eligibility for EBP reimbursement rates. Monthly outcome data are collected from all SE providers and SE providers-in-training by the University of Maryland.

Integrated Illness Management and Recovery (IIMR) is an EBP that provides information, support, and skills to help consumers manage their mental illnesses and somatic features as they move forward in their own recovery process. This EBP continues in Way Station-operated Psychiatric Rehabilitation Programs as part of a Health Home pilot project in Fredrick, Howard, and Washington counties locations. The IIMR provider is receiving training from the Dartmouth Psychiatric Research Center and continues to be monitored by MHA Adult Services. MHA Fidelity Monitors participate in technical assistance calls between Dartmouth and the IIMR provider on a regular basis.

Strategy Accomplishment:

This strategy was achieved.

(6-1B)

**Federal Mental Health Block Grant Strategy*

MHA, in conjunction with Baltimore Mental Health Systems, Inc. (BMHS) and the University of Maryland Systems Evaluation Center (UMD SEC), will produce preliminary outcome data reports from the administration of the Assertive Community Treatment (ACT) protocol.

Indicators:

- ACT outcome reports completed by providers and submitted to the Baltimore City CSA
- ACT data analyzed by UMD SEC
- Data reports disseminated to MHA and providers
- Strategies developed, findings incorporated into future planning

Involved Parties: Steve Reeder, MHA Office of Adult Services; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; Behavioral Health System Baltimore; UMD EBPC; UMD SEC

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2014 activities and status as of 6/30/2014 (end-year report):

ACT outcome reporting is being submitted to Behavioral Health System Baltimore (BHSB) [formerly BMHS] for validation and reporting out and to the Behavioral Health Administration (BHA) for monitoring of timely submission. Reports received are being validated through UMD SEC.

Involved parties are working to streamline the process to increase timeliness. MHA worked to identify issues with the present method of ACT outcome reporting and has worked with partners to improve the reporting process. Reports are now submitted electronically through an on-line process that facilitates accuracy and consistency of provider information as well as assuring that providers are given the data in a timely manner to be used to inform planning and quality improvement efforts. Current discussion includes establishing a Web-based reporting format that would be in use during the latter part of FY 2015.

Strategy Accomplishment:

This strategy was achieved.

(6-1C)

**Federal Mental Health Block Grant Strategy*

MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, local detention centers, DHMH, DPSCS's criminal justice team, and other key stakeholders, will develop and implement new practices to provide cost effective, coordinated, and recovery-oriented services to individuals who have mental illnesses or co-occurring substance abuse disorders who are incarcerated in local detention centers or prisons.

Indicators:

- Continue activities and supports of the second and final year of the Second Chance Grant to identify 75 individuals who have co-occurring disorders and are transitioning from prison to the community
- Assist local jurisdictions, upon request, in efforts to establish a court liaison or mental health court to divert appropriate individuals from detention centers to community programs or services
- Engagement in partnerships with Baltimore Mental Health Systems, Inc. (now known as Behavioral Health Systems Baltimore), state facilities, and DPSCS to promote data sharing to assist with community re-entry
- Engagement of WRCs and RWCs in aftercare planning
- Enhancement of the Maryland Community Criminal Justice Treatment Program (MCCJTP) to continue to effectively meet the aftercare needs of its participants

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; MHA Office of Forensic Services; MHA Office of Consumer Affairs; DPSCS; Core Services Agencies; local detention centers; MHAMD; WRCs and RWCs; ADAA; DDA; community behavioral health providers

MHA Monitor(s): Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

FY 2014 activities and status as of 6/30/2014 (end-year report):

Second Chance

The Second Chance grant was secured to serve approximately 75 offenders with moderate to high risk histories of chronic mental illness and substance use and/or dependence issues, to establish or re-establish community linkages. For MCCJTP, outcomes outlined in the Condition of Award agreements were met and/or exceeded by each of the participating 22 counties. Program indicators continue to be revisited to meet needs as determined by each jurisdiction. However, the goal of reaching 75 individuals was not accomplished due to challenges in the referral process. A no-cost extension application is being discussed among involved parties to maintain the program for an additional year. MHA will continue to support and work with DPSCS to continue their reach-in efforts through FY 2015.

In FY 2014, the Second Chance Grant quarterly data reports indicate 24 individuals were referred to the program with 20 enrolled. Ten of the 20 individuals were enrolled in post-release services with an average of 95% participating in somatic and behavioral health services. From the post-release group, 100% remained housed and collectively received a total of \$8,400 to offset basic expenses.

DataLink

DataLink, which enables the sharing of public mental health system treatment information with detention centers, has been implemented in Baltimore City and Howard and Anne Arundel counties. Booking data is sent by the DPSCS to the administrative service organization for MHA. A DataLink subcommittee continues to work toward establishing new sites for expansion.

Maryland Community Criminal Justice Treatment Program (MCCJTP)

In FY 2014, MCCJTP quarterly data reports indicated that services were delivered to more than 7,000 justice-involved individuals. Services included a combination of interventions such as psychiatric, psychotherapy, and/or case management services. More than 200 individuals among the treatment population identified themselves as Veterans. In addition to direct service, Core Service Agency contracts were modified to further support the development of re-entry services. BHA continues to work closely with CSAs and local detention centers to identify and close gaps through reentry in an effort to reduce recidivism.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.2. MHA will monitor and evaluate the performance of its key contractors the administrative service organization (ASO) and the Core Service Agencies (CSAs), requiring improvement as needed.

(6-2A)

**Federal Mental Health Block Grant Strategy*

In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.

Indicators:

- Contract requirements monitored
- Information shared with key stakeholders
- Monthly and quarterly reports generated by ASO; analysis of reports by involved parties
- Analysis of utilization management practices

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Audrey B. Chase, MHA Office of Compliance; MHA Office of CSA Liaison; Fiona Ewan, MHA Office of Fiscal Services; Susan Bradley, MHA Office of Management Information System (MIS) and Data Analysis; MHA Management Committee; UMD SEC; ValueOptions@Maryland; CSAs; representatives of key stakeholder groups

MHA Monitor: Daryl Plevy, MHA Office Deputy Director for Community Services and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

The contract requirements of the administrative services organization (ASO) are monitored for compliance with corrective actions taken as necessary. Monthly and quarterly reports are: generated by the ASO; analyzed by involved parties; and shared with key stakeholders (information related to public mental health system services including cost, number served, services provided, and types of diagnoses). Reports are used to inform decisions related to public mental health system planning and operation. Analysis of utilization management practices is conducted to ensure that consumers are receiving timely access to the appropriate level of care.

MHA has continued to serve individuals of all ages with mental illnesses, even as it has assumed fiscal and administrative responsibility for mental health care for the total Medicaid population under the MA 1115 waiver. In FY 1999 (first year of available data), over 68,000 individuals were served. Sixty-three percent were adults and 37 percent were children and adolescents. Fifty-two percent met the diagnostic criteria for individuals with serious mental illness (SMI) and 72 percent met the criteria for individuals with serious emotional disorders (SED). Since then, the number of individuals served has grown by more than 90,000 people.

In FY 2014, MHA served 161,889 individuals who had claims paid for mental health services received through the fee-for-service system. Of the total 102,049 were adults (age 18+), 63 percent (63.04%); and 59,840, almost 37 percent (36.96%) were children and adolescents.

Sixty-two percent (61.64%) of adults served met the diagnostic criteria for SMI; and seventy-four percent (74.20%) of the children and adolescents served met the diagnostic criteria for SED. (Data collected by claims paid through June 30, 2014 and therefore is approximate due to the allowed twelve month lag in the public mental health system's claims submission.)

Strategy Accomplishment:

This strategy was achieved.

(6-2B)

In collaboration with the ASO, DHMH's Office of Health Care Quality (OHCQ), DHMH's Office of the Inspector General, and CSAs, review providers' clinical utilization, billing practices, and compliance with regulations.

Indicators:

- Number of audits conducted
- Audit reports and compliance activities reviewed
- Corrective actions identified/implemented as needed

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Audrey B. Chase, MHA Office of Compliance; Steve Reeder, MHA Office of Adult Services; Al Zachik, MHA Office of Child and Adolescent Services; Office of Health Care Quality (OHCQ); ValueOptions@Maryland; CSAs

MHA Monitor: Audrey B. Chase, MHA Office of Compliance

FY 2014 activities and status as of 6/30/2014 (end-year report):

In FY 2014, MHA's Office of Compliance worked with the ASO to ensure the completion of more than 70 program audits. Many were scheduled as a result of data mining activities identifying high volume or high paid billers. Others were scheduled as a result of follow-up on fraud/abuse tips and complaint investigation findings. The outcome of MHA's review of provider utilization, billing practices, and regulatory compliance was program accountability. All audits were conducted as retrospective reviews of services provided. Provider entities included psychiatric rehabilitation programs (PRPs), outpatient mental health clinics, residential treatment centers, and hospitals.

MHA initiated appropriate sanctions against providers who failed to achieve regulatory compliance within their service delivery and billing practices. Such sanctions ranged from the implementation of a program improvement plan, to monetary retraction, to program revocation. In all instances audit findings were presented in a formal audit report. MHA's (now BHA's) Office of Compliance continues to work with the Office of the Inspector General to prevent fraud and abuse as well as identify opportunities for further investigation and recovery.

Strategy Accomplishment:

This strategy was achieved.

(6-2C)

Review and approve Core Service Agency (CSA) mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.

Indicators:

- Provision by UMD SEC of behavioral health data templates and technical assistance as needed
- Plans submitted from each CSA
- Compliance with MHA planning guidelines for CSA Plans evaluated
- Letters of review and recommendation received from each LMHAC and CSA board
- Previous fiscal year annual reports received
- MHA letter of review sent to the CSAs

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Cynthia Petion and Robin Poponne, MHA Office of Planning; MHA Office of CSA Liaison; MHA Office of Administration and Finance; MHA Review Committee (includes representatives of all major MHA offices); UMD SEC; CSAs; LMHACs; CSA advisory boards

MHA Monitor: Cynthia Petion, MHA Office of Planning

FY 2014 activities and status as of 6/30/2014 (end-year report):

Each year an extensive plan development process is implemented, beginning in January, with the submission to MHA of local mental health plans and budgets from the CSAs. The CSA Plan and Budget guidelines are developed through MHA's Office of Planning to guide the development of local plans that identify priorities, strengths, needs, and service gaps of the local public mental health system as well as a description of

stakeholder input. An official comprehensive Plan is usually submitted by each CSA every three years with updated documents developed and submitted during the two years in between. However, due to the DHMH Behavioral Health Integration Process, CSAs were required, in FY 2014, to submit only a one-year plan for FY 2015.

The CSAs' FY 2015 Mental Health Plan and Budget documents were reviewed by a committee consisting of MHA budget, planning, special needs populations, and behavioral health services staff, as well as the MIS and Office of Consumer Affairs (OCA) staff. Budget documents were submitted and reviewed first in January and February, followed by the submission of the CSA Annual Reports and Program Plans in March and April.

To simplify data submissions, each CSA continued to include standardized data templates in its submission. This year, CSAs were requested to discuss the following eleven state priority areas (based on MHA and federal Mental Health Block Grant requirements) and identify eight to discuss in-depth and to include in the goal/strategy area of the plan:

- Recovery supports
- Public awareness and education
- Tobacco/Smoking Cessation
- Behavioral health workforce development efforts
- Suicide prevention
- Efforts to address co-occurring disorders/dual diagnosis capability training
- Access to services across the lifespan
- Evidence-based practices
- Health disparities/cultural competency
- Diversion efforts
- Outcomes/quality

Additionally, each plan included, as required, a letter of review with recommendations from the local mental health advisory committee of that jurisdiction or documentation of review from the CSA Board of Directors.

CSAs were also required to electronically submit their fiscal year 2013 Annual Reports. The plans and annual reports included discussions of: the CSAs' achievements; interagency collaborations and partnerships; local and statewide initiatives; and financial plans linked to mental health services. All plans were found to be in compliance with MHA's Guidelines Regarding Fiscal Year 2015 Plans/Budgets. Letters of review/approval were sent at the end of FY 2014.

Strategy Accomplishment:

This strategy was achieved.

(6-2D)

Monitor and collect documentation on each CSA's performance of its duties, as required in the annual Memorandum of Understanding (MOU), on risk-based assessment of each CSA through a sample of specific MOU elements; and notify the appropriate MHA program director of issues that may require corrective action or additional technical assistance.

Indicators:

- Development and update of monitoring tools and instructions for reports from each CSA, emphasizing electronic transmission
- Reports from each CSA reviewed, in response to periodic instructions issued, regarding its administrative duties and expenditures, the execution of its subvendors' contracts, year-to-date expenditures/performance measures, and any required audits
- Evaluation of compliance with the Conditions of Award for State General Funds and Federal Mental Health Block Grant funds
- Three reviews scheduled for the first, second and fourth quarters of the fiscal year
- Written letter issued to each CSA regarding each periodic report, appropriate follow-up conducted as needed

Involved Parties: John Newman, Sandy Arndts, and Richard Blackwell, MHA Office of CSA Liaison; appropriate MHA Office Directors; MHA staff; CSAs

MHA Monitor(s): John Newman and Richard Blackwell, MHA Office of CSA Liaison

FY 2014 activities and status as of 6/30/2014 (end-year report):

The MHA Office of CSA Liaison completed three quarterly monitoring exercises, conducted by conference calls, for all 19 CSAs for compliance with the MOU for FY 2014. (The fourth quarterly monitoring process [third quarter] consisted of the MHA review of CSA Program Plans, Annual Reports, and Budgets.) Quarterly monitoring for each CSA's administrative oversight and for its sub-vendors included:

- Review the use of both state general funds and federal block grant dollars
- Report from each of the 19 CSAs submitted regarding the timely execution of their sub-vendors' contracts
- Type of contract used
- Requirement for an audit, its due date, and copy of CSA audit review
- Administrative reports on selected elements of the MOU and a fiscal update on year-to-date expenditures
- Performance measures with projections for the fiscal year for the CSAs' administrative oversight and sub-vendors
- Review of the use of Consumer Support funds
- Assessment of CSAs' efforts toward cooperating with the Office of Health Care Quality in handling complaints
- Assessment of CSAs' complaint policies
- Assessment of CSAs' relationships with substance use coordinators
- Assessment of CSAs' readiness to implement crisis response and crisis intervention services

The FY 2014 monitoring process, as a result of the legislative auditor's report, emphasized timely execution of deliverables and congruency between each sub-vendor's contractual conditions of award (COA) with the COA contained in the MHA/CSA MOU. Selected samples of sub-vendors' contracts at each CSA were reviewed, including the contract, budget for cost reimbursement, programmatic report from the sub-vendor, invoice, payment, audit (if required), documentation of the CSA's review of the audit, report validation site visit by the CSA, and payment internal controls by the CSA.

Of the 74 contracts (58 State General Fund and 16 Federal Block Grant) monitored in the fourth quarter FY 2014:

- 74 (100%) contained all COAs
- 68 (92%) had site visits to the vendor to validate Program Reports
- 66 (89%) demonstrated CSA use of internal controls to assure payments to vendors are based on satisfactory performance
- Of the 36 required sub-vendor audits, 31 were received and reviewed by the CSA
- All 19 (100%) of the CSAs provided the latest audit of the CSA by the DHMH auditors and/or an independent audit

The Office of CSA Liaison retains quarterly monitoring materials provided by the CSAs on file. This includes both verbal feedback through scheduled conference calls and documentation of findings for each CSA. A follow up letter is distributed to each CSA. Copies are forwarded to the BHA Management Committee and are available for review in BHA's Office of CSA Liaison.

Strategy Accomplishment:

This strategy was achieved.

(6-2E)

Review MHA's budget and behavioral health system of care expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.

Indicators:

- Quarterly expenditure management plans developed and reviewed
- Regular meetings held with MHA facility chief executive officers (CEOs)
- Expenditures and needs reviewed by clinical directors and financial officers

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; MHA Office of Administration and Finance; Lisa Hadley, MHA/ADAA Office of the Clinical Director; MHA Facility CEOs; clinical directors and financial officers

MHA Monitor(s): Brian Hepburn, MHA Office of the Executive Director and MHA Office of Administration and Finance

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA monitors facility budgets regularly and reviews developed expenditure plans and reports. Quarterly reviews are held regularly, plus additional meetings and reviews are held on an ad hoc basis. Corrective actions are developed and implemented consistent with applicable regulations, policies, and procedures. Also, MHA and the ASO have reviewed weekly and quarterly expenditure and utilization reports to ascertain trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, and correcting any

problems that may be identified. Additionally, the CSAs routinely review various Crystal Reports detailing claims and utilization for consumers and providers within their respective counties.

In FY 2014, MHA's office of Administration and Finance has been working closely with ADAA, Medicaid, and other pertinent segments of the behavioral health system of care to prepare for behavioral health integration. The new Medicaid financing model means that Medicaid expects to expand its enrollment by 250,000. This is expected to lead to improved data collection, quality measures, and improved understanding of costs, system-wide.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.3. MHA, in collaboration with CSAs, state facilities, the administrative services organization (ASO), other state agencies, and key stakeholders, will utilize data and health information technology, through a variety of approaches, to evaluate and improve the appropriateness, quality efficiency, cost effectiveness, and outcomes of mental health services within the behavioral health system of care.

(6-3A)

Continue to monitor the implementation of the Outcomes Measurement System (OMS).

Indicators:

- Development and dissemination of training materials, including a statistical workbook, related to OMS data analysis and interpretation
- Continued collaboration with ASO regarding how OMS monitoring utilization and questionnaire completion rates can be coordinated with the ASO Quality Improvement Incentive Program (QuIP) project
- Continued collaboration with ASO regarding OMS Datamart monitoring and maintenance, including monthly data validation and quarterly OMS Datamart refreshes

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; Sheba Jeyachandran, MHA consultant; MHA Management Committee; ValueOptions@Maryland; CSAs; UMD SEC; CBH; providers; consumer, family, and advocacy groups

MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs

FY 2014 activities and status as of 6/30/2014 (end-year report):

The UMD SEC/MHA, with input from provider and CSA representatives, developed and finalized several OMS resources. These are intended to assist providers and CSAs to understand and use the data available through OMS. The resources were posted on a revamped OMS section of the ASO Web site and include: *Introduction to Data and Data Analysis; How OMS Items Are Analyzed; Determining Statistical Significance for OMS Data: Step-by-Step Guide; and How to Administer the OMS Interview (power point).*

Some collaboration regarding the Quality Incentive program (QuIP) has continued to occur between MHA and the ASO. The Behavioral Health Administration (BHA) will continue to be involved in the regularly scheduled meetings between the ASO and the QuIP providers. Utilization monitoring occurs at a high level.

Monthly telephone meetings with the ASO to update the OMS continue, troubleshooting occurs as needed, and quarterly OMS Datamart refreshes occur as scheduled.

Strategy Accomplishment:

This strategy was achieved.

(6-3B)

MHA will continue to monitor the utilization of telemental health services to the underserved populations in the rural Western and Eastern Shore counties.

Indicators:

- Number of telemental health encounters and services utilized through behavioral health system of care claims data
- Outcome Data aggregated and reviewed with designated area CSAs to inform planning
- Process compared with Medicaid (MA) system of telemedicine expansion

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; MHA Medicaid Policy Analyst; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; MA; CSAs; ValueOptions@Maryland

MHA Monitor: Daryl Plevy, MHA office of the Deputy Director for Community Services and Managed Care

FY 2014 activities and status as of 6/30/2014 (end-year report):

As of FY 2014, seventeen providers and local health departments across the state, mostly from the Lower and Eastern Shore, are telemental health providers and participate in telemental health service encounters:

In FY 2014, 1,133 unduplicated consumers were served with expenditures of \$352, 215. In FY 2013, 952 unduplicated consumers were served with expenditures of \$354,635. Although providers have up to 12 months from date of service in which to submit a claim for payment, data for FY 2014 shows a 19% increase in the number of individuals served utilizing telemental health services.

The CSAs continue to promote the development of a provider network in their jurisdictions. The Telemental Health strategy of the StateStats was reported each month

in FY 2014 to DHMH Secretary's SpeedStat meetings. MHA monitors utilization through the number of unique individuals using telemental health services and has found that the average monthly amount of individuals receiving telemental health services is 322. The results have shown improved access and reduced barriers for a number of services.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.4. MHA, in collaboration with CSAs, the ASO, and key stakeholders, will promote the use of technology as a tool to improve information sharing, data collection, training, evaluation and performance, and outcomes.

(6-4A)

Enhance behavioral health data collection and utilization through continued activities to develop and/or refine management information systems and promote the use of data.

Indicators:

- Technical aspects of management information systems refined; logic of reports enhanced to reflect recovery orientation; accuracy and usefulness of current reports identified
- Continued practices to promote data integrity for behavioral health data
- Promotion of and technical assistance provided on the Web-based Outcomes Measurement System (OMS) datamart for access to point-in-time and change-over-time information as an effective tool to assist providers in management and planning efforts
- Enhance capacity for CSAs and other stakeholders to utilize behavioral health data to measure service effectiveness and outcomes to inform policy and planning
- Continue disseminating data in a manner that is accessible and meaningful to end users, including production and dissemination of Data Shorts
- Promotion of managerial and county-wide access to dashboard reports and behavioral health data through ASO reporting system
- Reports generated and posted to designated data reporting section on administrative Web site, making behavioral health demographic data available to users outside of state agencies
- Establish Web-based data collection system for reporting residential rehabilitation program (RRP) bed counts and waiting list information

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of MIS and Data Analysis; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; Cynthia Petion, MHA Office of Planning; UMD SEC; CSAs; ValueOptions@Maryland

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2014 activities and status as of 6/30/2014 (end-year report):

Monthly data and information technology (IT) conference calls are conducted with current ASO, ValueOptions@Maryland, around the refinement and release of relevant public mental health system data reports.

Change-over-Time and Point-in-Time data are available via datamart for the CSAs and providers.

Monthly CSA/MHA/ASO Data Committee calls were conducted to inform all CSAs about initiatives, updates, and progress. The calls also served as a forum for CSAs to troubleshoot data reports and ask questions. All available data and reports were shared with the CSAs for policy and planning purposes. A series of training events will be made available for CSA staff to access and utilize all published reports on reporting platform. Data such as the Veteran's report, Inpatient Data Sheet, Quarterly reports, etc. continued to be released to all CSA representatives. Dashboard reports remain on-site for Executive Level staff usage and CSAs and providers are given access to county-specific and client-level OMS data.

Quarterly reports and specialized data reports such as State Psychiatric Monthly Statistical reports, Readmission reports, and average length of stay (ALOS) reports, and monthly Statestat reports, are posted regularly for public consumption on the BHA/MHA Web site.

Data Shorts is a BHA project in collaboration with the University of Maryland, Systems Evaluation Center (UM SEC) with topics ranging from comparison of consumers receiving mental health services with and without substance use disorders, functioning scales related to recovery both in adults and youth, mental illness stigma, and challenges to continuity of care for adults receiving behavioral health services. There were a total of 12 Data Shorts released within FY 2014. The Data Shorts are distributed via Twitter and published electronically on the BHA Web site.

A Web-based system for collecting data on residential rehabilitation program (RRP) bed availability was launched in FY 2014. Data collected for the last quarter included information for 15 jurisdictions.

Strategy Accomplishment:

This strategy was achieved.

(6-4B)

Maintain accreditation of MHA facilities by the Joint Commission.

Indicator:

- All MHA facilities accredited

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Mary Sheperd, MHA Office of the Deputy Director for Hospitals and Adolescent Residential Treatment; Lisa Hadley, MHA/ADAA Office of the Clinical Director; MHA Management Committee; MHA Facility CEOs; appropriate facility staff

MHA Monitor: Mary Sheperd, MHA Office of the Deputy Director for Hospitals and Adolescent Residential Treatment

FY 2014 activities and status as of 6/30/2014 (end-year report):

The Joint Commission visited two state psychiatric facilities and two Regional Institutes for Children and Adolescents in FY 2014. All MHA facilities have maintained their Joint Commission accreditation status. Three of the hospitals received honors as top performers from the Joint Commission. Clifton T. Perkins, Spring Grove Hospital Center, and Thomas B. Finan Center were recognized for exemplary performance using evidenced-based clinical processes shown to improve care for inpatient psychiatric services. Top Performer Organizations must achieve a cumulative performance of 95% or above across all reported accountability measures.

Health and Safety Management Teams continue to operate as collaborative efforts between facility management and direct care staff. Each team develops recommended activities based on data at its specific facility. Team participation has: positively impacted collaboration across disciplines; increased awareness of ward milieu; reduced staff and patient assaults; and increased opportunities for active participation of ward staff in the treatment team meetings.

The state psychiatric facilities are significant participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland.

Strategy Accomplishment:

This strategy was achieved.

(6-4C)

Continue efforts to enhance communication and education through the use of social media technology.

Indicators:

- Social media outlets, such as Facebook or Twitter, utilized to promote public mental health awareness and improved communication among MHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, produce 25 micro-blogs pertaining to mental health efforts and information
- Promote @DHMH_MHA Twitter account and increase percentage of “Followers” by 15% within the year.
- Continue exploration of appropriate social media outlets to bolster Child and Adolescent initiatives and/or to provide Peer-to-Peer support

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of MIS and Data Analysis

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2014 activities and status as of 6/30/2014 (end-year report):

MHA, through DHMH departmental-wide efforts, established social media outlets through Facebook and Twitter as a means of disseminating behavioral health data and news among MHA, CSAs, providers, advocates, consumers, family members, and the public at large.

Since July 1, 2013, the @DHMH_MHA Twitter account has posted 65 tweets or micro-blogs pertaining to behavioral health and issues on the local and national level. The account is currently “following” 154 other Twitter accounts relating to governmental, public health, and behavioral health issues. The @DHMH_MHA Twitter feed is followed by 536 unduplicated accounts, all which by virtue of their accounts disseminate the information tweeted to their resources. This is a 46% increase so far in the fiscal year over the number of followers from last year.

Both social media sites disseminate information provided by the DHMH Secretary, staff, and other stakeholders that are involved with the Administration. Monthly data, regarding the increase in the number of followers to the @DHMH_MHA account, are submitted via StateStats. As new technology emerges, MHA (now BHA) will continue to explore alternative social media outlets that bolster child and adolescent initiatives and that are geared more towards a “tween or teen” population.

Strategy Accomplishment:

This strategy was achieved.

Appendix A

Mental Hygiene Administration Liaisons to Maryland State Government Agencies

Maryland Department of Disabilities (MDOD)	Governor's Office for Children (GOC)	Governor's Office of the Deaf and Hard of Hearing (ODHH)	Maryland State Department of Education (MSDE)	Division of Rehabilitation Services (DORS)	Department of Human Resources (DHR)	Department of Housing and Community Development (DHCD)	Maryland Department of Aging (MDoA)	Department of Public Safety and Correctional Services (DPSCS)	Department of Juvenile Services (DJS)	Department of Veterans Affairs	Judiciary of Maryland
Brian Hepburn, M.D.	Al Zachik, M.D. Tom Merrick	Marian Bland	Al Zachik, M.D. Cyntrice Bellamy	Marian Bland and Steve Reeder	Daryl Plevy, Al Zachik, M.D. and Marian Bland	Steve Reeder and Marian Bland	Marian Bland and Steve Reeder	Erik Roskes, M.D., and Marian Bland	Al Zachik, M.D., Cyntrice Bellamy and Office of Forensic Services	Shauna Donahue, DHMH, Director, Maryland's Commitment to Veterans	Erik Roskes, M.D.

Mental Hygiene Administration Liaisons to Maryland State Government Agencies

DHMH Alcohol and Drug Abuse Administration (ADAA)	DHMH Family Health Administration (FHA)	DHMH Developmental Disabilities Administration (DDA)	Maryland Health Care Commission (MHCC)	Health Services Cost Review Commission (HSCRC)	The Children's Cabinet	DHMH Medical Care Programs (Medicaid)	DHMH Office of Health Care Quality (OHCQ)	DHMH Office of Capital Planning, Budgeting, and Engineering Services	DHMH AIDS Administration	Maryland Emergency Management Administration (MEMA)	
Lisa Hadley, M.D., J.D., Cynthia Petion and Carole Frank	Al Zachik, M.D.	Stefani O'Dea, Lisa Hovermale, M.D., DDA, and Erik Roskes, M.D.	Brian Hepburn, M.D.	Brian Hepburn, M.D.	Al Zachik, M.D.	Brian Hepburn, M.D., Daryl Plevy, Lisa Hadley, M.D., J.D.	Sharon Ohlhaber And Audrey Chase	Cynthia Petion and Robin Poponne	Marian Bland	Mary Sheperd	

Appendix B

The Strategic Initiatives

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.
2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.
3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.
5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.
6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).
7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Source: SAMHSA Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014, page 3.