



CHANGING
Maryland
for the Better

Department of Health and Mental Hygiene

***FY 2015 ANNUAL STATE
MENTAL HEALTH PLAN
IMPLEMENTATION REPORT***

A CONSUMER – ORIENTED SYSTEM

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December 2015

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EXECUTIVE SUMMARY

FY 2015 was a significant year for the behavioral health community. On July 1, 2014, the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) merged into the unified Behavioral Health Administration. Maryland House Bill 1510 required the Department of Health and Mental Hygiene, Behavioral Health and Disabilities to convene a stakeholder workgroup to make recommendations on issues related to behavioral health. Thus, statewide stakeholder participation continued as the process of behavioral health integration progressed. The Behavioral Health Integrated Regulations Workgroup strengthened the foundation for an integrated behavioral health care system by integrating the regulations applicable to services for community-based mental health and substance-related disorders in Maryland. Also, as of January 1, 2015, the implementation of a combined mental health and substance-related disorders data system began.

This operational plan supported many of these changes from the early inclusion of staff and members of the substance-related disorders community in its development to the incorporation of specific strategies that addressed the delivery of services for mental health, substance-related, and co-occurring disorders. Our process to develop strategy concepts for this plan took place in April, 2014 and included a broad spectrum of participants from mental health and substance use arenas. Consumers, families, providers, advocacy organizations, various professionals, and interested citizens met together to complete this process.

Although this plan was not yet considered a fully integrated behavioral health plan, opportunities were taken, wherever possible, to use language, concepts, and inclusivity to prepare for full integration in the development of all future documents. This was not so difficult a task since our planning processes and effective blending of services over the years have, for children, adolescents, transition-age youth, adults, and older adults, been the result of already existing interagency cooperation, as well as public and private partnerships.

To further support continued improvements in the delivery of prevention, treatment, and recovery support services and to focus the Administration's efforts toward promoting expansion of behavioral health, we have continued to organize many FY 2015 plan activities based on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Eight Strategic Initiatives (Listed in the Appendix).

Additionally, both former administrations (MHA and ADAA) recognized that stigma remains a barrier to appropriate treatment throughout the service system. Many of the strategies in this plan are intended to emphasize and support the mission, vision, and values of the Public Behavioral Health System, which that facilitate recovery, hope, and the strengths of a collective community as we move forward in the completion of the behavioral health integration process.

STATE OF MARYLAND BEHAVIORAL HEALTH ADMINISTRATION

MISSION

The Behavioral Health Administration, through publicly-funded services and supports, promotes recovery, resiliency, health, and wellness for individuals who have, or are at risk for, behavioral health disorders.

VISION

Improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care.

VALUES

The values underpinning this system are:

(1) *SUPPORTIVE OF HUMAN RIGHTS*

Promote a quality system of care that is supportive of individual rights and preferences. Persons with psychiatric and/or substance-related disorders have the same rights and obligations as other citizens of the state. Individuals 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) *CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES*

Promote respect and responsiveness to the health beliefs, practices, and cultural and linguistic needs of diverse population groups. Increase knowledge of cultural attitudes and contributions to the process of behavioral health treatment, recovery, and the elimination of health disparities system-wide.

(3) *RESPONSIVE SYSTEM*

The behavioral health system of care must be responsive to the people it serves, coherently organized, and accessible to those individuals needing behavioral 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 behavioral health system of care. 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.

(4) *EMPOWERMENT*

Individuals, families, and advocates will be involved in decision-making processes at the treatment level and collectively in the planning and operational aspects of the behavioral health system. An array of services and programs must be available to allow for individual choice in obtaining and using necessary services.

(5) *COMMUNITY EDUCATION*

Wellness is promoted and enhanced 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 behavioral health services come from increased awareness and understanding of psychiatric and substance-related disorders and treatment options.

(6) 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.

(7) LEAST RESTRICTIVE SETTING

An array of services will be available throughout the state to meet a variety of individual needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.

(8) WORKING COLLABORATIVELY

While recognizing that co-occurring conditions are common, collaborations with other agencies at the state and local level will be fostered so support to individuals with substance-related and mental health disorders is inclusive in all activities of life. This will promote a consistently appropriate level of behavioral health services.

(9) EFFECTIVE MANAGEMENT AND ACCOUNTABILITY

Accountability is essential to consistently provide an adequate level of behavioral health services. Essential management functions include monitoring and self-evaluation, rapid response to identified gaps in the system, adaptation to changing needs, and improved technology. A high priority is placed on measuring client perception of care and satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.

(10) LOCAL GOVERNANCE

Local management of resources 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.

(11) STAFF RESOURCES

The presence of a competent and committed staff is essential for the provision of an acceptable level of behavioral 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

ACT	Assertive Community Treatment
ASO	Administrative Services Organization
BHA	Behavioral Health Administration
B-HIPP	Behavioral Health Integration in Pediatric Primary care
BI	Brain Injury
CBH	Community Behavioral Health Association of Maryland
CMS	Center for Medicare/Medicaid Services
COA	Conditions of Award
CoC	Continuum of Care (formerly Shelter Plus Care)
CFAP	Community Forensic Aftercare Program
CIT	Crisis Intervention Team
CSA	Core Service Agency
CPRS	Certified Peer Recovery Specialist
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
EBP	Evidence-Based Practice
EIP	Early Intervention Program

FLI	Family Leadership Institute
FPE	Family Psycho-Education
GOC	Governor’s Office for Children
HT	Healthy Transitions
HUD	Federal Department of Housing and Urban Development
IDDT	Integrated Dual Disorder Treatment
IFSC	Interagency Forensic Services Committee
IIMR	Integrated Illness Management and Recovery
LAA	Local Addiction Authority
LAUNCH	Maryland Linking Actions for Unmet Needs in Children’s Health
LEAP	Leadership Empowerment and Advocacy Project
LIFT	Maryland Launching Individual Futures Together
LMHAC	Local Mental Health Advisory Committee
LGBT	Lesbian, gay, bi-sexual, transgender
LTSS	Long-Term Services and Supports
MA	Medical Assistance or Medicaid
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
MCV	Maryland Commitment to Veterans
MDoA	Maryland Department of Aging
MDOD	Maryland Department of Disabilities
MFP	Money Follows the Person
MH	Mental Health

MHAMMD	Mental Health Association of Maryland, Inc.
MHBG	Federal Mental Health Block Grant
MHFA	Mental Health First Aid
MPAH	Maryland Partnership for Affordable Housing
MSDE	Maryland State Department of Education
MT	Mobile Treatment
NAMI MD	National Alliance on Mental Illness-Maryland
OA	Older Adult
OCA	Office of Consumer Affairs
ODHH	Office of Deaf and Hard of Hearing
OHCQ	Office of Health Care Quality
OFS	Office of Forensic Services
OMS	Outcomes Measurement System
OOOMD	On Our Own of Maryland, Inc.
PASRR	Pre-admission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness
PBHS	Public Behavioral Health System
PCCP	Person Centered Care Planning
RCC	Recovery Community Centers
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SDC	Self-Directed Care
SE	Supported Employment
SED	Serious Emotional Disorders
SEFEL	Social and Emotional Foundations for Early Learning
SMI	Serious Mental Illness

SOAR	SSI/SSDI, Outreach, Access, and Recovery
SPA	State Plan Amendment
SPMI	Serious and Persistent Mental Illness
SRD	Substance-Related Disorder
SSI/SSDI	Supplemental Security Income/ Social Security Disability Insurance
TAY	Transition-Age Youth
TIC	Trauma Informed Care
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

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GOAL I. INCREASE PUBLIC AWARENESS AND SUPPORT FOR IMPROVED HEALTH AND WELLNESS; REDUCED IMPACT OF HOMELESSNESS AND LIFE THREATENING FACTORS FOR VULNERABLE INDIVIDUALS

Objective 1.1. The Behavioral Health Administration (BHA), 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) Mental Health Block Grant (MHBG)

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), 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 pertinent materials
- Continued promotion and implementation of the Youth Mental Health First Aid education and training program to increase community awareness of and responsiveness to behavioral health issues among youth
- Continued research, development and piloting of curriculum supplements for specialized audiences
- Number of people trained
- Trainings implemented for Maryland Commitment to Veterans (MCV) Regional Resource Coordinators to train veterans, families, and those working with veterans/families on MHFA
- Continued partnership with MHAMD and Core Service Agency (CSA) 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: Behavioral Health Administration (BHA) Offices of the Executive Director, the Deputy Director of Operations, and 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; other behavioral health advocacy groups

Monitor(s): Daryl Plevy, Office of the Deputy Director of Operations

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA, in collaboration with DHMH, and MHAMD, continues to expand the Mental Health First Aid (MHFA) program in Maryland. This eight-hour course assists the general public in developing strategies to help individuals with a mental health problem or in a mental health crisis before professional or other assistance, including peer and family support, can be engaged. This initiative is in partnership with the National Council for Community Behavioral Health and the Missouri Department of Health.

- Almost 450,000 of the core Mental Health First Aid Participant Manuals, and more than 6,136 core instructor kits have been distributed nationally since the program began.
- Baltimore County Public Schools have begun efforts to train principals and senior administrators in all county schools. The University of Maryland, Baltimore County (UMBC) and several other colleges and universities offer MHFA training to their faculty, staff, students, families, and communities.
- In FY 2015, the implementation and promotion of the Youth Mental Health First Aid continued. Since the formal launch of the Youth MHFA Program in October 2013, nearly 215,000 youth manuals and 4,014 youth instructor kits have been sold.
- The Maryland State Department of Juvenile Services has required all employees to be certified in Youth Mental Health First Aid.
- MHAMD adopted the Youth Module for Spanish-speaking audiences, which was released June 2015.

Curriculum/modules were piloted for the following specialized audiences:

- Older Adults - released
- Military, Veterans and Families - released
- Public Safety - released
- Higher Education - released
- Faith-based module initially developed by the Missouri collaborators, additional review led by MHAMD
- Webinars held for instructors in FY 2015 on working with “Healthy New Moms”

In FY 2015,

- 438 MHFA trainings were conducted, certifying more than 5,664 Marylanders to be MHFA Responders. The State now has 13,548 individuals certified with these important Responder skills
- 222 new individuals were certified as MHFA instructors in FY 2015. The State now has more than 700 certified instructors across both the adult and youth curricula, with 90 individuals dually trained.
- Technical assistance has been provided to instructors to maintain the fidelity and delivery of a quality program.

- Groups/organizations participating in MHFA training included: consumers and family members; public safety workers (including law enforcement, emergency medical and corrections); Maryland's Commitment to Veterans; administrative law judges; human resources professionals; core service agencies; primary health and behavioral health organizations; health and social services providers; corporations; and students, faculty, and staff at a number of colleges and universities across the state.

Strategy Accomplishment:

This strategy was achieved.

(1-1B)

In collaboration with the Core Service Agencies (CSAs), 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 and related behavioral health issues, as well as 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) – NAMIWalk, 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
- Core Service Agencies (CSAs) – outreach/media campaigns
- Wellness & Recovery Centers (WRCs) and Recovery Community Centers (RCCs) – outreach efforts to further integrate consumer-run support services, training, and programs
- Peer Support – Two day peer conference with a focus on workforce development and collaborations

Involved Parties: BHA Offices of Planning, Deputy Director of Children's Services, Adult and Specialized Behavioral Health Services, Workforce Development and Training, and Consumer Affairs, Forensic Services; key BHA staff; CSAs; MCF; MHAMD; NAMI MD; OOOMD; Wellness and Recovery Centers (WRCs) and Recovery Community Centers (RCCs); community providers

Monitor: Robin Poponne, Office of Planning

FY 2015 activities and status as of 6/30/2015 (end-year report):

Children's Mental Health Matters Campaign

In FY 2015, MCF and MHAMD, continued the partnership with a number of community organizations and stakeholders, including 200 community partners and School Champions, 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. The FY 2015 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.

FY 2015 Campaign Highlights during Children's Mental Health Awareness Week in Maryland included:

- A Campaign Poster reception
- *The Power of Secrets: Raising Mental Health Awareness Through Art* at the American Visionary Art Museum
- Youth panels at the University of Maryland Baltimore County including a mental health awareness flash mob
- Baseball Mental Health Awareness night - literature on resilience and well-being were available to families (at least 100 community members) at the Shorebirds game in Salisbury
- Work continues with plans to develop and promote a Lifespan Resilience poster campaign
- The Maryland Schools Superintendent endorsed the school partnership program for the third year in a row

Materials distributed included:

- Fact sheets about children's mental health
- Social media tools such as the Web site, Google Calendar, and a Facebook page used to disseminate information; the campaign's Web site is www.childrensmentalhealthmatters.org.

The campaign continued its partnership with local broadcast affiliates in radio and television including a live call-in segment on Baltimore Metro News. In addition to traditional print and broadcast media, the Campaign distributed:

- 150 social emotional books
- Back pack connection handouts
- 300 Family Leadership Institute (FLI) flyers
- Launch brochures and Social and Emotional Foundations for Early Learning (SEFEL) resource information

NAMIWALKS

BHA 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 2015, NAMIWALKS highlights included:

- More than 1,500 people attended the Walk
- The Waterfront Partnership continued to collaborate with NAMI MD toward the success of this event
- The Walk and other fund raising activities supported some of the costs of many other NAMI programs as including peer support provided by 80 trained teachers and mentors to 460 individuals
- The Walk continues to highlight the importance of education, advocacy, and support for persons diagnosed with a serious mental illness and their families and

helps reduce stigma often associated with mental illness by providing an opportunity for positive interactions and networking

Below are various support education groups taught, facilitated, and/or presented by peers and family members in FY 2015 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 trained relatives - 26 Family-to-Family courses were held enrolling more than 440 individuals.
- The Peer-to-Peer classes - includes education on individual empowerment, family and peer support, relapse prevention, and enhancement of personal activity and communication skills – more than 140 individuals living with mental illness were enrolled in nine courses throughout FY 2015.
- NAMI Basics – groups held that bring together parents/caregivers with teens to address issues facilitating family support – Six groups held with 50 attending.
- 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 2015, two hundred and twenty presentations occurred, reaching more than 3,700 individuals.

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

In collaboration with BHA, On Our Own of Maryland (OOOMD), a statewide mental health consumer education and advocacy group, leads the development and implementation of many projects that promote outreach, education and recovery. One of the oldest projects, the Anti-Stigma Project (ASP), celebrates its 21st year in 2015 as it continues to collaborate efforts to fight stigma within the behavioral health system. Since the inception, ASP has trained more than 21,000 people directly and impacted countless others indirectly. During this fiscal year, the ASP:

- Presented 52 workshops throughout the state, which
- Trained more than 1,000 people in the full program
- Hired three personnel representing law enforcement, transition-age youth, and the Governor's Office on Crime Control and Prevention
- Adopted additional marketing tools including fact sheets, poster, magnets, postcards, and tee shirts
- Secured a campaign Web site – www.distortedperceptions.org

Team-facilitated workshops offered included: *Stigma...in Our Work, in Our Lives; An Inside Look at Stigma; Stigma: Language Matters; and Stigma: It Doesn't Discriminate*. ASP workshops may be designed and tailored to address specific populations and situations. Additionally, a committee was convened to work on outreach to law enforcement and examine issues such as public misconceptions regarding the correlation between mental illness and gun violence. A preliminary version of a workshop, tailored to this group, was developed.

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 behavioral health services in all of Maryland's 24 jurisdictions. All CSAs have worked with the site administrator to update and maintain county-specific information and have been encouraged to support, at the county level, the expansion and promotion efforts of NOC.

In FY 2015, the Maryland Network of Care usage included at least 1,631,972 sessions (number of people who logged in to access information) for mental health and at least 316,251 sessions for veterans and families who signed in through the veterans' portal. (www.maryland.networkofcare.org).

In addition to the specialized service information provided for Veterans and families to help service men and women returning from Iraq and Afghanistan with behavioral issues, NOC behavioral health sessions can be tailored to youth, providing access to specialized service information for that age group.

Outreach Campaign for Older Adults

Through the Mental Health Association of Maryland's (MHAMD) "Coalition on Mental Health and Aging," representatives of BHA, Maryland Department of Human Resources (DHR), Maryland Department of Aging (MDoA) work collaboratively to plan opportunities, cross-trainings, client-sharing responsibilities, and opportunities for additional partnerships. BHA's Mental Health First Aid (MHFA) trainer, certified in new Older Adult module, has conducted three MHFA older adult trainings in FY 2015 with Maryland Access point staff. *Mental Health in Later Life: a Guidebook for Older Marylanders and the People Who Care for Them* continues to be distributed by MHAMD to facilitate education and awareness of resources regarding behavioral health and aging.

Several Core Service Agencies (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)

CSAs plan, develop and manage a full range of treatment and rehabilitation services for children and adults with behavioral health disorders. There are 19 CSAs in Maryland which are often the gateway to public behavioral health services. CSAs work collaboratively with other human services agencies to promote comprehensive services, wellness, evidence-based practices, and integrated care. Included among the FY 2015 outreach activities were: trainings for community members on available services and supports; Mental Health First Aid; availability of community resources; housing services development; 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 and Recovery Community Centers

Throughout Maryland there are 26 local Wellness & Recovery Centers (WRCs) and 20 Recovery Community Centers (RCCs) that are established as places of ongoing peer support and training opportunities. There is an increased focus on the involvement of the WRCs/RCCs in surrounding community organizations and activities to allow the centers and their members to become active participants in the greater community. In FY 2015, each of the WRCs/RCCs provided education forums internally and outreach sessions on behavioral health topics to consumers in hospitals, outpatient mental health clinics, and other sites that provide behavioral 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/RCCs also produced newsletters and/or calendars containing announcements and write-ups of special events.

Peer Conference – Workforce Development

In March of 2015, the BHA Office of Consumer Affairs held its first Annual Certified Peer Recovery Specialist Summit to address the needs for expansion of the peer workforce. More than seventy-five Certified Peer Recovery Specialists were in attendance. The conference covered the following:

- Documentation requirements
- Peer support and advocacy
- Case Scenarios Workshop

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 behavioral health awareness and improved communication among BHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, release eight Data Shorts pertaining to somatic and behavioral health data
- Continue to build electronic distribution list serve as well as avenues for dissemination and distribution of Data Shorts

Involved Parties: BHA Offices of the Executive Director and Epidemiology and Evaluation; UMD SEC; University of Maryland Evidence-based Practice Center (UMD EBPC)

Monitor: Susan Bradley, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

The Behavioral Health Administration (BHA), in collaboration with the University of Maryland Systems Evaluation Center (UMD SEC), has released a total of nine Data Shorts within FY 2015. Data Shorts' topics range from Public Behavioral Health System (PBHS), service integration, substance use intoxication deaths, spreading use of heroin, to Medicaid expansion. The Data Shorts electronic distribution list has more than 200 behavioral health advocates, providers, and administrative contacts. The Data Shorts are distributed via Twitter and published electronically on the BHA Web site.

A Data Shorts Committee meets regularly to identify topics related to mental health, substance-related disorders, and behavioral health issues. This year the Data Shorts committee was integrated with mental health and substance-related disorders staff and a good number of the topics produced involved Behavioral Health Integration. The distribution list was expanded to include those in the area of substance-related disorders.

Strategy Accomplishment:

This strategy was achieved.

(1-1D)

In collaboration with the Core Service Agencies (CSAs), continue to facilitate an all-hazards approach to emergency preparedness and response for the BHA 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
- All Hazards Disaster Planning template provided by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) under review for use by all jurisdictions
- Process identified and steps developed towards a Behavioral Health All-Hazards Disaster Plan

Involved Parties: BHA Office of Adult and Specialized Behavioral Health Services; Facilities CEOs; Facilities Emergency Managers; CSAs

Monitor: Marian Bland and Darren McGregor, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 12/31/15 (end-of-year report):

BHA, through the Office of Adult and Specialized Behavioral Health Services has the responsibility for coordinating the delivery of community behavioral health services in response to trauma from natural and man-made disasters in partnership with the local Core Service Agencies and Local Addiction Authorities (CSAs/LAAs). BHA's Office reviews, facilitates updates to, and assists in the revision of the All-Hazards Behavioral Health Disaster Plans for BHA and all the CSAs/LAAs.

Statewide and locally, CSA Hazards Plans that cover 24 jurisdictions, have been updated and reviewed. The final plans will be submitted in the fall of 2015. Several agencies have adopted the All-Hazards Disaster Planning template provided by MIEMSS. In addition to the technical assistance (TA) provided to the Core Service Agencies/LAAs,

an independent consultant was engaged to assist with the drafting and completion of the statewide Behavioral Health Hazard Plan for BHA.

BHA, in collaboration with the CSAs/LAAs, 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.

Strategy Accomplishment:

This strategy was achieved.

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

(1-2A)

MHBG

In collaboration with On Our Own of Maryland (OOOMD), and other key staff, continue to support statewide activities to further enhance peer recovery supports, utilizing best practices within the consumer movement.

Indicators:

- Training and consultation for Wellness & Recovery Centers and Recovery Community Centers (WRC/RCC) implemented for co-occurring support groups and peer-run centers
- Exploration of the development of peer supports specifically for older adults
- Increased consumer and family participation on policy and planning committees across the state, to include No Wrong Door approach and health home initiatives

Involved Parties: BHA Offices of Consumer Affairs, the Deputy Director of Operations, Adult and Specialized Behavioral Health Services, and the Deputy Director Clinical Services; Medicaid, Behavioral Health Division; OOOMD; CSAs; WRCs; RWCs; mental health and substance use disorder advocacy groups; peer specialist and recovery coach organizations; Maryland Coalition on Mental Health and Aging

MHA Monitor: Brandee Izquierdo, Office of Consumer Affairs

***Federal Mental Health Block Grant Strategy**

FY 2015 activities and status as of 6/30/2015 (end-year report):

The BHA Office of Consumer Affairs worked in collaboration with community partners to develop work groups around the needs of the consumers and peer support within communities. 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) via the Office of Consumer Affairs and On Our Own of Maryland in collaboration with the Peer Integrated Care Advisory Council (PICAC). Training and consultation have continued within the Wellness and Recovery Centers and Recovery Community Centers (WRC/RCC) with the introduction of Intentional Peer Support (IPS) Training, a training that focuses on mutual relationship building through a developed awareness of personal and relational patterns. Additionally, a Forensic Peer Support Work Group has been formed to focus on developing curriculum for peer support endorsement training and expansion of peer support within the criminal justice systems and re-entry programs.

The Office of Consumer Affairs (OCA) continues to expand consumer/peer involvement in state and local committees and to increase the inclusion of areas of mental health, substance use, and co-occurring disorders. These committees include the Peer Recovery Support Services Work Group, Peer Integrated Care Advisory Council, and the Peer Medicaid Reimbursement Work Group, among others. OCA strategic planning includes the commitment to conduct WRC/RCC site visits throughout the state of Maryland in an effort to encourage increased consumers participation on these committees, boards, and advisory councils. Particular focus, in FY 2015, has been on the Medicaid Reimbursement Work Group as it attempts to incorporate a No Wrong Door approach into the process of facilitating reimbursement for peer support so the State of Maryland can expand the peer workforce and create sustainability.

The OCA has built a relationship with the Maryland Coalition on Mental Health and Aging around peer support efforts specifically for older adults. The OCA will continue these efforts in FY 2016 to create a curriculum for endorsement training of peer support for older adults as BHA moves forward in workforce expansion of peer support.

Strategy Accomplishment:

This strategy was achieved.

(1-2B)

MHBG

The BHA, in collaboration with the MDQuit Center of the University of Maryland/Baltimore County (UMBC), consumers, providers, the CSAs and LAAs, 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:

- Number of trainings conducted for behavioral health treatment provider/agency staff (administrative and clinical levels) to enable staff to provide smoking cessation services in their treatment/provider programs
- Prevalence data measures, incorporated into StateStat and Outcomes Measurement Systems datamart, tracked and evaluated

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Operations, Epidemiology and Evaluation, Special Projects Office (Problem Gambling, Tobacco Compliance, Enforcement and, Smoking Cessation), Office of Adult and Specialized Behavioral Health Services, and Children's Services; other BHA staff; BHA Consultants; UMBC MDQuit Center; University of Maryland Systems Evaluation Center (UMD SEC); DHMH Tobacco Prevention and Control; Managed Care Organizations (MCOs); Maryland Medicaid; CSAs; local health departments; Community Behavioral Health Association (CBH); OOOMD; MHAMD; MCF

Monitor(s): Kathleen Rebbert-Franklin, Office of the Deputy Director of Population-Based Behavioral Health

FY 2015 activities and status as of 6/30/2015 (end-year report):

The collaboration of BHA and the MDQuit Resource Center continues to generate new strategies, enhanced trainings, and a wide range of resources for the behavioral health

community in Maryland. By the end of FY 2015, the MDQuit had delivered *Breaking the Habit in Behavioral Health* (BH2) Trainings to 100 behavioral health agencies. The trainings have reached 600 behavioral health professionals, providing them with comprehensive technical assistance and intensive training in smoking cessation for consumers. MDQuit provides BH2 trainings onsite as well as at the UMBC South Campus facility.

The 9th Annual Best Practices Conference of MDQuit was held on January 22, 2015 with 165 individuals participating. The keynote focused the theme of integrating tobacco cessation into behavioral health practices and included a workshop showcasing the role of peer mentors in promoting smoking cessation in persons with serious mental illness.

During FY 2015, BHA worked with DHMH's Center for Health Promotion, Education & Tobacco Use Prevention, to utilize a co-developed metrics system and submitted 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 Quitline; and the number of nicotine replacement therapy materials distributed.

Strategy Accomplishment:

This strategy was achieved.

(1-2C)

Explore the expanded use of self-directed approaches throughout the state.

Indicators:

- Self-Directed Care (SDC) plans in Washington County 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
- Provide young adult consumers, in the Healthy Transitions Initiative (HTI) grant program, a self-directed care option for directing a limited grant funded budget to support their overall recovery plans
- Offer participant-directed services and respite care services through the 1915(i) State Medicaid Plan Amendment

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services, Consumer Affairs and Child and Adolescent Services; BHA staff; Washington County CSA and providers; OOOMD; consumers and family members

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA in collaboration with the Washington County CSA and the local WRC, Office of Consumer Advocates, continues to implement a consumer self-directed care program. In FY 2015, 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

The recovery plans include directing the use of benefits to access both public mental health services and non-traditional support services such as driver education, gym memberships, continuing education classes, and text books. Person Centered Care Planning 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.

As part of the Office of Consumer Advocates, Inc. (OCA, Inc.), an affiliate of OOOMD that operates in Washington, Allegany, and Garrett counties, the SDC Program has Peer Advocates who offer WRAP classes 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 is offered to staff to implement additional support when stressors occur.

Throughout the existence of the Healthy Transitions Initiative (HTI) grant, some funds were used to promote self-directed care efforts and address barriers to progress on goals not covered by other funds. Washington County CSA managed these HTI funds, working with youths and their providers to identify barriers to timely completion of goals and make sure that the requests could not be covered by other sources. In FY 2015, 18 individuals were served (a total of 26 approved requests) and disbursed \$2,729 in total, to assist the individuals' goals which included vocational, education, housing and tools for independent living (such as driving school costs and technology accessibility).

Additionally, the Section 1915 (i) State Plan Amendment (SPA) entitled, *Intensive Behavioral Health Services for Children, Youth, and Families*, was approved by Center for Medicare/Medicaid Services (CMS), effective October 1, 2014. As a result, an assortment of specialized services will be offered to children and youth who are enrolled. These will include: respite; family peer supports; intensive in-home services; crisis stabilization; expressive and experiential therapies, for (ex: art, music); and equine assisted therapy within a unique program of participant-directed, customized goods and services. Implementation of this program will be incremental based on jurisdictional readiness.

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.

Indicators:

- Resilience Committee meetings held to develop planned outcomes toward developing criteria and strategies for promoting wellness, prevention, and resilience at system, organizational, community, family, and individual levels
- Expand collaboration with the University of Maryland for resilience-based curriculum development
- Number of Resilience Trainings requested and provided
- Continue efforts to collaborate with substance use and other behavioral health staff to integrate efforts that enhance wellness (resilience) and prevention across the life span, into BHA strategies

Involved Parties: BHA Office of Children's Services; University of Maryland School of Medicine, Department of Psychiatry; the BHA Resilience Sub-Committee of the Maryland Blueprint Committee; CSAs; family members, advocates, and providers

Monitor(s): Al Zachik, and Joan Smith, Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (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) met on a monthly basis to develop and promote training for: organizational resilience; community resilience; and resilience for individuals across the lifespan.

The Committee gathered information toward the development of 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

In FY 2015, the following eight resilience-based activities were facilitated with a total of more than 520 participants: 1) six trainings addressed strategies to promote resilience efforts in the Public Behavioral Health System and included topics such as: adolescents, resilience across the lifespan, trauma and resilience, and personal and professional resilience; also, 2) two focus groups, with 20 attendees, were completed on June 2015 in Salisbury - these groups highlighted community resilience and discussed areas of strength in the community, and how increased community involvement and expression of needs can be encouraged in ways that improve neighborhood resilience.

The Maryland Resilience Breakthrough Series Collaborative (BSC), a recent quality improvement model for children's behavioral health service providers, bridges the gap between resilience theory and behavioral health service practices with workforce training strategies that promote resilience in the provision of behavioral health services. The

model specifies that provider teams across the state attend resilience training sessions and incrementally implement practice improvements at their agencies. BSC-facilitated changes have been mostly in the areas of resilience-enhanced assessment and treatment practices, as well as family and community resilience. Considered a best practice in an article published in the journal *Psychiatric Services* (2015), the Maryland BSC quality improvement model and approach was noted for combining scientific knowledge and real-world practices and adapting them for child welfare and mental health settings.

Strategy Accomplishment:

This strategy was achieved.

(1-2E)

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

Indicators:

- Conduct analysis of existing CSA grant-funded programs specific to older adults
- Continue to support the CSAs and provider system to include older adults in all health, wellness, recovery initiatives and activities
- Promote, in collaboration with advocacy organizations and others, education of service providers, health care workers, older adults, caregivers and the public to inform them about the special behavioral health needs of older adults
- Evaluate and modify the protocols and the process for the Pre-admission Screening and Resident Review (PASRR)
- Encourage partnerships with local Areas on Aging regarding participation in the chronic disease self-management programs

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

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Efforts are continuous to encourage the CSAs/LAAs and provider system to include older adults in all health, wellness, recovery initiatives and activities. The BHA Office of Adult and Specialized Behavioral Health Services reviews local behavioral health plans to ensure that older adult programs, funded by BHA, are identified and analyzed.

An analysis of all older adult (OA) conditions of award (COA) were performed as well as site visits conducted through BHA, UMD EBPC, and the Older Adult Policy Consultant. Findings include:

- Nine counties have special COAs within their plans related to older adults
- Baltimore City, Prince Georges County and Washington County offer a specialized geriatric residential program
- Baltimore City, as well as Baltimore, Calvert, Frederick, Garrett, and Washington counties, offer elderly outreach through in-home services
- Some CSAs have Psycho-geriatric Coordinators

- Other various programs throughout the jurisdictions include training, outreach, and consultation regarding the needs of older adults

BHA 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. One of BHA's Mental Health First Aid (MHFA) trainers, certified in the new Older Adult module, has conducted three MHFA older adult trainings in FY 2015 with Maryland Access Point (MAP) staff.

In an effort to identify and implement Evidence-Based Practices (EBPs) for older adults, BHA hired an Older Adult (OA) Policy Consultant in FY 2015. The consultant also conducted site visits at the above mentioned programs.

The OA consultant also assisted with the first older adult behavioral health policy summit and round table discussion held in June 2015. This first summit meeting included representatives from BHA, University of Maryland, and the CSAs that currently have COAs specific to older adult. The purpose of the meeting was to share best practices, identify opportunities for maximizing federal funds, and discuss standardized deliverables, reporting methods, and site visit summaries.

BHA has been participating in meetings with Medicaid (MA) and Developmental Disabilities Administration (DDA) to identify needed changes in the Preadmission Screening and Resident Review (PASRR) process protocol. This group is also reviewing the PASRR Level I tool and other related systems and training needs. This process will continue into FY 2016.

A meeting was held with Chronic Disease self-management program leadership in December of 2014. While formal partnerships between the local Area Agencies on Aging and the chronic disease self-management programs have not yet been established, BHA continues to promote education and increased participation among local entities. BHA's OA consultant will also research EBPs in Chronic Disease self-management.

Strategy Accomplishment:

This strategy was achieved.

Objective 1.3. 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
- Continued planning and implementation activities for a youth and family-oriented Consumer Quality Team

Involved Parties: BHA Offices of Consumer Affairs, Planning, Office of Adult and Specialized Behavioral Health Services, the Deputy Director for Behavioral Health Facilities, and Epidemiology and Evaluation; state facility representatives; CSAs; MHAMD; MCF; Maryland Association of Resources for Families and Youth (MARFY) – Residential Treatment Center Coalition; NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH)

Monitor: Cynthia Petion, Office of Planning

FY 2015 activities and status as of 6/30/2015 (end-year report):

The CQT is a consumer-run program under the auspices of the MHAMD and supported by funding from BHA through state funds and the federal mental health block grant (MHBG), dedicated to quality improvement of services throughout the Public Behavioral Health Services. CQT, staffed by consumers and family members, is authorized by BHA to conduct site visits, announced and unannounced, to programs and state facilities in the Public Behavioral Health System. During the site visits, consumers who volunteer are confidentially interviewed and share their concerns and satisfaction with CQT.

In FY 2015, CQT interviewed more than 1,260 consumers during 338 site visits to psychiatric rehabilitation programs (PRPs) and inpatient facilities. These site visits included:

- 95 PRP – 190 site visits
- 33 inpatient adult units – 104 site visits
- 8 Youth residential treatment centers – 44 site visits

Site visit reports are shared and feedback meetings are held to review issues, concerns and discuss resolutions with the facility/program directors, consumers, the CSAs, and BHA leadership.

Beginning, in FY 2015, CQT received funding to expand its focus to include child and adolescent services and conducted site visits to eight residential treatment centers.

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; On Our Own of Maryland, Inc. (OOOMD) Taking Flight and other 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
- Number of youth participating in OOOMD’s “Taking Flight” and Anti-Stigma activities.
- Continued development and maintenance of professional partnerships that support LEAP training and promote behavioral health integration activities for both mental health and substance use peers.
- Increased consumer and family participation in state and local policy planning for behavioral health system of care

Involved Parties: BHA Offices of the Deputy Director of Children’s Services and Consumer Affairs; MCF; OOOMD: CSAs

Monitor(s): Al Zachik, Office of the Deputy Director of Children’s Services and Brandee Izquierdo, Office of Consumer Affairs

FY 2015 activities and status as of 6/30/2015 (end-year report):

Family Leadership Institute

The Maryland Coalition of Families for Children’s Mental Health (MCF) held its twelfth Family Leadership Institute (FLI) in FY 2015 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. Since FLI began, more than 364 family members from all 24 Maryland jurisdictions have graduated from the program.

In 2015, between January and March, twenty-four participants attended the six weekend (60 hour) program. Participants represented a diverse group in terms of: geography - western Maryland, Eastern Shore, Baltimore City, and Central Maryland; ethnicity; and caregiver status (one dad, one grandmother, one great-grandmother, three couples, and seven foster parents). Also, two caregivers whose children had primary issues of substance use attended the sessions. 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 Maryland

Resources; Child-Serving Systems and Agencies; Clinical Updates; Legislative Policy and Family Advocacy; Partnering with Schools/education system; Stress/Self Care; and other relevant topics. Families met with agency administrators, policymakers, medical directors, psychiatrists, and other experts in children's behavioral health in Maryland.

One hundred percent of the participants reported being "strongly satisfied" (highest rating on Likert scale) with the training program.

Youth and Young Adult Involvement

The Maryland Coalition of Families' (MCF) and On Our Own of Maryland (OOOMD) promote councils/groups that give youth who receive or have received services in the PBHS the opportunity to come together as peers for mutual support and systems change. *What Helps, What Harms Maryland* is a year-long initiative launched by OOOMD's Transition-Aged Youth Project in partnership with MCF's Taking Flight, which will infuse the youth and young adult voice into strategic policy actions and planning structures for systemic change in the state of Maryland. *What Helps/What Harms* is a model created and endorsed by Youth MOVE National which creates opportunities for young adults to spend time with one another in facilitated discussions analyzing their community network, resources, services, and environment. Sixteen groups were held with young adults serving public service organizations across the state. Approximately 98 young people participated in the discussion groups. Three (3) presentations were made (by the end of the summer of 2015) at statewide behavioral health conferences and one at a county provider council meeting which shared the details of the project, and some of its preliminary findings, with an audience of more than 100 people.

Leadership Empowerment Advocacy Project (LEAP)

The BHA Office of Consumer Affairs (OCA) is involved in coordinating and implementing LEAP which has been funded by the Mental Hygiene Administration (now BHA) 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 2015, LEAP training was postponed due to employment transitions. However, plans are underway to continue this project in FY 2016 with an advocacy approach that incorporates integration and affords peers and consumers supplemental training opportunities in the expansion of peer workforce development. Former LEAP graduates continue to serve on committees, federal and state advisory boards, as well as participate in the state planning process for the Public Behavioral Health System (PBHS).

Strategy Accomplishment:

This strategy was achieved.

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

Objective 2.1. 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, 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. Outcomes 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
- Continued support after 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
- Training of providers and promotion of use of the Prescription Drug Monitoring Program (PDMP) for improved coordination of prescribing related controlled substances
- Integration of elements of coordination of care in behavioral health system of care through the Community Mental Health Medical Directors Consortium

Involved Parties: BHA Office of the Medical Director; BHA-MCO Coordination of Care Committee; University of Maryland Systems Evaluation Center (UMD SEC); Community

Monitor: Jean Smith, Office of the Medical Director

FY 2015 activities and status as of 6/30/2015 (end-year report):

The following activities facilitate efforts in the coordination of care activities that are part of community behavioral health services. Data analysis is focused on measuring the impact of wellness and coordinated care activities.

- Pharmacy data continue to be downloaded to providers on a regular basis from the administrative services organization (ASO). DataLink information is now being used by the CSAs to coordinate care between the Department of Public Safety and Corrections and Community service providers. The Outcomes Measurement System (OMS) public Web-based datamart site now provides aggregate data for use by policy experts in prevention efforts.
- Medicaid Pharmacy Data program has reported a decrease in the frequency of use of antipsychotic medication in children

- Through training and outreach efforts the number of Health Homes increased to 75, by March, 2015 (up from 67 in January).
- The Coordination of Care committee has enlarged its coordination role by increasing access to services for individuals with co-occurring substance related use disorder and mental health disorder; the No Wrong Door Project, for coordinating HIV care with behavioral and somatic care in the Baltimore area was completed and new structures are in place to continue this coordination.
- Training of physicians in the use of the Prescription Drug Monitoring Program continues. Data from this program are being used by the Drug Overdose Prevention team to track and analyze drug overdose deaths.
- Community Mental Health Medical Directors have participated in the new Clozapine Expansion Work Group, which will educate, train and support physicians in the safe use of clozapine, a highly effective medication for treatment of schizophrenia. The work group will help primary care physicians in the community to collaborate with hospital physicians to facilitate discharge from hospital and stability in the community.

Strategy Accomplishment:

This strategy was achieved.

(2-1B)

Participate in DHMH's Behavioral Health Integration process to support the implementation of the behavioral health financing and systems integration model, and the establishment of the new Behavioral Health Administration.

Indicators:

- Stakeholders Workgroup meetings convened between June and October of 2014
- Recommendations identified through Stakeholders workgroup process on issues related to behavioral health including, statutory and regulatory changes toward full integration of mental health and substance use
- Findings and recommendations of the workgroup reported to the Governor and General Assembly on or prior to December 1, 2014
- Requirements addressed from Maryland House Bill (HB) 1510 which details the establishment and duties of the Behavioral Health Administration
- Staff support provided to facilitate mental health and substance use advisory councils in creating a Behavioral Health Advisory Council

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Population-Based Behavioral Health, the Deputy Director of Clinical Services, and the Deputy Director of Operations; BHA staff as appropriate; DHMH; Behavioral Health Integration Stakeholder Workgroups; providers; consumers; advocacy organizations

Monitor: Brian Hepburn, Office of the Executive Director

FY 2015 activities and status as of 6/30/2015 (end-year report):

The DHMH's Behavioral Health Integration process included the following activities:

The Behavioral Health Integration Process

- In June 2014, the Department moved forward with its decision to implement a performance based carve-out of mental health and substance use services and to merge the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) into a single administration, the Behavioral Health Administration (BHA).
- The Behavioral Health Integration (BHI) process included the development of the Request for Proposal (RFP) to select an ASO to administer the new MA financing model. On September 3, 2014, Value Options (VO), was awarded the new performance – based contract for the carve-out for mental health and substance use services. DHMH facilitates integrated care across the healthcare service delivery system. VO will operate as a single point of entry to the Public Behavioral Health System (PBHS) for individuals with substance use and mental health disorders.

The Behavioral Health Integrated Regulations Workgroup

- House Bill 1510 required the Department of Health and Mental Hygiene, Behavioral Health and Disabilities to convene a stakeholder workgroup to make recommendations on issues related to behavioral health. The DHMH aims to strengthen the foundation for an integrated behavioral health care system by integrating the regulations applicable to community-based mental health and substance use disorder services in Maryland.
- As part of 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 MHA and ADAA, 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.
- MHA (now BHA) staff attended all workgroup meetings as well as all stakeholder meetings and will continue to do so in FY 2015.

The Combined Council's Process to Create the State Behavioral Advisory Council

The creation of a new Behavioral Health Advisory Council has been supported and facilitated through the efforts of the Combined Council (consisting of the Maryland Advisory Council [Joint Council] and the State Drug and Alcohol Abuse Council [SDAAC]) who put forth recommendations for a model Behavior Health Advisory Council, most of which were included in the In FY 2015 legislation to establish the new council. This bill, submitted as SB 174/HB 1262, established the new Council with the purpose of promoting and advocating for: “planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state; and a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members”. This legislation replaces prior state statutes for

the mental health and substance use councils (the Joint Council and SDAAC) with statute that delineates the parameters for the Behavioral Health Advisory Council, effective October 1, 2015.

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: BHA Offices of the Deputy Director of Children's Services and the Deputy Director for Community Programs and Managed Care; other BHA 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

Monitor: Al Zachik, Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Collaborative efforts with the University of Maryland resulted in a medication authorization process and established contracts that seek to improve pharmacological utilization in children under the age of 18 years:

- Maryland's Medicaid Pharmacy Program (MPP) implemented a peer-review authorization process to ensure safe and effective use of antipsychotic medication and 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.
- Contracts have been established with the University of Maryland at Baltimore for implementation, through its School of Pharmacy, to review Baltimore City child welfare caseloads for their pharmacological utilization; link 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.

- The Peer Review Program includes all youth under the age of 18 year. From July 1, 2014 to June 30, 2015, the Peer Review Program served 5,776 patients. During this time period, the Program received 17,101 requests. The requests are greater than the number of patients due to factors such as requests for multiple medications, medication changes, renewals and missing data submitted by the prescriber.

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 2015 activities and status as of 6/30/2015 (end-year report):

- **Maryland Department of Disabilities (MDOD)**, BHA continues to collaborate with MDOD in the development and implementation of cross-agency initiatives such as Money Follows the Person (MFP), transition-age youth projects, and the identification of action steps to promote affordable housing efforts.
- **Maryland Department of Aging (MDoA)**, BHA interfaces with MDoA through participation in meetings and workgroups around Maryland Access Point (MAP), Maryland's No Wrong Door approach to long-term services and supports. BHA supports MDoA in this endeavor by providing behavioral health information for the MAP Web site and assisting with development of formal and informal agreements among the local Area Agencies on Aging (AAAs), Maryland's CSAs, and the Brain Injury Association of Maryland. BHA also provides behavioral health and brain injury training to all MAP staff.
- **DHMH Developmental Disabilities Administration (DDA)**, BHA, DDA, and MDoD serve on several statewide councils together which include the Maryland TBI Advisory Board, the Brain Injury Waiver Advisory Committee, and the Brain Injury Waiver Providers Council (BHA and DDA). BHA and DDA coordinate on training around brain injury with BHA providing a trainer for DDA-sponsored training events.
- **Department of Public Safety and Correctional Services (DPSCS)**, 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 on Criminal Justice Information System (CJIS) standards and measures. The Director of the OFS co-chairs the meetings of the Interagency Forensic Services Committee. 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 provided assessment of community needs and developed case management plans to prepare individuals for a successful transition to the community. BHA 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, have trauma issues, and who are pregnant or mothers of infants.
- **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 and continue to work 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. BHA routinely meets every two weeks with multi-agency review teams (DSS, MSDE, and DJS) and also routinely collaborates with DJS's interdepartmental workgroups to develop recommendations for the behavioral health needs of Maryland youth served by DJS.
 - **DHMH Office of Health Care Quality (OHCQ)**, OHCQ hired a new manager for its Behavioral Health Unit who remains in frequent contact with BHA's Office of Compliance and other staff within BHA as needed. The focus of the collaboration has been on regulation/policy clarifications, participation in the behavioral health regulations development process, and participation in various compliance-related activities.
 - **Governor's Office of the Deaf and Hard of Hearing (ODHH)**, The Behavioral Health Administration continues to act as liaison to and monitor of services provided by providers who receive state funding through the CSAs to provide signing therapist in outpatient mental health settings, supported employment, psychiatric rehabilitation programs, and residential rehabilitation programs. BHA will continue to provide TA and collect quarterly reports from providers about the services rendered.
 - **Department of Veterans Affairs (MDVA)**, BHA collaborates with the MDVA through its participation on DHMH's Veterans Advisory Committee and with the SSI/SSDI 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-related disorders. DHMH also administers the Maryland Commitment to Veterans (MCV) Initiative, which partners with the VA to address the behavioral health needs of veterans. MCV connects veterans to behavioral health services through BHA as well as other community providers.
 - **Department of Human Resources (DHR)**, BHA collaborated with DHR to provide training to Adult Protective Services staff on Adult Services and Special Needs Populations. BHA 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. The BHA Office of Women's Services, through the Temporary Cash Assistance (TCA) initiative, offered substance use screening for individuals receiving social services benefits.
 - **Department of Housing and Community Development (DHCD)**, The Behavioral Health Administration continued its collaborative work with DHCD through involvement with the Maryland Partnership for Affordable Housing (MPAH) and the Department of Disabilities (MDOD) to implement Section 811 vouchers. BHA

- participated, in collaboration with DHCD and DHR, in the implementation of the Housing First model in Maryland.
- **Governor’s Office for Children (GOC)/Children’s Cabinet**, As an active participant of the Children’s Cabinet, BHA 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 BHA’s ongoing planning processes.
 - **Division of Rehabilitation Services (DORS)**, BHA continued to meet with DORS staff quarterly to plan strategically, review issues or barriers, and to build upon the foundation of integration of vocational services and braided funding. Updates to the DORS cooperative agreement with new DORS vendors have been made, establishing an expectation of the provider working to achieve EBP status over a period of a year. BHA staff and DORS staff collaborate to provide orientation to new vocational providers and communicate weekly (and often daily) to address progress and barriers to progress of providers.
 - **Maryland State Department of Education (MSDE)**, BHA 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.
 - **DHMH Prevention and Health Promotion Administration**, BHA collaborates on Maryland’s implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program for low-income, first-time parents and their children), 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.
 - **Maryland Emergency Management Agency (MEMA)**, BHA 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**, BHA, 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 and recovery housing for individuals with behavioral health disorders.
 - **Maryland Health Care Commission (MHCC)**, BHA collaborates with MHCC on health policy studies involving mental health services, reimbursement rates for hospitals, and issues involving health insurance coverage and the uninsured population.
 - **Health Services Cost Review Commission (HSCRC)**, BHA and HSCRC meet periodically to update the rate-setting process for hospital rates for inpatient services.
 - **DHMH Office of Operations and Eligibility - Medical Care Programs/Behavioral Health Unit**, BHA continues to collaborate with Medicaid (MA) on the development and implementation of behavioral health integration services and policies within the Medicaid Behavioral Health Unit. BHA participated in the MA Advisory Committee and in the Medical Care Organizations’ (MCOs) monthly directors’ meetings. BHA worked with Maryland’s Medical Assistance (MA) program on State Plan Amendments (SPA) and Waiver Programs such as the

1915 (i) SPA for Children, Youth and Families and telemental health services. BHA continues to review provider billings and refers providers of concern to Maryland Medicaid Fraud Control Unit.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.2. 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)

MHBG

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 continued 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: The BHA Office of the Deputy Director of Children's Services; MSDE; Maternal and Child Health Bureau; University of Maryland; CSA; the Maryland Early Childhood Mental Health Steering Committee

Monitor: Al Zachik, Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

The following collaborations form infrastructure for improving the delivery of high quality mental health programs and services for young children and their families. Data has been utilized to develop effective future strategies for policy and other initiatives.

Maryland Project LAUNCH

Maryland continues to implement LAUNCH through the development of comprehensive early childhood intervention strategies/programs by coordinating key child-serving systems, behavioral and physical health services in the pilot community of Prince George's County. The project is funded by a five-year grant awarded to DHMH and the BHA by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- The early childhood demonstration program in Prince George's County continues to roll out effectively
- Through the Transforming Neighborhoods Initiative, 10 schools serve 27 classrooms and 540 children
- Public Awareness Campaign distributed 540 books to children and over 540 Parent Information sheets on the social and emotional development of children
- A 14-week evidenced based parenting program called, Strengthening Families, 14 families participated
- Project LAUNCH held a Dynamic Dads events with more than 20 people and held a Parent Leadership Institute with six parent participants
- Completed fifty home visits with seven agencies
- The Prince George's County Child Resource Center has reached 200 parents of young children, created 13 Parent Resources Tip Sheets and provided training to Twenty-one program Directors on Adverse Childhood Effects and the Impact of Grief as part of a the Public Awareness Campaign, "Children's Mental Health Matters; More than 17 Early Childhood Centers have been served, 28 teachers received teaching resources, and 46 children engaged in child-centered consultations.

SEFEL

- Maryland was initially one of three states to receive a grant from the [Center for Social Emotional Foundations for Early Learning \(SEFEL\)](#), a framework for teaching social and emotional skills to children implemented in a variety of different child care settings, and adapted for preschool and elementary school settings. In addition, experts in Maryland are currently training parents, home visitors, child welfare workers and first responders in the SEFEL model.
- In FY 2015 the following data was reported on SEFEL Training Modules: (44 participants completed four infant/toddler modules, 31 participants completed three preschool modules, also 28 attendees completed a leadership module. Forty-three coaches attended a one-day training session, 48 attendees for a one-day parent training program, with several teaching coaching Webinars, and teaching assistance programs.

Summary of implementation data was reviewed.

Strategy Accomplishment:

This strategy was achieved.

(2-2B)

MHBG

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

Indicators:

- Annual Suicide Prevention conference conducted with inclusion of training sessions on issues/needs of special needs populations such as veterans and individuals who are lesbian, gay, bi-sexual, transgender, (LGBT)
- Continued implementation of Governor's Commission on Suicide Prevention final recommendations, especially in the area of increased awareness through education, outreach, and resource development
- Participation in and addressing recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA) Zero Suicide Policy Academy
- Promotion of increased number of "followers" for the Maryland Crisis Network Facebook account and the Maryland Suicide Prevention Twitter account
- Implementation of deliverables of suicide prevention grants (if awarded) - the Garrett Lee Smith (GLS) Suicide Prevention Grant for youth; the SAMHSA National Strategy for Suicide Prevention, focusing on individuals ages 25-64

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Children's Services, Planning, and Adult and Specialized Behavioral Health Services; Maryland Department on Aging; The Maryland Crisis Hotline Network; WRCs; MSDE; CSAs; Johns Hopkins University; University of Maryland; local school systems; other key stakeholders

Monitor(s): Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA efforts that include various methods and suicide prevention activities and strategies for youth, adults, and older adults throughout the State of Maryland continue.

- The 2014 Annual Suicide Prevention Conference took place on October 7th with more than 400 participants in attendance. Workshop sessions featured issues pertaining to various at-risk populations such as veterans, LGBT youth and older adults, individuals with substance-related disorders, and victims of human trafficking.
- The Governor's Commission on Suicide Prevention continues to meet quarterly to refine recommendations that will improve awareness, community outreach, and the development of the State Plan for Suicide Prevention. A social marketing campaign was conducted by the Governor's Commission. Through this effort the following items were purchased to enhance the public's awareness and utilization of the Maryland Crisis Hotline. The following materials have been distributed at many events in Maryland such as the "Children's Mental Health Matters" campaign sponsored by the Maryland Coalition of Families (MCF) which reached over 2,500 families:
 - 10,000 information cards with the hotline number printed on it
 - 10,000 brochures with the suicide hotline number, social media accounts, and other suicide efforts
 - 5,000 posters with the hotline number
 - 10,000 ink pens with the hotline number
 - 2,500 T-shirts with the hotline number

The Governor's Commission on Suicide Prevention expects to reach new populations such as disconnected youth, address bullying prevention measures, work with individuals with lived experience (suicide loss and attempts), along with continued work with Veterans, the LGBT community, and youth through school-based initiatives. The Commission also supports the development of Suicide Prevention Resources such as the Maryland Crisis Hotline, the National Suicide Prevention Lifeline, and the Suicide Prevention Website.

- The SAMHSA/Zero Suicide Grant was received in October 2014. Practices were implemented based on the National Strategies for Suicide Prevention with strategies from the Zero Suicide Academy.
- Social media accounts on Facebook (www.facebook.com/MDSuicidePrev) and Twitter (twitter.com/MDSuicidePrev) reached more than 100 followers last year on suicide prevention pages. Outreach efforts to increase the number of social media account followers will continue.
- The Garrett Lee Smith (GLS) Suicide Prevention Grant implementation process continues. Numerous outreach events and trainings were done for the GLS grant, including eight emergency professionals trained in suicide prevention screening and assessment.
- The Kognito Training Program, funded through the MD-SPIN SAMHSA grant, is an online Avatar-based, interactive training program (<http://kognito.com/maryland>) that follows evidence-based practices. Various versions of the program were available to train faculty, staff, and students at no cost to the user during this project. More than 300 trainees have been enrolled. Maryland Kognito usage rates during year 1 (January 1 – September 30, 2015)) reached 828 students in grades K-12 and 526 students in higher education.
- The BHA collaborated with MCF and the Suicide Prevention Resource Center (SPRC) on several suicide prevention efforts. MD-SPIN partnered with the following hospitals to enhance screening, assessment and follow-up of individuals in Emergency Departments (ED) with the chief complaint of psychiatric distress: Johns Hopkins Medical Center, Bayview Hospital, and the University of Maryland Medical Center. Future ED partners will include: Franklin Square Hospital and the entire Medstar System.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.3. In collaboration with the CSAs and other stakeholders, 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)

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

Indicators:

- Sustainability and replication plan developed
- Proposal developed and submitted to SAMHSA for new Healthy Transitions (HT) grant
- Critical ingredients of model intervention replicated in selected jurisdictions

Involved Parties: BHA Offices of Children's Services and Adult and Specialized Behavioral Health Services; MDOD; MSDE; CSAs; DHR; MCF; Governor's Interagency Transition Council for Youth with Disabilities; the University of Maryland; National Alliance on Mental Illness-Maryland (NAMI MD); OOOMD; local school systems; parents; students; advocates; other key stakeholders

Monitor(s): Tom Merrick, Office of Children's Services and Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Plans were developed through cross-agency and department collaborations that resulted in sustaining and expanding integrated home and community-based services.

The Healthy Transitions Initiative (HTI) Sustainability and Replication Plan was developed and operationalized. Ongoing training and technical assistance were developed to maintain empirically supported practices that were scheduled as part of final HTI grant months. Training efforts were designed to be consistent with the Maryland Model of Transition-Age Youth (TAY) supports and associated fidelity assessments (focus groups, feedback sessions, July and September documentation/chart reviews) developed by staff at HTI sites. Person Centered Care Planning (PCCP) training was implemented to bring treatment planning documentation closer to sustainably funded services standards.

Maryland submitted a new Maryland Healthy Transitions (MD-HT) a grant application to SAMHSA for a new Healthy Transitions (HT) grant. The application was approved and funding was awarded to further implement programs that serve TAY in a number of jurisdictions.

The HT grant will address the special needs of the emerging adult population through a joint effort between the BHA Offices of Adult Services and Children's Services. The MD-HT project was developed in full partnership with two communities in Maryland where two local laboratories will be located-Howard County and in the Southern Maryland Tri-County region. Collaborative support is provided by consumers, youth, families, local and state agencies, and stakeholders. MD-HT utilizes Maryland's past and current TAY initiatives which include strategies such as family and youth involvement, evidence-based practices, methods for improving access to care, and strategies to bring about policy changes at the state and local level. Training at the new MD-HT sites and 12 TAY provider sites will be ongoing throughout the fiscal year.

Strategy Accomplishment:

This strategy was achieved.

(2-3B)

MHBG

In concert with psychiatrists and social workers at Johns Hopkins and University of Maryland, continue implementation of the Behavioral Health Integration in Pediatric Primary care (B-HIPP) to provide consultation on assessment, medication, resources and treatment to any Pediatrician statewide as well as provide additional social work support on the Eastern Shore.

Indicators:

- Data on numbers of consultations provided statewide
- Additional resources and support provided to pediatric offices on the Eastern Shore, through Salisbury University, to offset psychiatrist workforce shortages

Involved Parties: BHA Office of the Deputy Director of Children's Services; University of Maryland School of Medicine; Johns Hopkins University; Salisbury University

Monitor: Al Zachik, Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

A collaboration between Johns Hopkins University, the University of Maryland, and Salisbury State University to implement B-HIPP services in the Eastern Shore counties of Maryland will continue.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)

A lack of trained specialists, workforce shortages in rural areas, and provider capacity issues have resulted in a gap between a need for services and the availability of child behavioral health services. To address this need, a collaboration among the BHA's Office of Children's Services, the University of Maryland's School of Medicine, Johns Hopkins School of Public Health, and Salisbury University was developed to implement a free-service available to all pediatric primary care providers (PCPs) in Maryland. The aim of this collaboration is to increase the capacity of PCPs to identify, refer and/or treat child and adolescent mental health problems. There are more than 375 providers enrolled in the B-HIPP services statewide.

Services B-HIPP Provides

- B-HIPP continues to provide resources and support the efforts of PCPs, including pediatricians, family physicians, nurse practitioners and physician's assistants, to assess and manage mental health concerns in patients from infancy through transition to young adulthood.
- B-HIPP continues to provide to PCPs telephone consultation services that offer advice on screening, diagnosis, treatment, referrals, and other resources from child and mental health specialists (i.e., psychiatrists, psychologists, and clinical social workers) located at the University of Maryland and Johns Hopkins.
- Continuing education courses are offered for PCPs and their staff to develop and enhance mental health knowledge and skills.
Assistance with local referral and resource networks are provided to linkages between PCPs and mental health providers in their community.
- A partnership with Salisbury University's Department of Social Work will place graduate students in four pediatric primary care practices on the Eastern Shore of Maryland as part of a B-HIPP pilot social work co-location program aimed at providing on-site mental health consultation.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.4. 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)

MHBG

In collaboration with DHMH, continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability in Mental Health Treatment (DDCMHT).

Indicators:

- Technical assistance (TA) provided to Core Service Agencies requesting assistance in promoting DDCMHT within their jurisdictions
- Training and consultation for agencies requesting assistance in implementing practice changes, which promote agency-wide DDCMHT
- Continued TA to the substance use specialists and team leaders of Assertive Community Treatment (ACT) teams to enhance DDCMHT within those groups
- 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
- Education, training, and technical assistance for behavioral health providers on the use of evidence-based geriatric screening and assessment tools, as well as treatment modalities and recovery supports for older adults
- Provision of training and TA on Person Centered Care Planning (PCCP) principles and practices, within the context of county and agency substance use and mental health services integration projects

Involved parties: BHA Offices of Planning, Workforce Development and Training, and Adult and Specialized Behavioral Health Services; University of Maryland Evidence-Based Practice Center (UMD EBPC); MHAMD; Johns Hopkins Geriatric Education Center; ACT teams; behavioral health providers

Monitor(s): Steve Reeder, Office of Adult and Specialized Behavioral Health Services; Cynthia Petion, Office of Planning; Carole Frank, Office of Workforce Development and Training

FY 2015 activities and status as of 6/30/2015 (end-year report):

Collaborations will continue in the provision of technical assistance and consultation services to Core Service Agencies (CSAs) that promote Dual Diagnosis Capability in Mental Health Treatment (DDCMHT).

Technical Assistance and Training

- UMBC EBPC Trainer and Consultant worked collaboratively with CSAs and other agencies in providing federal assistance and training in areas of screening and assessment and implementation of practice changes that promote agency-wide Dual Diagnosis Capability (DDC).

Screening & Assessment

- 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 Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental

Health Treatment (DDCMHT) instruments. The CODC/T assisted agencies with analysis of aggregate data collected through the multiple assessments completed.

Person Centered Care Planning (PCCP)

- Trainings in January and April of 2014 also included PCCP (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.

Assertive Community Treatment (ACT)

- In FY 2015, there were 48 participants (including ACT Team leaders and Substance-Related Disorders [SRD] Specialists) attending four trainings on the American Society for Addiction Medicine (ASAM) six dimension assessment format.

Strategy Accomplishment:

This strategy was achieved.

(2-4B)

The BHA 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, as well as 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
- Development and dissemination of Data Shorts (behavioral health data and analysis) on adults in the PBHS with substance-use issues

Involved parties: BHA Offices of Planning and Epidemiology and Evaluation; UMD SEC; UMD EBPC; ASO

Monitor: Susan Bradley, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

Data analysis that will examine the utilization of services in the behavioral health system of care by individuals with co-occurring disorders will be conducted in collaboration with the BHA and the University of Maryland. Data results are being used to inform improvements in service delivery for this population.

Outcomes Measurement System (OMS) Data

The Outcomes Measurement System (OMS), operational since 2006, was expanded in 2015 under the newly established BHA to include recipients of Level 1 Substance-Related Disorders (SRD) services. OMS outcome data is available at the statewide and county-specific level for individuals in public behavioral health system outpatient treatment services between the ages of 6-64 years. OMS data is viewed through a public Web-based OMS Datamart system which provides two types of aggregated data analysis: individual interview data and comparisons of interviews over time for each individual. Clinicians conduct OMS intake interviews covering multiple life domains and conduct

interviews every six-months thereafter. Authorization of outpatient services is based on the OMS interview process.

- OMS data allows changes in the data set to be compared and contrasted over time for consumers with co-occurring substance abuse and mental health disorders and those who do not have co-occurring disorders.
- Data sets consisting of a group of individuals served by both administrations were created to better understand shared characteristics for this demographic, diagnostic category and to track associated outcomes.
- The focus on co-occurring disorders data is consistent with the merge in administrations and service modalities. As the merged BHA grows, it will be vital for the BHA to understand the data for individuals who fall within the co-occurring diagnostic category.
- UMD SEC continues to refine the OMS Datamart. A monthly report on public Web-based Datamart captures changes and updates to this data system.
- A joint presentation, “Exploring Behavioral Health Integration through Data,” presented an analysis of mental health and substance use disorder data at the 2014 Annual BHA Conference.

Data Shorts

Data Shorts is a new project released by the BHA in collaboration with the UMD SEC to provide concise behavioral health data and analysis. The aim of Data Shorts is to provide the reader with data that is related to behavioral health issues of focus throughout the fiscal year, which include data related to suicide, smoking, legal matters, Medicaid expansion, substance use, and consumer prescription care and wellness. Data Shorts are distributed on the BHA Web site.

- 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) is generated and shared on BHA Web sites.
- The presentation was well-received and well-attended and yielded a series of Data Shorts.

Strategy Accomplishment:

This strategy was achieved.

(2-4C)

MHBG

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 use 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, BHA Office of the Deputy Director of Children's Services; BHA Staff; MBHC; CSAs; Health Departments; providers; youth and young adults; consumers; families; advocates

Monitor: Al Zachik, Office of the Deputy Director of Children's Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Services that are representative of an integrated behavioral health system continue to be planned and implemented.

Project LIFT (Launching Individual Futures Together)

Launching Individual Futures Together (LIFT) is a residential treatment level of care project funded with a SAMHSA Systems of Care (SOC) grant developed to address transition-age youth (TAY). LIFT uses the Wraparound service delivery model that incorporates the SOC core competencies and values to link youth and families with community-based services. LIFT is closely tied to the 1915 (i) SPA but has been expanded to include individuals with co-occurring substance disorders.

- Project LIFT continues to provide training based on the Managing and Adapting Practice system to community behavioral health providers. The Managing and Adapting Practice system is designed to improve the quality, efficiency, and outcome of children's mental health services.
- Project LIFT aims to address several goals for the development of infrastructure in the state of Maryland: 1) the development of Maryland's Health Home model and Target Case Management (TCM); 2) efforts for strengthening workforce development and training by training the children's behavioral health workforce in alliance with Wraparound SOC core competencies (curriculum developed through the SOC Planning Grant), including specific training on co-occurring practice, cultural and linguistic competency, trauma-informed care, and evidence-based practice through existing programs WRAPTMS and Practice WISE, and Web-based virtual training centers; and 3) increased family and youth involvement through partnerships with Youth MOVE, Youth Council, and MCF. Also, enhanced areas of the Peer Support curriculum to include distinct components and TAY adaptation.

System of Care (SOC) Expansion Grant

Maryland was one of the states awarded the System of Care (SOC) Expansion grants, the BHA's Office of Children's services developed the Maryland Behavioral Health Collaborative (MBHC). The MBHC was composed of various stakeholders, including advocacy organizations for family members, state agency providers and other partners charged with developing recommendations and strategies to improve behavioral health outcomes and to integrate a SOC approach into child and youth service delivery systems. The MBHC efforts were aligned with the state's behavioral health integration process as well as the Administration's planning process that promoted and integrated infrastructure to support promotion, prevention, and early intervention for a recovery and resilience oriented system of care.

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 BHA 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)

MHBG

The Office of Forensic Services (OFS) will continue to provide training and consultative services to providers of forensic services who work with individuals residing in the community on conditional release from the Behavioral Health Administration (BHA) and the Developmental Disabilities Administration (DDA) facilities.

Indicators:

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

Involved Parties: BHA Office of Forensic Services (OFS); Community Forensic Aftercare Program; Developmental Disabilities Administration; the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Monitor(s): Erik Roskes, Richard Ortega, and Lori Mannino, Office of Forensic Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

The OFS oversees services provided for individuals with mental health and substance – related disorders and developmental/intellectual disabilities who are court-involved. OFS includes four divisions: Pretrial Services, Juvenile Pretrial Services, Justice Services-Addictions, and Community Forensic Aftercare Program (CFAP).

In FY 2015, 25 OFS trainings were conducted between November 2014 and June 2015 for 131 community providers, educators, administrators, and other behavioral health, correctional, and medical professionals. Topics included discharge planning, correctional transfers, pre-trial issues, ACT as a resource, cross-trainings (mental health, developmental disabilities, and substance use), and trainings for staff/providers who were new to the forensic population. Additionally, trainings were provided throughout the year for court evaluators and forensic coordinators. Individual meetings were scheduled with providers requiring additional technical assistance. These meetings or consultations occurred via telephone, visits, and email correspondence.

Throughout the year, provider linkages were established through community visits by monitors to problem-solve with providers and consumers, with the goal of affording individuals the opportunity to remain in the least restrictive setting possible (avoiding return to hospital or detention center) where their clinical issues could be safely managed. These visits occurred at residential programs, community mental health centers, assisted living providers, and hospitals. The average number of visits completed monthly numbered 29 during the latter part of FY 2015.

With the available community enhancements and monitoring, the majority of individuals in CFAP are successful in the community. The average caseload for a conditional release monitor is 110 consumers. Six hundred and sixty-nine individuals on conditional release and 43 additional individual placed on pre-trial conditions of release were monitored by CFAP in FY 2015, bringing the total census of individuals monitored by CFAP to 712. However, 76 out of 712 individuals returned to BHA/DDA facilities on hospital warrants. The number one reason for the return was non-compliance with housing rules and requirements. Medication non-compliance was the second reason followed by non-compliance with mental health treatment. The number of hospital warrants decreased from 88 in FY 2014 to 76 in FY 2015.

Strategy Accomplishment:

This strategy was achieved.

(3-1B)

The OFS will develop a Peer Review Program to assist the Qualified Community Evaluators (QCEs) to identify complex clinical issues involving competency and criminal responsibility of court-involved individuals.

Indicators:

- Workgroup formed to develop protocols
- Identification of the number of QCE prepared evaluations to be reviewed annually
- Presentation by workgroup to senior management staff

Involved Parties: BHA Office of Forensic Services; DDA; the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Monitor(s): Erik Roskes and Richard Ortega, Office of Forensic Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

A workgroup was brought together briefly in 2013 and plans for a structured, more formalized peer review process were presented to senior management. However, shortage of staff and focus on the Behavioral Health Integration process prevented the full implementation of the plans, as originally specified. Instead, it became more effective, since OFS and QCEs interfaced so often during the course of their duties, to structure increased monitoring and mentoring opportunities into the weekly and monthly schedule. Thus education of the evaluators is ongoing through the frequent interactions and daily consultation, which involve not just specific advice but models of language and relevant readings in the professional literature. QCE evaluations are closely monitored and receive full reviews periodically during the year.

Strategy Accomplishment:

This strategy was achieved.

Objective 3.2. Continue to work collaboratively with appropriate agencies to improve access to behavioral health services for children with behavioral disabilities and individuals of all ages with psychiatric disorders and co-existing conditions, including but not limited to: court and criminal justice involvement, deaf and hard of hearing, brain injury (BI), homelessness, substance use, developmental disabilities, and victims of trauma.

(3-2A)

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

Indicators:

- Plans of care developed and monitored for approximately 75 individuals participating in the Brain Injury (BI) waiver
- 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
- Implementation of Web-based Long-term Services and Supports (LTSS) tracking system for waiver administrative and quality assurance activities
- Eligible participants enrolled in Money Follows the Person (MFP) Project
- MFP enhanced federal match (re-balancing funds) spent on initiatives that expand community capacity

Involved Parties: BHA Office of Adult and Specialized Behavioral Health Services; Medical Assistance Division of Waiver Programs; Coordinators for Special Needs Populations in state facilities; CSAs; Traumatic Brain Injury Advisory Board; Brain Injury association of Maryland; Western Maryland Hospital Center; approved brain injury waiver providers

Monitor: Stefani O'Dea, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA 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. In FY 2015, plans of care were developed and monitored for approximately 77 individuals participating in the BI waiver.

There are two full-time administrative case managers for this initiative. Additionally, there is shared caseload with a full-time transitional case manager at the Brain Injury Association of Maryland (BIAM) funded with MFP rebalancing funds. Enhanced transitional case management was provided to 10 individuals this fiscal year and program education provided to total of 55 people to assist individuals with accessing the program. BHA continues to contract with BIAM to provide program education, application assistance, and transitional case management for the BI waiver.

A Web-based Long-term Services and Supports (LTSS) tracking system was implemented July 2014 for waiver administrative and quality assurance activities. This system has added many efficiencies to the waiver enrollment and case management processes.

Additionally, an enhanced federal match was obtained for 10 individuals who enrolled in the BI Waiver through Money Follows the Person (MFP). MFP rebalancing funds were utilized to support BI training for human service professionals, enhanced transitional case management services, and the LTSS tracking system. If requested, rebalancing funds are available to fund expansion of residential settings.

No additional providers were enrolled or incentives provided in FY 2015. Efforts will continue to be promoted to enhance provider interest and development.

Strategy Accomplishment:

This strategy was achieved.

(3-2B)

Increase outreach activities and refine policies that include integration of behavioral health services to consumers who are deaf or hard of hearing.

Indicators:

- Provide information to behavioral health providers on services available to individuals who are deaf or hard of hearing
- Revise existing policies and disseminate information to CSAs, local health departments, and the administrative services organization (ASO)
- Revise Web site to provide updated information on resources/services available through the Public Behavioral Health System (PBHS)
- Policy and process developed to increase access to qualified, comprehensive language interpretation services to be utilized across populations and with individuals with co-occurring disorders
- Explore resource opportunities, i.e. grants, to expand services for individuals who are deaf or hard of hearing across the life span and on the local level

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services, Planning, and Children's Services; CSAs; Local Addiction Authorities (LAAs); Governor's Office of the Deaf and Hard of Hearing (ODHH); DDA; consumers and family groups; state and local agencies; colleges and universities; nonprofit providers who receive state funding to provide services to deaf and hard of hearing; other local service providers

Monitor: Marian Bland, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

The Deaf and Hard of Hearing Services of BHA oversees services, as well as contracts that offer public behavioral health services, to individuals who have: a mental health condition; co-occurring substance-related disorder and mental health condition; or substance-related disorder. BHA also provides technical assistance to CSAs, LAAs, providers, consumers, and advocates regarding access to the PBHS. BHA updated the Web site to include information about the programs funded by BHA to provide specialized services to individuals who are deaf and hard of hearing.

Existing policies, that include integration of behavioral health services to consumers who are deaf or hard of hearing and policies to increase access to qualified, comprehensive language interpretation services, remain in effect and are periodically reviewed.

BHA's Office of Adult and Specialized Behavioral Health Services continues to disseminate information to providers on services available for individuals who are deaf or hard of hearing. Services are provided through the PBHS, based on the consumer meeting medical necessity criteria for these services, through specialized programs funded through state grants to local CSAs/LAAs, health departments, or a designated provider. Some of these state or federally-funded programs include:

- Arundel Lodge - a nonprofit agency that employs licensed mental health professionals proficient in American Sign Language (ASL) and provides outpatient behavioral health services, residential rehabilitation services, and psychiatric rehabilitation services in Anne Arundel County. This agency also provides outpatient mental health services for the Eastern Shore counties through a tele-mental health project with Mid-Shore Mental Health Systems, Inc.
- The Community Support Services for the Deaf - a nonprofit organization that provides services for individuals who are deaf or hard of hearing and have a mental illness or co-occurring substance-related disorder. The program provides support for individuals through the use of signing staff in the psychiatric rehabilitation program, residential programs, a senior day program, and onsite psychotherapeutic services.
- People Encouraging People, Inc. - a nonprofit agency that operates a specialized program for individuals who are deaf. Grant-funded sign language staff provide outpatient mental health treatment, psychiatric rehabilitation, residential rehabilitation, and supported employment services in Baltimore City.
- Family Services Foundation - a nonprofit agency that provides outpatient mental health treatment services through a licensed mental health professional proficient in ASL, psychiatric rehabilitation services, and residential rehabilitation services.
- University of Maryland, Deaf Addiction Services at Maryland (DASAM) - a nonprofit agency that provides statewide addiction treatment services to adults who are deaf or hard of hearing.

BHA also operates a unit at Springfield Hospital Center which provides a full array of inpatient services to adults who are deaf or hard of hearing. The unit employs a complement of deaf behavioral health professionals who provide these services and are fluent in ASL or other visual communication methods.

Limited funding is available to pay the cost for an interpreter in order for PBHS-eligible individuals to access outpatient behavioral health services. Approval for interpreting services funding may be accessed through the local CSAs for mental health conditions or mental health conditions co-occurring with a substance-related disorders and through the local health departments for substance-related disorders prior to service delivery.

BHA has outreached to other states on best practices and has researched opportunities to enhance services through federal grants to increase provider capacity. BHA has requested technical assistance from SAMHSA on enhancing cultural sensitive and appropriate services to transition-age youth including individuals who are deaf or hard of hearing.

Strategy Accomplishment:

This strategy was achieved.

(3-2C)

Increase sensitivity to trauma experiences and incorporate trauma-informed care principles and practices in treatment in 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
- Upon availability, Peer Support Specialists included on the treatment team
- Selected environmental changes made to support positive on-unit experiences

Involved Parties, BHA Offices of the Deputy Director for Behavioral Health Facilities, the Deputy Director of Clinical Services, and Consumer Affairs; Peer Support Specialists

Monitor: Mary Sheperd, Office of the Deputy Director for Behavioral Health Facilities

FY 2015 activities and status as of 6/30/2015 (end-year report):

All facilities include assessment of patients upon admittance. Currently, in addition to risk/initial assessments, 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.

All facilities have incorporated trauma-informed care (TIC) practices and principles in mandatory orientation training and updates throughout the year. New employees are required to attend the TIC training within the first week of employment. All staff, including clinical, support, dietary, housekeeping, maintenance, and contractual are trained and an attendance list of annual trainings is kept on file.

Additionally, Peer Support Specialists are available as consultants to staff and patients and in many facilities, they are included as part of the treatment team.

In addition to TIC training, policies were revised to create uniform response and report procedures with regard to sexual assault and harassment. Facility responses to individuals who have been victims of sexual abuse and harassment range from all patients given written information about policies, to receiving education following any type of sexual assault, harassment or disclosure made regarding sexual abuse, to some facilities choosing to screen newly admitted patients and take specific steps to design individualized interventions to address disclosed abuse and trauma.

Selective environmental changes to enhance the on-unit experience have been made such as the use of comfort rooms, to reduce environmental noise and to promote relaxation. These set-aside areas may include items such as rocking chairs, pet and/or music therapy, scents, and stress balls. These techniques continue to be upgraded and expanded in all the BHA facilities.

Strategy Accomplishment:

This strategy was achieved.

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

(3-3A)

MHBG

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 and crisis intervention teams throughout the state
- Implementation of Center of Excellence For Early Intervention
- Community education and outreach activities promoted, i.e. Mental Health First Aid (MHFA) and Critical Incidents Stress Management (CISM)

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Operations, the Deputy Director of Clinical Services, Forensic Services, CSA Liaison and Adult and Specialized Behavioral Health Services; State Facility CEOs; Maryland Medicaid; CSA directors in involved jurisdictions; UMD EBPC; Mental Health Association of Maryland (MHAMD); other stakeholders

Monitor(s): Marian Bland, Office of the Deputy Director of Clinical Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Crisis Services

Nearly all of Maryland's 24 jurisdictions provide crisis services. These efforts include crisis response systems, mobile crisis programs, hospital/jail diversion, urgent care, crisis beds, and assertive community treatment (ACT) services. Six counties have continuums in place with six or more non-hospital based crisis services. A Mobile Crisis Team (MCT) is currently available in each of 13 jurisdictions. Crisis residential beds are available in all but four jurisdictions and almost all counties offer short-term, state-funded crisis respite beds as both an alternative to and a step-down from psychiatric inpatient services. The development of crisis services continues to expand as two additional jurisdictions are in the process of adding Urgent Care services and two are in the process of implementing Mobile Crisis services.

Another important component of a crisis continuum is the Crisis Intervention Team (CIT) program. In FY 2015, BHA, through a supplemental budget appropriation, addressed several behavioral initiatives to further support the expansion of CIT. As of FY 2015, 11 of the counties (46%) have fully implemented CIT, which means they are now independently training law enforcement agencies in their jurisdictions. Ten counties (42%) are actively working collaboratively with law enforcement agencies and are in the process of implementing CIT. In some of these jurisdictions, law enforcement has obtained training from other jurisdictions, which serve as mentors, or is working with another jurisdiction to share resources such as a training academy. A collaborative training process for CIT continues in Maryland with a CIT Train-the-Trainer Program, which is scheduled for November 2015.

Early Intervention

The Maryland Center of Excellence for Early Intervention Program, evidence-based approach, has been implemented. 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 is comprised of four components: 1) Outreach and Education Services; 2) Clinical Services; 3) Consultation Services; and 4) Training and Implementation Support.

Maryland established an early psychosis intervention program in Baltimore in July 2009, through the National Institute of Mental Health (NIMH) study entitled, Recovery After an Initial Schizophrenia Episode (RAISE) Connection. Maryland also established an Early Intervention Program (MEIP) that offers specialized programs with expertise in early identification, evaluation and comprehensive psychiatric treatment for adolescents and young adults at risk or in early stages of a mental illness with psychosis.

Additionally, at the national level, SAMHSA has been directing states to set aside 5% of its Mental Health Block Grant to support the efforts of evidence-based programs that address the needs of individuals with early Serious Mental Illness (SMI), including psychotic disorders.

Maryland is using the 5% Block Grant set-aside to further expand RAISE Connection and MEIP by creating two additional teams. These teams are located in Montgomery County and Baltimore City.

Community Education/Outreach

Mental Health First Aid (MHFA) trainings have expanded to include Youth MHFA and trainings for military, veterans, and their families. MHAMD and BHA continue to work to coordinate trainings statewide. Additionally, BHA continues to support CSA efforts to train in Critical Incident Stress Management (CISM) skills (a standard of care comprising a range of crisis intervention services) as an approach to reduce unwarranted hospital admissions and arrests.

Strategy Accomplishment:

This strategy was achieved.

(3-3B)

In collaboration with Maryland Medicaid, 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
- Facilitate successful transition of financing mechanism responsibility to Medicaid staff
- Participate in ASO review process
- Ensure appropriate parties are involved in the transition of identified service monitoring
- Conduct data analysis to review success of transition

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Operations, Adult and Specialized Behavioral Health Services, Local Planning and Management, and Finance and Procurement; Maryland Medicaid-Office of Health Services

Monitor: Daryl Plevy, Office of the Deputy Director of Operations

FY 2015 activities and status as of 6/30/2015 (end-year report):

In June 2014, DHMH moved forward with its decision to implement a performance-based carve-out of mental health and substance use services and to merge the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration into a single administration, the Behavioral Health Administration (BHA). The BHA, in collaboration with Medicaid (MA), oversees the Public Behavioral Health System (PBHS), which includes policy development, statewide planning, resource allocation, and continuous quality improvement. House Bill 1510 required DHMH's Office of Behavioral Health to convene a stakeholder workgroup to make recommendations on issues related to behavioral health. Thus, statewide stakeholder participation continued as the process of behavioral health integration (BHI) progressed.

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

The Behavioral Health Integrated Regulations Workgroup strengthened the foundation for an integrated behavioral health care system by integrating the regulations applicable to community-based mental health and substance-related disorders services in Maryland.

An RFP for an administrative service organization (ASO) to serve the PBHS was issued earlier in the spring. ValueOptions@Maryland was awarded the contract and prepared for the implementation of new elements of the PBHS, as overseen by BHA and Medicaid, to begin January 1, 2015.

BHA staff met with Medicaid staff bi-weekly to review the progress of Behavioral Health Integration (BHI), as well as the ASO contract implementation. BHA and Medicaid staff

held monthly meetings with providers to discuss any changes to the PBHS as well as any problems that providers were encountering.

Also on January 1, 2015, as part of the PBHS, the implementation of a combined mental health (MH)/substance-related disorders (SRD) data system began. All required MH/SRD Treatment Episode Data Set (TEDS) elements were built into ValueOption@Maryland. The financing changes moved data collection from the SMART system for substance use disorders to the new ASO. The ASO now collects required data for all SRD services, whether or not it manages or reimburses those services.

Strategy Accomplishment:

This strategy was achieved.

(3-3C)

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

Indicators:

- Monitor the implementation of the Medicaid Emergency Psychiatric Demonstration (MEPD)
- Work with ASO and Medicaid to monitor outcomes, including number of consumers admitted to in-patient services and average length of stay
- Work with Medicaid to monitor implementation of the health home model to serve people with serious and persistent mental illness (SPMI), substance use disorders, and/or co-occurring chronic somatic health conditions
- Number of health homes approved/implemented
- Number of individuals served

Involved Parties: BHA Offices of the Executive Director, the Deputy Director of Operations, Adult and Specialized Behavioral Health Services, Local Planning and Management, and Finance and Procurement; Maryland Medicaid-Office of Health Services

Monitor: Daryl Plevy, Office of the Deputy Director of Operations

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA collaborated with Medicaid to act on funding opportunities related to the Patient Protection and Affordable Care Act. These opportunities include the Medicaid Emergency Psychiatric Demonstration, which was awarded in March 2012, and the development of a Health Homes program, which went live October 2013.

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. In FY 2015, BHA continued to monitor the admission of consumers aged 21-64 with emergency psychiatric conditions for inclusion in the MEPD (which ended June 30, 2015). During FY 2015 in Maryland, 2,116 individuals were admitted to private psychiatric hospitals for treatment of an emergency psychiatric condition. This increase is largely due to the expansion of Medicaid.

Maryland's Medicaid Health Homes Initiative

BHA, in collaboration with Maryland Medicaid, developed a plan for the implementation of a Chronic Health Home State Plan Amendment (SPA). Maryland's implementation model enables Health Homes to act as a locus of coordination for individuals with a serious and persistent mental illness (SPMI) or serious emotional disorder (SED), in combination with meeting medical necessity criteria for psychiatric rehabilitation programs (PRP) or mobile treatment (MT) services; or an opioid substance - related disorder that is being treated with methadone, and at risk for an additional chronic condition due to current alcohol, tobacco, or substance use.

Health Home services also include: comprehensive care management; health promotion; comprehensive transitional care; individual and family support; and referral to community supports. As of June 2015, 75 sites were approved as Health Home providers (60 PRPs; 10 MT programs; and five opioid treatment programs). These programs served a total of 5,608 individuals (494 children and adolescents and 5,114 adults).

Strategy Accomplishment:

This strategy was achieved.

(3-3D)

In collaboration with the State Psychiatric Facility chief executive officers (CEOs), CSAs, and providers, 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: BHA Offices of the Deputy Director for Behavioral Health Facilities and Adult and Specialized Behavioral Health Services; CSAs; facility CEOs; providers; other stakeholders

Monitor: Mary Sheperd, Office of the Deputy Director for Behavioral Health Facilities

FY 2015 activities and status as of 6/30/2015 (end-year report):

In an effort to further facilitate the discharge of long-stay state hospital residents, the former Mental Hygiene Administration (MHA), now the BHA, began an initiative in FY 2013 to develop new community services tailored to the needs of individuals hospitalized primarily at Spring Grove Hospital Center. A committee of stakeholders was formed to oversee the discharge initiative and to make recommendations to improve the process and service continuum planning. The committee included representatives from: various stakeholder, advocacy, consumer, and provider groups; local behavioral health authorities (core service agencies); BHA; and staff from Spring Grove Hospital Center (SGHC).

As a result of the committee efforts, several recommendations were identified and implemented. These included, among others, the development of a real time process for: identification of patients ready for discharge; provision of community "in-reach" for patients who were not ready for, or resistance to discharge; peer support before and after discharge; resolution of financial issues; on-site monthly orientations; and improved process of Medicaid enrollment. The project was implemented in two phases. Phase one incorporated 70 new services and Phase two incorporated 10. Services included: ACT

with housing; Assisted Living; and residential rehabilitative programs (RRP) intensive level. The Discharge Initiative was completed in FY 2015.

Regional Institutes for Children and Adolescents also developed a process for facilitating mainstreaming into school/community and supported weekend visits with parents/guardians, or group homes in preparation for living in less restrictive environments. Additionally, as part of the discharge planning process, the CQT interviewed patients at SGHC to inquire about their preferences for discharge services and community support. This information proved invaluable in helping providers and hospital staff support the consumer's preference. Interview results were made available in the medical charts.

These planning efforts continue at each facility. All hospital clinical staff work with health care providers to develop a continuum of care discharge protocol allowing for services to be tailored to meet the needs of patients about to be discharged. Additional discharge planning protocols include: meetings with the Core Service Agencies (CSAs) to resolve barriers and to identify placement; treatment team interface with providers; and treatment team interface with Forensic Review Board on matters related to continuum plans for individuals with criminal justice involvement. Every client that is discharged is connected to continued behavioral health services either in their next placement or in the community. Additionally, efforts are underway with the CSAs and other providers to develop a cloud-based system of sending, receiving, and tracking referrals and dispositions.

Strategy Accomplishment:

This strategy was achieved.

(3-3E)

In collaboration with the DHMH Long-Term Care & Community Support Services Administration, identify and implement specific changes within the behavioral health service delivery system to ensure adherence to Center for Medicare/Medicaid Services (CMS) requirements for the Balancing Incentive Payment program, designed to promote shifts in state Medicaid spending from institutional to community-based care.

Indicators:

- Assist in the identification, selection, and implementation of a core standardized assessment instrument for all specialty mental health services
- Assist with analysis of programs, contracts, and regulations to identify conflicts in case management systems
- Promote access to Maryland long-term care services and supports (LTSS) for individuals with behavioral health disorders

Involved Parties, BHA Office of Adult and Specialized Behavioral Health Services; DHMH Medical Care Programs (Medicaid); CSAs; Maryland Access Point (MAP); Aging and Disability Resource Centers (ADRCs)

Monitor: Stefani O'Dea, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

The Medicaid/Office of Health services, and MFP/BIP staff are working towards implementation of the BIP-required structural changes to enhance the community-based care funding process for the delivery of behavioral health services. This program is a multi-year project and most structural changes have been implemented. However, much of the analysis of programs, contracts, and tools are in process.

A core standardized assessment tool, which can be used with the behavioral health population, has been identified but not yet implemented. Maryland Medicaid will be taking the lead on implementation with assistance from BHA. Once in place, the BHA system of care is expected to utilize this tool a great deal. Additionally, BHA worked closely with Maryland Medicaid to identify and select a core standardized assessment instrument for all specialty mental health services, as well as for the Brain Injury Waiver program.

BHA has submitted to Maryland Medicaid all requested information regarding mental health case management to ensure compliance with conflict-free case management requirements.

BHA continues to participate in the bi-monthly MFP/BIP stakeholder meetings, Mental Health and Aging Coalition meetings, and other ad hoc workgroups to implement the final structural changes as required through BIP. BHA also participates in meetings and workgroups with Maryland Department of Aging (MDoA) to facilitate access to Maryland long-term care services and supports (LTSS) for individuals with behavioral health disorders through Maryland Access Point.

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. In collaboration with CSAs and state agencies, develop employment options and supports to increase the number of consumers employed.

(4-1A)

MHBG

Continue to implement the Maryland Mental Health Employment Network (MMHEN), a consortium of Maryland mental health supported employment providers, under the auspices of the Social Security Administration's (SSA's) Ticket-to-Work Program, to increase access to and availability of supported employment and services to promote long-term career development and economic self-sufficiency.

Indicators:

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

Involved Parties: BHA Office of Adult and Specialized Behavioral Health Services; Maryland Department of Disabilities (MDOD); Harford County Office on Mental Health-MMHEN; UMD EBPC; UMD SEC; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ASO; SSA; consumers and family members

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end of year report):

BHA also takes note of the increased number of individuals employed each year from the Maryland Ticket-to-Work initiative. The Ticket-to-Work program assists people who receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) to return to meaningful work, maintain employment, and to pursue ongoing career advancement.

Data was reported to BHA quarterly as well as in a comprehensive Annual Report. Throughout this reporting period, the program served 295 beneficiaries total of which 195 were employed. Seven participating programs were assigned to MMHEN, which was an increase from FY 2014.

MMHEN continued to provide high-quality intensive benefits counseling services to Social Security beneficiaries who otherwise did not have access to the specialized benefits counseling services of a Certified Work Incentives Coordinator. During FY 2015, 21 beneficiaries received individualized benefits counseling services through

MMHEN in addition to 60 others that utilized the toll-free benefits counseling hotline as a resource. Significant emphasis was placed on planning the further growth and development of benefits counseling services and resources through MMHEN.

In FY 2015, eight full-day benefits advocacy training sessions were hosted in various locations throughout Maryland, which resulted in 100 individuals receiving training and information on Social Security benefits, state-specific benefits, and work incentives.

Additionally, in an effort to foster efficacy in the program a Policy and Procedures manual was created for MMHEN which outlines program policies as well as procedures for reporting data, wages, and providing quality services to beneficiaries.

Strategy Accomplishment:

This strategy was achieved.

(4-1B)

In collaboration with National Alliance on Mental Illness-Maryland (NAMI MD) and the University of Maryland Evidence-Based Practice Center (UMD EBPC), educate consumers and family members about the access to and availability of benefits counseling and supported employment and the role each plays in facilitating consumer recovery and economic self-sufficiency.

Indicators:

- Increased understanding of the BHA'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
- Resource materials developed and disseminated
- Supported employment and work incentives training provided
- Incorporation of supported employment content in Family-to-Family classes available to selected NAMI affiliates

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services and Consumer Affairs; MDOD; UMD EBPC; Dartmouth Psychiatric Research Center; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ASO

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end of year report):

BHA and UMD EBPC staff continued to participate in Dartmouth Learning Collaborative calls and attended Dartmouth's Johnson & Johnson training and break-out session on the Family Advocacy Project. BHA, the Maryland Employment Network, and UMD EBPC staff collaborated to update a Supported Employment flyer to be distributed by NAMI. Eighteen benefits trainings were attended by 155 individuals. An action plan was developed to further enhance outreach efforts to family members to join the team and recruitment of family members to have a core group of family members leading this project. The Family Advocacy Team and members presented at the DORS conference. The session was attended by 45 individuals. The team leader provided a workshop with

26 employment specialists in attendance. In addition to conference presentations, the Family Advocacy Project provided 20 trainings on supported employment and work incentives with a total attendance of 226 participants.

Strategy Accomplishment:

This strategy was achieved.

Objective 4.2. 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)

MHBG

Continue to promote workforce development by providing opportunities to enhance the quality and the qualifications of Peer Support Specialists and Supervisors providing behavioral health services.

Indicators:

- Recruit and provide regional training to peer recovery support providers and supervisors
- Peer training provided in four domains required for certification to a minimum of 100 peers to become certified by March 1, 2015
- Supervision training provided to a minimum of 40 potential or current peer supervisors

Involved parties, BHA Offices of Workforce Development and Training, Adult and Specialized Behavioral Health Services, and Consumer Affairs; the Maryland Addiction Professional Certification Board (MAPCB) - Certified Peer Recovery Specialist (CPRS) Credential; Danya Institute

MHA Monitor(s): Office of Workforce Development and Training and Office of Consumer Affairs

FY 2015 activities and status as of 6/30/2015 (end of year report):

As of March 2015, 172 persons were trained in the area of Peer Supervision, 152 persons trained in Advocacy, 181 in Ethics, 150 in Mentoring/Education, and 87 trained in Recovery/Wellness Support. Additionally, the BHA's Office of Consumer Affairs (OCA) held its first annual Peer Summit of all Certified Peer Recovery Specialists (CPRS) and those seeking certification. More than 75 were in attendance. This summit brought together peers with behavioral health disorders to discuss the future of peer support and the needs of those in the workforce. The outcome of this summit led to further integration efforts and the current development of training to address issues of mental health, substance-related, and co-occurring disorders on a peer level.

As of June 30, 2015, 98 peers have been certified by the Maryland Addiction and Behavioral-health Professionals Certification Board (MAPCB). Recovery Planning (held July, 2014) and Advocacy training (held August, 2014) were given as domain training via the DANYA institute.

In September, 2015, the OCA will support efforts for peers to take part in Intentional Peer Support training for enhanced support of re-certification. This will lead to facilitator training in FY 2016 to further the efforts of peer integration within the state.

Strategy Accomplishment:

This strategy was achieved.

(4-2B)

Explore potential of and determine mechanism for financing peer support services.

Indicators:

- Define Medicaid reimbursable services that are inclusive of areas of mental health, substance use, and co-occurring; define which Peer Specialist responsibilities are best suited for reimbursement
- Determine timeline for consideration of 1915(i) waiver for above potentially to include peers, family/youth peer support

Involved parties: BHA Offices of the Executive Director, Deputy Director of Clinical Services, Deputy Director of Operations, Consumer Affairs, and Planning; Medicaid Chief, Behavioral Health Division; BHA Medical Assistance Liaison; OOOMD; CBH; WRCs/RCCs; mental health and substance-related disorder advocacy groups; peer specialist and recovery coach organizations

Monitor(s): Office of the Executive Director and the Office of Consumer Affairs

FY 2015 activities and status as of 6/30/2015 (end of year report):

The DHMH Workgroup/Committee for Medicaid Reimbursable Certified Peer Recovery Specialist reconvened to further efforts on defining reimbursable services for peer support within Adult services. In FY 2015, the Committee drafted the “Scope of Practice” and is currently under review, for an effective workforce initiative that defines the main purpose of the Certified Peer Recovery Specialist (CPRS) and essential job functions/responsibilities. Further efforts are underway to develop and implement a functional and financial sustainable CPRS workforce delivery system.

Additionally, Maryland’s 1915(i) State Plan Amendment (SPA) entitled ‘Intensive Behavioral Health Services for Children, Youth and Families’, was approved by Center for Medicare/Medicaid Services (CMS). Two chapters of regulations have been promulgated to govern the operation of the SPA and a new Targeted Case Management program SPA designed to provide intensive care coordination utilizing the wraparound practice model with a set of highly specialized.

For children who are enrolled in the SPA, an assortment of specialized services not available to all Medicaid recipients will be offered. These include respite care, family peer support, intensive in-home services, crisis and stabilization services, expressive and experiential therapies, for example, art, music, and equine assisted therapy, with a unique program of participant-directed customized goods and services.

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)

In collaboration with key stakeholders, 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 BHA” with increased administrative and programmatic leadership involvement to integrate cultural competency throughout the behavioral health system
- Exploration of the expansion of the Behavioral Health Dialogue with use of telecommunication, from a cultural perspective, to reach a broader base of providers and programs
- Incorporation of sensitivity awareness and cultural competence training efforts to eliminate behavioral health disparities in state, federal, and local planning activities

Involved Parties: BHA Office of Planning; BHA staff; CSAs; Maryland Advisory Council on Mental Hygiene/ Cultural and Linguistic Competence Advisory Committee (CCAC); OOOMD; consumers; family members; advocacy groups

Monitor: Iris Reeves, Office of Planning

FY 2015 activities and status as of 6/30/2015 (end-year report):

The BHA’s Office of Planning continued the Behavioral Health Dialogue identified by facilitating a full day dialogue on April 14, 2015 with more than 20 participants from CSAs and Local Addiction Authorities (LAAs). The theme “Improving Cultural Competence: Finding the Gaps and Filling Them” focused on a collaborative dialogue, which addressed ways in which an integrated Public Behavioral Health System (PBHS) could work more effectively in supporting the programs and policies of the new Behavioral Health Administration. The mission of the workshop, cultural and linguistic competence, was supported by Dr. Vivian Jackson who presented a lecture, “Implementing and Evaluating Cultural and Linguistic Competency for Comprehensive Community Mental Health Services,” followed by an analytical exercise that highlighted the importance of cultural competence in behavioral health service. Dr. Jackson is a member of the faculty at the National Center for Cultural Competence at the Georgetown University Center for Child and Human Development which provides technical assistance and consultation related to cultural and linguistic competence to state, federal and other organizations and agencies. During the workshop, methods for assessing the need for technical assistance and community-based provider training in the development

of sensitivity awareness and to increase cultural competence in promoting cultural and linguistically appropriate behavioral health services provided through the CSAs and LAAs were also discussed with participants.

Cultural Competency efforts continue to be a state priority area and are monitored as part of the CSA and LAAs planning process. Efforts or actions taken to accomplish goals related to cultural competence in the delivery of behavioral health services are documented and presented to BHA by CSAs annually as part of a local Behavioral Health Plan review process. Suggestions and recommendations are provided by BHA that support the development of culturally responsive clinical skills in evaluation and treatment and the implementation of objectives and strategies that focus on cultural competence in order to increase the effectiveness of behavioral health services and in the coordination of care in the delivery of services to individuals with mental illness and co-occurring disorders in jurisdictions across the state. Ensuring that cultural competence is part of the state strategic planning processes requires the development of solid cultural competence plans which are part of an ongoing systematic organizational approach to increasing cultural competence among community-based providers and in providing culturally responsive behavioral health services to individuals throughout the state.

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 to address the needs of individuals with mental health, substance use, and co-occurring disorders
- 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 proposals
- Programs 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: BHA Offices of Planning and Adult and Specialized Behavioral Health Services; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; DHCD; MDOD; Developmental Disabilities Administration (DDA); local housing authorities; housing developers

Monitor: Robin Poponne, Office of Planning

FY 2015 activities and status as of 6/30/2015 (end-year report):

BHA continues to prioritize the development of affordable, safe housing for individuals with behavioral health disorders. The number of affordable housing project applications approved for FY 2016 Community Bond awards (approved in 2015) totaled six, creating affordable homes for 87 individuals with a mental illness or co-occurring/dual diagnosis (with substance-related disorder or a developmental disability).

To date, more than 640 housing units have been developed through Office of Capital Planning, Budgeting, and Engineering Services' Administration-Sponsored Capital Program grant (Community Bond) funding in partnership with community housing development organizations, mental health provider organizations, and other entities providing affordable housing.

Additionally, numerous supported housing providers, as well as a few developers, have applied for tax credits through DHCD and are using Community Bond funding to develop housing through blended or leveraged funding.

FY 2015 was the first year of the merger of Mental Hygiene and the Alcohol and Drug Abuse Administration to become the BHA and the first year that a combined process for reviewing mental health and substance-related disorders applications for Community Bond was established. The BHA Offices of Planning and Treatment and Recovery Services worked together through the following Bond activities:

- Pre-application meeting held at the end of January 2015 and attended by more than 30 substance use and mental health housing providers to become informed about the benefits of community bond funding as a method to increase affordable housing or recovery housing options
- Revision of application guidelines to include both mental health (MH) and substance-related (SRD) disorders
- Planning and attending site visits, meetings with applicants – all visits included participants of both MH and SRD regardless of type of application
- Review of all applications and a unified set of recommendations presented to BHA leadership

BHA Offices of Planning and Treatment and Recovery work collaboratively with DHMH's Office of Capital Planning, Budgeting, and Engineering Services to monitor the development of housing projects as proposed. As Community Bond funding is awarded, data is collected and maintained for each awardee including items such as: the number of housing units developed; when and how the funds are totally encumbered; and how many individuals receive housing. As appropriate, contacts are made to monitor the continued operation of the projects. DHMH and BHA will continue to monitor Community Bond projects for timely and qualitative expedition of funds.

Strategy Accomplishment:

This strategy was achieved.

Objective 5.2. Continue to work collaboratively with appropriate agencies to improve access to behavioral 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
- Track the number of youth, 18 years and older who are or were homeless, that received a federal Department of Housing and Urban Development (HUD) voucher and whose information was entered in the homeless management of information system
- Maximize use of Continuum of Care (CoC) funding (formerly called Shelter Plus Care Housing) and other support systems to provide rental assistance to individuals with mental illness who are homeless or were formerly homeless, using HUD funding
- Collaborate with MDOD, Maryland Partnership for Affordable Housing (MPAH), and DHMH to increase access to rental assistance programs, such as HUD's Section 811 Project Rental Assistance (PRA) Program and the Weinberg Foundation grants

Involved Parties: BHA Office of Adult and Specialized Behavioral Health Services; other BHA staff; MDOD; MPAH; DHCD; CSAs/LAAs; state psychiatric facilities; Continuum of Care Homeless Boards; local detention centers; HUD; local service providers; consumers; case management agencies; housing authorities; other nonprofit agencies; PATH service providers

Monitor(s): Marian Bland and Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Projects for Assistance in Transition from Homelessness (PATH)

The PATH program provides services to individuals who became homeless or are at imminent risk of becoming homeless. In FY 2015, the PATH program continued to provide funding to all 23 counties and Baltimore City. Four geographic regions - Central, Eastern, Southern and Western Maryland – had access to PATH services. BHA was notified by SAMHSA on September 4, 2014 that funding would continue. The total federal funding was \$1,271,000, which was an increase by \$68,000 over FY 2014. Nineteen out of the 25 PATH providers in the state of Maryland provide outreach services and case management. Many people were outreached, enrolled, received case management, linked to services in the community, and provided housing assistance. Overall, quarterly reports and the Annual Progress Reports show that PATH outreached to 7,685 individuals and enrolled 2,368. Five counties are approved to provide one-time-only funds to prevent evictions; this year 22 individuals were assisted.

Quarterly reports provide a snapshot of services provided during the year for people who are homeless. An Annual Progress Report is submitted to SAMHSA to provide statewide data on individuals who are homeless and are assisted through PATH for the year, as well

as the services and linkage to housing provided. 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. In addition, four quarterly meetings were held this year. In attendance were representatives of BHA, CSAs, PATH providers, housing, human service providers, and other homeless services.

Maryland Homeless Youth Count Demonstration Project

Out of the recommendations of a 2013 Task Force to Study Housing and Support Services for Homeless Unaccompanied Youth, (HB 794), a data base was established to collect information about needs and characteristics of homeless youth. Beginning July 2014, six continuums of care, or jurisdictions, are required to count unaccompanied homeless youth. These jurisdictions include Baltimore County, Annapolis/Anne Arundel County, Baltimore City, Hagerstown/Washington County, Prince George's County, and Wicomico/Somerset/Worcester counties. On or before September 30, 2017, a report will be submitted to the General Assembly on the results of the Project.

Continuum of Care (CoC) Program

BHA disseminates federal HUD funding to CSAs to provide rental assistance to individuals who are homeless or were formerly homeless through the Continuum of Care (CoC) Program (formerly called Shelter Plus Care Housing). In January 2014, BHA re-applied for funding for its 18 renewal grants and in April 2014, was funded at \$4.8 million for FY 2015 for a total of 317 units. BHA maximized the CoC funding and thus subsidized an additional 66 units (now totaling 383). In FY 2015, these units provided rental assistance and housing to 698 persons (which included families, single individuals, and children along with other adults).

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. This Annual Performance Report is submitted to HUD yearly and quantifies the amount of individuals served, as well as supportive services received during the course of the year.

BHA's Office of Adult and Specialized Behavioral Health Services continues to: participate in local Continuum of Care Homeless Boards; give technical assistance to providers on a daily basis via telephone, email, or written correspondence; assist with resolving crisis situations; and/or handle problematic situations that may occur. In addition, BHA meets with CSAs, case managers, consumers, CoC monitors, and providers quarterly.

Agency Collaboration – Rental Assistance

Collaboration is ongoing between MDOD, DHCD, DHMH (DDA and BHA), and MPAH in an effort to increase affordable housing opportunities using federal subsidies across the state. Some of the projects are as follows:

- \$10.9 million awarded by Weinberg Foundation for the new construction and rehabilitation of 150 units of Section 811 housing in Maryland across disabilities
- During FY 2015, an additional \$9.8 million for another 150 HUD/Weinberg units of Section 811 housing in the greater Baltimore and Washington, D.C. Metro regions
- HUD’s Affirmative Fair Housing Marketing Plan (AFHMP) making Section 811 housing available to various disability groups represented by DHMH based on demographic data
- Funding secured for BHA to develop a Housing First Pilot in Baltimore City, Montgomery and Prince George’s counties to provide rental assistance to individuals who are homeless or were formerly homeless

Additionally, BHA’s Housing Coordinator sponsored four regional trainings on Housing 101, which included information about the referral process and eligibility standards required for the HUD 811 housing. A total of 200 persons were trained.

Strategy Accomplishment:

This strategy was achieved.

(5-2B)

MHBG

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, workgroups expanded, and new partnerships, including those from a substance use background, trained in SOAR
- Technical assistance provided to local workgroups and individuals to ensure appropriate knowledge of the SOAR application process
- Increase in the number of fully SOAR certified case managers
- Process developed, in collaboration with State Hospitals and Social Security Administration (SSA), to expedite the reinstatements of benefits to patients as part of discharge planning
- Data collated and submitted to State Stat on a monthly basis

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services and Epidemiology and Evaluation; Policy Research Associates; SSA, Disability Determination Services; colleges and universities; Department of Public Safety and Correctional Services (DPSCS); DHR; Veterans Administration; SOAR Leads; PATH-funded providers; other community and facility-based providers

Monitor(s): Marian Bland and Caroline Bolas, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Since July 1, 2014, five more counties (Mid Shores Region) are now implementing SOAR, bringing the total number of counties to 22 plus Baltimore City. Meetings have been held with the last remaining county, Calvert, and it is anticipated that this county will be implementing SOAR by the end of FY 2016.

Each local SOAR Lead holds regular workgroup meetings during which the SOAR process is reviewed and best practices shared. BHA's Director of the SOAR Initiative attends as many of these meetings as possible to provide ongoing technical assistance and ensure fidelity to the SOAR model. In conjunction with work by the National SOAR TA Center, there has been increased emphasis on working more closely with peer specialists and those serving veterans. The National SOAR TA center also publishes a regular newsletter as well as delivering bi-monthly Webinars. All SOAR providers are encouraged to participate in these Webinars. Four Stepping Stones to Recovery SOAR training sessions were held in FY 2015, training more than 90 people including case managers, mental health professionals, social workers, and others.

As of June 2015, 20 people have been approved for full SOAR Certification and five providers have undergone SOAR re-certification. Following a comprehensive evaluation, the SOAR certification process was revised and expanded across all established SOAR sites.

Work is ongoing to help ensure that, upon discharge from state hospitals, disability benefits can be reinstated or obtained in the most efficient manner. In an effort to expedite benefits for patients, a full time SOAR case manager position has been established at Spring Grove Hospital Center to undertake SOAR applications. Additionally, dedicated SOAR case managers based in Montgomery County and Prince George's County have been working with Spring Field Hospital Center and Clifton T Perkins Hospital Center on a number of SOAR applications.

Data on numbers of approvals, SOAR processes, and processing times is collected monthly from all SOAR sites and is used to produce a monthly data report. Data has been submitted to StateStat as required. It is also submitted annually to the National SOAR TA Center.

Maryland has one of the highest state approval rates for SOAR claims within the country. In FY 2015, approved SOAR applications numbered 170 (77% of those submitted). Maryland's approval rate for initial cases is 85% of all initial claims submitted (compared with a SOAR National average of about 65%) with an average processing time of just 76 days.

Strategy Accomplishment:

This strategy was achieved.

(5-2C)

Establish partnerships with the State Department of Human Resources (DHR), the Department of Housing and Community Development (DHCD), Core Service Agencies (CSAs), and other appropriate agencies to make homelessness a rare or brief occasion, and to develop policies and programs to prevent or reduce the duration of homelessness for all individuals, including those who have behavioral health disorders.

Indicators:

- Develop MOU with DHCD for technical assistance to BHA, PATH, Continuum of Care (COC - formerly called Shelter Plus Care Housing), and other behavioral health providers on collecting, entering, and analyzing Homeless Management Information Systems statewide and local data, generating reports, and determining local needs
- Implement Housing First Pilot in Baltimore City, Montgomery, and Prince George's counties
- Engage in State Interagency Council on Homelessness, reestablished through HB 1086/SB 796, to examine system barriers, develop policies, and promote new programming

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services, Children's Services, and Special Projects (Veterans, Gambling, Tobacco, Smoking Cessation); DHMH Office of Health Services; DHR; DHCD; CSAs; Maryland Veterans Administration; Regional Coordinators; other state and local agencies; other community providers

Monitor: Marian Bland, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Homeless Management Information Systems - Memorandum of Understanding (MOU)

BHA has been collaborating with DHCD to develop an MOU for the provision of technical assistance to behavioral health providers who deliver services to individuals who are homeless. The MOU will include updates in Health Insurance Portability and Accountability Act (HIPAA) laws including the 42 CFR Part 2 (commonly referred to as "Part 2", the federal regulations governing the confidentiality of drug and alcohol use treatment and prevention records). The MOU is expected to be finalized in the fall of 2015. BHA has to ensure that all information entered into the Homeless Management Information Systems (HMIS) will be protected for all individuals in the behavioral health system regarding their mental health and/or substance-related disorders.

Housing First

BHA contributed funding and in collaboration with DHCD and DHR implemented the Housing First Model in Maryland to increase the number of permanent supportive housing units across the state. The project started in January of 2015 and is overseen by the CSA in Baltimore City (BHSB), serving individuals in Baltimore City, Montgomery and Prince George's counties to assist those who have a mental illness or a mental illness and co-occurring substance use disorder. Eligible individuals must also be either: a) homeless or at risk for homelessness and being served by the SOAR Program; b) in the process of being discharged from state psychiatric hospital; or c) transitioning from a residential rehabilitation program (RRP) to permanent housing. Additionally, all individuals must have incomes at or below 50% of area median income (AMI).

Baltimore City's goal is to house a total of 36 persons (10 already housed as of June 2015), and the selected provider is Healthcare for the Homeless. Montgomery County will house 24 persons (13 as of June 2015), and Prince George's County will house a total of 12 persons (five as of June 2015). Both Montgomery and Prince George's counties have selected the Assertive Community Treatment (ACT) provider, People Encouraging People, to implement the project.

Interagency Council on Homelessness

BHA participated in the State Interagency Council on Homelessness (ICH). ICH includes representatives from 12 state agencies including the Governor's Office for Children and Families, three representatives from local Continuum of Care, and six advocates throughout the state, as well as members who have experienced homelessness. The purpose of the group is to identify system barriers to decreasing homelessness and work on developing policies to address areas of concern.

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

(6-1A)

MHBG

Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide evidence-based practice (EBP) implementation in supported employment, assertive community treatment (ACT), family psycho-education (FPE) and First Episode Psychosis Program; facilitate local implementation of Integrated Illness Management and Recovery (IIMR), Integrated Dual Disorder Treatment (IDDT), and other empirically-supported promising and best practices, as appropriate, within selected sites.

Indicators:

- Annual evaluation of programs to determine eligibility for EBP reimbursement rates
- Ongoing data collection on EBPs receiving training and meeting fidelity
- Number of new programs established
- Development of a plan of transition to an enhanced, recovery-oriented fidelity assessment tool for measuring ACT fidelity - the Tool for Measuring Assertive Community Treatment (TMACT)
- Development and implementation of First Episode Psychosis Program/Early Intervention Program team in two sites
- Identification, review, and evaluation of EBPs for older adults and exploration of the feasibility of implementation
- Increased number of programs meeting fidelity standards to become EBP programs
- Continued monitoring of IDDT pilot project in Baltimore City
- Continued monitoring of IIMR pilot project implementation and fidelity assessment at three sites (Frederick, Washington, and Howard counties)
- Empirically-supported Transition to Independence Process (TIP) curriculum and fidelity assessment protocols refined and piloted within selected Transition-Age Youth (TAY) programs and sites

Involved Parties, BHA Offices of Adult and Specialized Behavioral Health Services, the Executive Director, the Deputy Director of Clinical Services, the Deputy Director of Operations, and Planning; ASO; Dartmouth Psychiatric Research Center; University of Maryland, Department of Psychiatry (RAISE Connection Program); UMD EBPC; UMD SEC; Baltimore City and Montgomery County CSAs; Maryland Coalition on Mental Health and Aging; community mental health providers

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (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 EBP Center Trainer/Consultants. Providers continue to request fidelity assessment 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 BHA Fidelity Monitors to determine each program's eligibility to receive the enhanced EBP reimbursement rate:

- As of 2015, there are 61 approved community mental health provider sites that provide Supported Employment (SE) services and supports to individuals with serious mental illness. Twenty-six (26) of those approved Mental Health Vocational Programs were determined to have met the established Evidence-Based Practice (EBP) Supported Employment (SE) fidelity standards. In addition to the 26 programs, 16 new programs have been trained in EBP SE principles and practices during FY 2015.
- The ACT Trainer/Consultant has provided ongoing consultation and training to six programs and is also working with five providers to develop fidelity action plans following their fidelity assessment. Additionally, 20 ACT Teams were determined to have met the established Evidence-Based Practice (EBP) Supported Employment (SE) fidelity standards.
- 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.
- Three sites are currently implementing FPE. Efforts are underway to explore implementation of EBP-FPE with two new transition-age youth programs supported through the Healthy Transitions and two supported through the Maryland Early Intervention Program.
- Integrated Illness Management curriculum based protocol continues in Way Station-operated psychiatric rehabilitation programs as part of a Health Home pilot project located in Frederick, Howard, and Washington counties. IIMR will also be implemented in a newer housing program of Way Station with technical assistance and consultation provided by Dartmouth Community Mental Health Program and continued monitoring by BHA Office of Adult and Specialized Behavioral Health Services. BHA Fidelity Monitors participate in technical assistance calls between Dartmouth and the IIMR provider on a regular basis. In May of 2015, Way Station had a fidelity review by Case Western with follow up scheduled early in this next fiscal year.

Through the federal Mental Health Block Grant (MHBG), two initiatives have been implemented. BHA hired an Older Adult (OA) Policy 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. OA EBPs are currently being researched. Also funded by the MHBG are two new First Episode Programs (specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with psychotic disorders) which is a result of a required 5% set-aside of the MHBG funds. These programs are located in Baltimore City and

Montgomery County. The programs are fully staffed and have served 27 individuals in FY 2015.

Other changes in relation to Evidence-based Practice models are: Integrated Dual Disorder Treatment (IDDT) funding was repurposed by BHA to target service delivery through intermediate level (3.7) residential beds monitored by the BHA Office of Treatment and Recovery Services; and BHA opted to develop its own empirical model (instead of Transition to Independence Process [TIP]) to support transition-age youth fidelity assessment protocol. A tool kit and fidelity scale are in process.

Strategy Accomplishment:

This strategy was achieved.

(6-1B)

***MHBG**

In conjunction with the University of Maryland Systems Evaluation Center (UMD SEC), produce preliminary outcome data reports from the administration of the Assertive Community Treatment (ACT) protocol.

Indicators:

- Refinement of data collection and submission protocols
- ACT data analyzed by UMD SEC
- Data reports disseminated to the BHA and providers
- Strategies developed, findings incorporated into future planning

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services, Quality Management and Community Programs, and Epidemiology and Evaluation; BHSB; UMD EBPC; UMD SEC

Monitor: Steve Reeder, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

ACT Outcomes Project

The SEC continues to work with BHA and the Behavioral Health System Baltimore (BHSB); formerly Baltimore Mental Health Systems) to collect outcomes information for individuals receiving Assertive Community Treatment (ACT) services. During the current reporting period, SEC activities have included:

- Scheduling and facilitating meetings with the ACT Outcomes workgroup, as well as writing and distributing meeting notes.
- Reviewing data received from BHSB with outcomes data, working to match the files to obtain administrative information requested in the reports, and resolving matching problems as needed.
- Analyzing the data received, identifying data problems, and working with BHA and BHSB to develop solutions.
- Developing a Web-based data collection and reporting system to be used in future data collection. This system includes the data elements included in the statewide project as well as additional elements used by BHSB.

- The new system was demonstrated to BHA administrators and modifications made based on the feedback received.
- The new system was also demonstrated to ACT team administrative assistants, who have primary responsibility for entering the data. Their feedback and questions will be used to finalize the system and Reference Guide.

Strategy Accomplishment:

This strategy was achieved.

(6-1C)

MHBG

BHA's Office of Adult and Specialized Behavioral Health Services, in collaboration with the Core Service Agencies (CSAs), local detention centers, DHMH, Department of Public Safety and Correctional Services' (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 use disorders, who are incarcerated in local detention centers or prisons.

Indicators:

- Continue activities and supports of the Second Chance Grant to meet the goals of treating 75 individuals with co-occurring disorders transitioning from prison to the community
- When requested, 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 Behavior Health System Baltimore (BHSB), state facilities, and DPSCS to promote data sharing, such as DataLink, to assist with community re-entry
- Enhancement of the Maryland Community Criminal Justice Treatment Program (MCCJTP) to continue to effectively meet the aftercare needs of its participants

Involved Parties: BHA Offices of Adult and Specialized Behavioral Health Services and Forensic Services; CSAs/LAAs; ASO; DPSCS; local detention centers; MHAMD; DDA; Correct Care Solutions; community behavioral health providers

Monitor(s): Marian Bland and Darren McGregor, Office of Adult and Specialized Behavioral Health Services

FY 2015 activities and status as of 6/30/2015 (end-year report):

Second Chance

Maryland's Co-Occurring Disorders Release Program, or the "Second Chance Program, was established through a partnership between the Maryland Department of Public Safety and Corrections (DPSCS) and the Maryland Department of Health and Mental Hygiene (DHMH). The goal was to improve the behavioral health and criminal justice outcomes of individuals with co-occurring mental illness and substance use disorders being released from DPSCS. The Second Chance program was designed to serve approximately 75 male ex-offenders returning to Baltimore City. However, due to challenges with referrals the target enrollment of 75 was not met.

Thirty-eight were referred to the program, of those, five were not interested in participating, resulting in 32 individuals. Of the 32 participants who were eligible and interested in participating in the Second Chance Program, 28 were enrolled (two had disqualifying infractions and one experienced mental decompensation and was moved to an inpatient unit). The overall recidivism rate among the 28 participants living in the community was 18%. Participants were linked to healthcare services, received assistance with health care enrollment, and utilized an array of community behavioral health and recovery support services.

DataLink

DataLink, which gives detention centers access to share Public Behavioral Health System treatment information to expedite community re-entry, had been initially implemented in Baltimore City and Howard and Anne Arundel counties. In FY 2015 implementation was expanded to include Carroll, Frederick, St. Mary's and Wicomico counties. DataLink identified 20,635 individuals during the period of July 25, 2014 to July 29, 2015. Out of that number, 6,379 had multiple interactions with law enforcement. BHA and ValueOptions@Maryland provided technical assistance to participating jurisdictions and continued to outreach to jurisdictions that are not participating in the project. BHA will continue to co-chair the Mental Health and Criminal Justice Partnership's Datalink subcommittee.

Maryland Community Criminal Justice Treatment Program (MCCJTP)

In FY 2015, MCCJTP continued to provide funding to assist local detention centers with the provision of behavioral health services to their inmate population. Core Services Agencies have provided an outline of re-entry efforts at the request of the BHA Office of Adult and Specialized Behavioral Health Services. More than 6,000 MCCJTP program participants were served in the 22 counties per the quarterly reports submitted by the CSA. 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 re-entry in an effort to reduce recidivism.

Strategy Accomplishment:

Strategy was achieved

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

(6-2A)

MHBG

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

Indicators:

- Participate in the ASO review process
- Data shared to monitor performance and inform policy
- 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: BHA Offices of the Deputy Director of Operations, Local Planning and Management, Finance and Procurement and Epidemiology and Evaluation; BHA Management Committee; UMD SEC; ASO; Maryland Medicaid-Office of Health Services; CSAs; representatives of key stakeholder groups

Monitor: Daryl Plevy, Office of the Deputy Director of Operations

FY 2015 activities and status as of 6/30/2015 (end-year report):

Since the creation of the BHA on July 1, 2014, the Administration has continued to serve individuals of all ages with mental illnesses and substance-related disorders. The integrated Public Behavioral Health System (PBHS), administered by ValueOptions@Maryland, became active on January 1, 2015.

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 Behavioral Health System services including cost, number served, services provided, and types of diagnoses). Reports are used to inform decisions related to PBHS planning and operation. Analysis of utilization management practices is conducted to ensure that consumers are receiving timely access to the appropriate level of care.

In FY 1999, (first year of available data for mental health), 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 SMI and 72 percent met the criteria for SED. In FY 2015, the number of individuals with mental illnesses served through the fee-for service system has grown to 180,493. Of the total, 117,064 are adults (age 18+), sixty-five percent (64.9%), and 63,429, thirty-five percent (35.1%), are children and adolescents. Seventy-five percent (75%) of the children and adolescents served met the diagnostic criteria for SED and fifty-seven percent (57.26%) of the adults served met the diagnostic criteria for SMI. (Data as of July 31, 2015).

Strategy Accomplishment:

This strategy was achieved.

(6-2B)

Review and approve Core Service Agencies (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 planning guidelines for CSA Plans evaluated
- Letters of review and recommendation received from each LMHAC and CSA board
- Previous fiscal year annual reports received
- Letter of review sent to the CSAs

Involved Parties: BHA Offices of the Executive Director, Planning, CSA Liaison, and Finance and Procurement; Review Committee (includes representatives of all pertinent BHA offices); UMD SEC; CSAs; LMHACs; CSA advisory boards

Monitor: Cynthia Petion, Office of Planning

FY 2015 activities and status as of 6/30/2015 (end-year report):

Annually, an extensive plan development process takes place, beginning in January, with the submission to BHA of local mental health/behavioral health plans and budgets from the CSAs. The CSA Plan and Budget guidelines are developed through BHA's Office of Planning to guide the development of local plans that identify priorities, strengths, needs, and service gaps of the local public behavioral health system. In some years, in the past, plan submissions have been multi-year or an update of a previous multi-year plan. However, due to the DHMH Behavioral Health Integration process, CSAs were required, in FY 2015, to submit only a one-year plan for FY 2016 and an Annual Report for FY 2014. 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/behavioral health services. The CSAs' FY 2016 Mental/Behavioral Health Plan and Budget documents were reviewed, January through March, by a committee representative of BHA leadership.

To simplify data submissions, each CSA continued to include standardized data templates in its plan. This year, CSAs were requested to discuss the following ten state priority areas (based on BHA and federal Mental Health Block Grant requirements) and, where appropriate, to include them in the goal/strategy area of the plan:

- Recovery supports
- Public awareness and education
- Prevention and wellness (includes suicide prevention, tobacco/smoking cessation, etc.)
- Crisis response services/systems
- 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 (jails and hospitals)
- Outcomes/quality

In FY 2015, as a result of the behavioral Health integration process and the merger of the Mental Hygiene and the Alcohol and Drug Abuse administrations, three CSAs who have themselves merged with local substance-related services authorities and would have been responsible for submitting two plans (one as a CSA and one as a LAA) agreed to explore a combined CSA/LAA Plan that would contain all the elements required by both plans. Prior to the submissions, the Offices of Treatment and Recovery Services and Planning, and other clinical and leadership staff met with the counties to discuss informal guidelines that allowed each CSA/LAA to have flexibility in their submissions. Ultimately, Baltimore City and Carroll County, each submitted combined plans which were reviewed by all the above mentioned staff as well as the BHA Office of Treatment and Recovery Services.

Additionally, each CSA 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. All submitted CSA Plans were found to be in compliance with BHA's Guidelines Regarding Fiscal Year 2016 Plans/Budgets. Letters of review/approval were sent at the end of FY 2015.

Strategy Accomplishment:

This strategy was achieved.

(6-2C)

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

Indicators:

- 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 administrative duties and expenditures, the execution of subvendors' contracts, year-to-date expenditures/performance measures, and any required audits
- Evaluation of compliance with performance measures contained in the MHA/CSA MOU Conditions of Award for State General Funds and Federal Mental Health Block Grant funds
- Three reviews scheduled during 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: BHA Office of Local Planning and Management; appropriate BHA Office Directors; BHA staff; CSAs

Monitor(s): John Newman and Richard Blackwell, Office of Local Planning and Management

FY 2015 activities and status as of 6/30/2015 (end-year report):

The BHA Office of CSA Liaison completed three quarterly monitoring exercises that occurred during the first, second, and fourth quarters, conducted through conference calls, for all 19 CSAs in compliance with the MOU for FY 2015. (The third quarter monitoring process consisted of the BHA review of CSA Program Plans, Annual Reports, and Budgets.) Quarterly monitoring for each CSA's administrative oversight and for its sub-vendors included: the review of sub-vendors' contracts; review of use of funding from state general funds, MHBG, deposited DHMH funds, and consumer support; audit reviews; budget reports; assessments of training efforts and response readiness; and assessment of participation/implementation of programs such as crisis services and Maryland's Commitment to Veterans.

The FY 2015 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 BHA/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.

The BHA Office of Local Planning and Management 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 with copies available for review in the Office of Local Planning and Management.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.3. In collaboration with CSAs, state facilities, the administrative services organization (ASO), other state agencies, and key stakeholders, 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:

- Finalize the development and dissemination of training materials, including a statistical workbook, related to OMS data analysis and interpretation; continued consultation with CSAs and providers on use of the training materials
- Continue collaboration with the ASO regarding how OMS monitoring utilization and questionnaire completion rates can be coordinated with other quality project initiatives
- Continue collaboration with the ASO regarding OMS Datamart monitoring and maintenance, including monthly data validation and quarterly OMS Datamart refreshes
- Develop and implement revisions to the OMS to coincide with a new ASO contract and include any additional items needed as a result of the behavioral health integration

Involved Parties: BHA Offices of the Executive Director and Epidemiology and Evaluation; BHA consultant; BHA Management Committee; ASO; CSAs; UMD SEC; CBH; providers; consumer, family, and advocacy groups

Monitor: Sharon Ohlhaber, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

In collaboration with the UMD SEC, several OMS training material documents were finalized and posted to the OMS section of the ASO Web site. The material included several narrative documents (*Introduction to Data and Data Analysis*, *Using your OMS Data*, and *Determining Statistical Significance for OMS Data*); as well as four Excel statistical workbooks, allowing the user to analyze item-level OMS data.

As part of the 2015 ASO contract implementation, there were also several activities related to modifying the existing OMS questionnaires and adding OMS to the authorization request workflow of substance-related disorders (SRD) Level 1 Outpatient Treatment providers. Among the modifications to the questionnaires were additional items emphasizing recovery, as well as more detail on tobacco products. The implementation of the OMS questionnaire modifications for the SRD Level 1 treatment providers occurred in January 2015, coinciding with the 2015 ASO contract initiation.

The questionnaire modifications with the mental health (MH) outpatient treatment providers were implemented just prior, in mid-December 2014. A number of documents were updated/developed in preparation for the 2015 changes, including all the OMS questionnaires, a conversion grid to assist MH providers with the transition between the current and modified questionnaires, and the *OMS Interview Guide*.

Finally, ongoing monthly OMS update meetings (including BHA, UMD SEC, and ASO staff) were held to plan for the significant changes that will need to be made to the OMS Datamart. These included the actual programming enhancements that will be needed to incorporate the OMS data collected by SRD providers; as well as the numerous changes required for the OMS displays themselves. Once completed, the user will be able to make several new filter selections, including additional population selections and length of time in treatment.

Strategy Accomplishment:

This strategy was achieved.

(6-3B)

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 system of telemedicine expansion

Involved Parties: BHA Offices of the Deputy Director of Operations and Epidemiology and Evaluation; CSAs; ASO

Monitor: Susan Bradley, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

As of FY 2015, fourteen 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 2015, 6,720 telemental health claims were submitted, 1,359 unduplicated consumers were served with expenditures of \$432,014. In FY 2014, 6,190 telemental health claims were submitted, 1,163 unduplicated consumers were served with expenditures of \$356,516. Although providers have up to 12 months from date of service in which to submit a claim for payment, data for FY 2015 shows a 17% increase in the number of individuals served utilizing telemental health services.

The CSAs/LAAs continue to promote the development of a provider network in their jurisdictions. The telemental health strategy of the StateStat is a part of the Departmental StateStat measures and reported on quarterly in FY 2015.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.4. In collaboration with CSAs, the ASO, and key stakeholders, 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
- Implement Web-based data collection system for reporting residential rehabilitation program (RRP) bed counts and waiting list information

Involved Parties: BHA Offices of the Executive Director, Epidemiology and Evaluation, and Planning; UMD SEC; CSAs; ASO

Monitor: Susan Bradley, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

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

All technical aspects of the OMS have been resolved. Change-Over-Time and Point-in-Time data are available via datamart for CSA and providers. Generation three of the OMS is set for a September 2015 launch.

Monthly CSA/BHA/ASO Data Committee calls are being conducted to inform all CSAs about data initiatives, updates and progress. The Committee promotes the use of available data and reports to all CSAs for policy and planning purposes. These calls are also a forum for CSAs to troubleshoot data reports and questions.

Data such as the Veteran's reports, Inpatient Data Sheet, Quarterly Reports, etc., continued to be released to all Maryland Association of Core Service Agencies (MACSA)/CSA representatives. New reports were developed and released to providers regarding MA eligibility. Also, a Maryland's Commitment to Veterans (MCV) contact report has been created.

Quarterly Reports as well as State Psychiatric Monthly Statistical reports, Readmission reports and average length of stay (ALOS) reports, are listed on the DHMH Web site for public consumption.

Data Shorts, a BHA project in collaboration with the University of Maryland, Systems Evaluation Center (UMD SEC), provides concise behavioral health data and analysis that can be used by various stakeholders. Various topics are presented throughout the year. During FY 2015, nine Data Shorts were disseminated via email, BHA Web site, and Twitter feed.

A Web-based residential rehabilitation program (RRP) bed availability database has been launched and data has been collected for FY 2015. All but four CSAs are in compliance. In the fall of 2015, CSAs and LAAs will have access to substance-related disorders data for the PBHS through ValueOptions@Maryland's IntelligenceConnect and will be able to generate reports from the information.

Strategy Accomplishment:

This strategy was achieved.

(6-4B)

Maintain accreditation of state psychiatric facilities by the Joint Commission.

Indicator:

- All state psychiatric facilities accredited

Involved Parties: BHA Offices of the Executive Director, the Deputy Director for Behavioral Health Facilities, and the Deputy Director of Clinical Services; BHA Management Committee; state psychiatric facility CEOs; appropriate facility staff

Monitor: Mary Sheperd, Office of the Deputy Director for Behavioral Health Facilities

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 BHA facilities have maintained their Joint Commission accreditation status.

A Focused Standards Assessment (FSA), a [tool that allows organizations to focus their self-assessment on a minimum subset of risk-related standards rather than all standards as required by the former full periodic review] was completed by May 2015 and licenses were renewed by OHCQ.

Health and Safety Management Teams continue to operate as the result of 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 BHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, produce 45 micro-blogs pertaining to mental health efforts and information
- Promote @DHMH_BHA Twitter account and increase percentage of “Followers” by 25% 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: BHA Offices of the Executive Director, and Epidemiology and Evaluation

Monitor: Susan Bradley, Office of Epidemiology and Evaluation

FY 2015 activities and status as of 6/30/2015 (end-year report):

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

Since July 1, 2014, the @DHMH_BHA Twitter account has posted 41 tweets or micro-blogs pertaining to behavioral health issues on the local and national level. The account is currently “following” 180 other Twitter accounts relating to governmental, public health and behavioral health issues. The @DHMH_BHA Twitter feed is followed by 845 unduplicated accounts, all of which by virtue of their accounts disseminate the information tweeted to their resources. This is a 58% increase so far in FY 2015 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 is sent to the @DHMH_BHA account and is submitted via StateStat. As new technology emerges, BHA will continue to explore alternative social media outlets that are geared more towards a “tween or teen” population.

Strategy Accomplishment:

This strategy was achieved.

Appendix A

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.