Maryland

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 04/04/2016 1.41.46 PM)

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 135218621

Expiration Date

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

Agency Name Department of Health and Mental Hygiene

Organizational Unit Behavioral Health Administration

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

City Catonsville

Zip Code 21228

II. Contact Person for the Grantee of the Block Grant

First Name Albert

Last Name Zachik

Agency Name Behavioral Health Administration-Department of Health and Mental Hygiene

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

City Catonsville

Zip Code 21228

Telephone 410-402-8452

Fax 410-402-8441

Email Address Albert.Zachik@maryland.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/1/2015 2:32:16 PM

Revision Date 4/4/2016 1:40:55 PM

V. Contact Person Responsible for Application Submission

First Name Cynthia

Last Name Petion

Telephone 410-402-8468

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Footnotes:

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
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Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Van T. Mitchell

Signature of CEO or Designee[1]: _____

Title: Secretary, Department of Health and Mental Hygiene

Date Signed: _____

mm/dd/yyyy

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

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Fiscal Year 2016

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Name of Chief Executive Officer (CEO) or Designee: Van T. Mitchell _____

Signature of CEO or Designee[1]: _____

Title: Secretary, Department of Health and Mental
Hygiene _____   Date Signed: _____8/20/15_____

mm/dd/yyyy

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

Footnotes:

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

LARRY HOGAN
GOVERNOR

July 1, 2015

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

Dear Grant Management Officers:

Several federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. In order to expedite the processing of federal grants, on my behalf, I designate the Secretary of Maryland's Department of Health and Mental Hygiene (DHMH), Van T. Mitchell to make future assurances, sign applications and agreements, and perform any similar act relevant to the Department of Health and Mental Hygiene.

Sincerely,

Larry Hogan
Governor

Cc: Van Mitchell, DHMH

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	Van T. Mitchell
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature: _____ Date: _____

Footnotes:

State Information

Disclosure of Lobbying Activities

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Standard Form LLL (click here)

Name	Van T. Mitchell
Title	Secretary
Organization	Department of Health and Mental Hygiene

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

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

Footnotes:

EXECUTIVE SUMMARY

In July 2014, through the passage of House Bill 1510 during the 2014 legislative session, Maryland's Mental Hygiene Administration merged with the Alcohol and Drug Abuse Administration to form the Behavioral Health Administration. (BHA). The BHA is responsible for all publically funded specialty mental health and substance related disorder (SRD) services. Maryland is providing separate applications for the FY 2016-2017 Mental Health Block Grant and Substance Abuse Block. However, the two applications represent information that reflect a new integrated public behavioral health system that support quality, integrated and coordination of care for individuals with mental health and substance related disorders, improve data collection, and promote a recovery oriented system. There are also common areas in which the applications for the MHBG and SABG provide joint responses.

The process to integrate services for mental health and substance use disorders emerged from a three phase, stakeholder-driven process that commenced in 2011. On September 3, 2014, Value Options, an Administrative Services Organization (ASO), was awarded a new performance-based contract for the carve-out for mental health and substance use services. Enacted through state legislation, the Maryland DHMH, Medicaid (MA) Office of Health Services and the Behavioral Health Administration (BHA) implemented a new integrated public behavioral health system (PBHS) effective January 1, 2015. The MA Office and the BHA oversee and have the authority over the PBHS, which includes policy development, state-wide planning, resource allocation, and continuous quality improvement. VO will assist with the management of the PBHS.

Additionally, the Advisory Councils for mental health disorders, the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council (Joint Council) and substance related disorders, the State Drug and Alcohol Abuse Council (SDAAC), have combined meetings and worked collaboratively to draft legislation to create one Council for the Behavioral Health Administration. Effective October 1, 2015, in accordance with state legislation, the Behavioral Health Advisory Council will be implemented.

Behavioral Health Assessment and Plan

B. Planning Steps

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

Overview of the State's Current Behavioral Health System:
The Behavioral Health Administration (BHA) is the division of the State of Maryland Department of Health and Mental Hygiene (DHMH) that is responsible for overseeing the delivery of public behavioral health services (PBHS). In general, Maryland currently provides or funds public behavioral health services in two ways, directly through its State psychiatric hospital system and by funding its managed fee-for-service system. As of July 1, 2014, the Mental Hygiene Administration (MHA) merged with the Alcohol and Drug Abuse Administration (ADAA) into one Behavioral Health Administration (BHA). Maryland's Medicaid, Office of Health Services, manages the Medicaid (MA) program. Funding for MA services for behavioral health was moved from the BHA budget to Medicaid, Health Care Financing (HCF), which created a specialized unit for behavioral health services for individuals funded by Medicaid. BHA handles clinical and systemic issues, whereas, HCF is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan.

BHA and HCF worked collaboratively to design integration of mental health and substance use services. In partnership with BHA, HCF's Medicaid Office of Health Services contracts with the ValueOptions, Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback. Hospital Detox, Outpatient, and Intensive Outpatient Program (IOP) Substance Use services managed through the ADAA moved from a managed care "carve in" to a managed fee-for-service "carve out" service system. When this change occurred in the mental health system in 1997, the locus of outpatient services generally moved from local health departments to private sector vendors. Most local health departments currently provide outpatient and IOP SRD services, and it is possible that a similar shift will occur in the provider community.

Maryland provides inpatient psychiatric services directly to it citizens through a network of five psychiatric hospitals, one of which is a forensic facility, and two regional institutes for children and adolescents, or State operated Psychiatric Residential Treatment Facility (PTRF). This is the only area in which Maryland operates services directly. These facilities served approximately two thousand individuals in FY 2015. Upon admission, these may be individuals who were or were not eligible for Medical Assistance (MA). Generally, if an individual has MA eligibility, every effort will be made to provide hospital care in a community based inpatient setting, either in the psychiatric sector of an acute general hospital or in a private psychiatric hospital. Some of these individuals will also participate in the fee-for-service system during the same year in which they have a stay in a State facility; others either remain in the facility for the entire year or elect not to access public care when not in the hospital.

The majority of community PBHS services are funded through a managed fee-for-service system. Both services that are eligible for MA reimbursement and services that are not eligible for MA (e.g., residential rehabilitation services, level III SRD services, and some supported employment services) are funded through this mechanism. Further, services are funded both for individuals who are eligible for MA and individuals who are not eligible for MA. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. This system serves over 220,000 people annually through a network of over 3,500 individual, group, agency, and institutional service providers.

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

Strengths and Needs
As stated in more detail in the Quality and Data Collection Readiness section, the BHA uses several sources of data to identify unmet service needs and gaps. The primary PBHS data system is currently managed by an Administrative Services Organization (ASO). The ASO data

systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on a July-June fiscal year. Over 50 standard reports are generated to assist in general planning, policy, and decision making.

Maryland service system has been strengthen by Health Care Reform and Behavioral Health. The implementation of ACA improved access to care for individuals with behavioral health needs. In 2014, provisions of the ACA allowed Maryland to expand Medicaid eligibility to most individuals under 138% of the federal poverty level (FPL), and these individuals have qualified for Medicaid's behavioral health benefits. Additionally, Maryland's state – operated health benefit exchange requires all participating health plans to cover the ACA's "essential health benefits" include behavioral health services. There is a continued need for grant funded services such as housing, education, employment and other non-Medicaid eligible recovery services.

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

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

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

enhanced efforts for stakeholders to have input in the identification of the systems strengths and needs.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

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

The identification and assessment of systems' strengths, needs and existing resources has been implemented through past and current efforts. This includes an Inventory of Resources and a Needs Assessment initiative through Maryland's Mental Health Transformation State Incentive Grant (MHT-SIG), and State and local planning activities that included broader representation of stakeholders from mental health and substance related disorders communities.

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

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

Workforce Issues

Maryland continues efforts to address the gap and the difficulty in accessing behavioral health services.   Factors contributing to this gap include a lack of trained specialists, workforce shortages, particularly in rural settings, and/or provider capacity issues. Through technology rural counties have benefited from telemedicine or telemental health services. Maryland implemented the telemental health policy with the goal of increasing access to health care rural areas such as Garrett, Allegany and Somerset counties. The former administration for substance related disorders (ADAA), now the BHA, implemented an initiative to promote the use of virtual technology as another tool to access services and reduce service gaps, called the AVATAR Virtual Counseling Project. This is a use of tested software application to allow individuals in outpatient services to access care in real time, using an internet based virtual reality gaming application.

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

University of Maryland and Johns Hopkins. Mental health topics covered include screening, resource and referral, and diagnosis and treatment;

2. Continuing education opportunities for PCPs and their staff to develop and enhance mental health knowledge and skills;
3. Assistance with local referral and resources to link families to mental health services in their community.
4. In partnership with Salisbury University Department of Social Work, Co-location of graduate level social work students in primary care practices to provide on-site mental health consultation.

The BHA will continue to train the behavioral health workforce as needed to ensure that each has the capability to offer a set of evidence-based treatment interventions, including Person-Centered Care Planning (PCCP), Trauma Informed Care (TIC), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) and cultural competence training regarding military/veterans, LGBTQ and youth. In addition to a trained workforce, there is a need for more cultural competency efforts.

Care Coordination

In the current system, while all Maryland jurisdictions have some mental health case management services for adults and children, there is a need to expand and improve integration of formal case management and care coordination for people with both mental illnesses and SUDs. Planning efforts are underway to further care coordination to ensure these case management services leverage formal partnerships with medical care and social services resources in Maryland. Beyond traditional 'professional' case management, peer and family support services will be partners in the expansion of these coordination services. The unique perspective of those with lived experience will be essential not only in furthering care coordination, but also in expanding outreach and engagement services. Maryland has experience in using peers to meet with clients who present in EDs or are admitted to inpatient detox as a result of an overdose. The peers work to engage the clients in SUD treatment, especially opioid replacement therapy, which enhances both initial engagement and ongoing participation in therapy.

Through planning activities, recommendations have been identified to improve peer and family support. The FY 2016 State Behavioral Health Plan has strategies that foster efforts and develop initiatives to improve the quality of peer and family support by using the expertise developed in Maryland's Statewide Consumer organization On Our Own (OOO) of Maryland and the statewide family network, the Maryland Coalition of Families for Children's Behavioral Health (MCF). These organizations lead a successful joint project that provides outreach, support, and leadership for young adults in the transition period between the adult and adolescent service sectors. Their shared roles and responsibilities on this project are unique nationally for their collaborative impact. These organizations provide peer and family support statewide and have the capacity to work with behavioral health providers to provide technical assistance and training on innovative approaches in the provision of peer and caregiver support, diversifying and supporting a peer workforce, and conducting outreach to local

affiliates. In addition, they have strong network capacity for cultural competence and provide specialized support for LGBTQ groups and individuals.

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

- Enriched linkages between the correctional behavioral health care system and the community-based system: Maryland currently operates a "data link" program with many local jails and state correctional facilities. Our ASO receives a daily feed of individuals arrested on the previous day from the Department of Public Safety and Correctional Services. The ASO provides a data feed to clinical staff of the local detention center or state correctional facility if the individual is in mental health treatment and/or on psychiatric medication. The mental health service provider is also notified by the CSA, the local mental health authority, of a client's arrest when possible and appropriate. This effort will be expanded to include SUD data once the necessary consents are built into the VO system.

- Improved crisis support services and a more substantial crisis follow-up service: While the mental health block grant supports crisis response and intervention systems two (2) counties and Baltimore City, which has two systems, one for children and adolescents and another for adults, much of the rest of the state has more limited resources. Almost every county has established crisis intervention teams, though they are not necessarily all available 24/7. Additionally, nearly all counties offer short term, state-funded crisis respite beds as both an alternative to, and a step-down from, psychiatric inpatient services. Every county already has access to a 24/7 behavioral health crisis hotline and emergency department psychiatric services. Crisis services continue to be priority as well as intervention, and follow-up stabilization services that utilize peer and family support.

- More robust outreach and engagement of difficult to reach and difficult to engage populations: expansions and enhancements of care coordination will enable Maryland's service system to more effectively reach out to individuals and families who have either not engaged with the system or are utilizing only emergency room services. By expanding the availability of care coordinators and peers of all ages who can follow-up after hospitalizations, detentions, and out-of-home placements, we will improve connection and engagement with the behavioral health service system. DHMH will also train behavioral health clinicians and care coordinators in techniques known to facilitate client engagement for particularly difficult to reach populations (e.g. young adults) and to encourage ongoing fully engaged participation in treatment and support services.

Cultural Competency
Established over 20 years ago, Maryland's Cultural Competence Advisory Committee worked with researchers to develop a consumer cultural competence tool and committee members have trained many Maryland providers. The cultural competence effort will be expanded into in concert with the training provided by our statewide consumer and family organizations. Each CCBHC will be evaluated through the lens of the specific identified needs of ethnic and cultural minorities within their service communities and a site-specific plan will be developed.

The BHA continued efforts to improve progress toward cultural competence through the development and implementation of the Cultural and Linguistic Competence Training and Consultation Project (CLC-TC) that was supported by Maryland's Mental Health Transformation State Incentive Grant (MHT-SIG), funded by SAMHSA. The goal and outcomes of the CLC-TC Project was to provide training and consultation to several adult Psychiatric Rehabilitation Programs (PRPs) to promote program changes that would increase cultural competency of the program and its recovery-orientation.

As a result of the CLC training/consultation, PRP providers gained an understanding and awareness of the role culture plays in treatment process and service provision. Organizational self-assessment of cultural competence were implemented as well as efforts to improve workforce and staff development, such as bilingual staff and interpreter services arranged. The lessons learned from this initiative further supported the Administration's commitment to identifying next steps in promoting cultural competence throughout services in the Public Behavioral Health System. State and local planning processes include strategies that foster training, assessments, and education. Each core service agency include in annual plans jurisdictional demographic information to reflect racial/ethnic composition and progress on strategies that address cultural competence and behavioral health disparities.

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

Maryland's Commitment to Veterans (MCV)
The Department continues to prioritize efforts to address the behavioral health needs of veterans and their families. Maryland's Commitment to Veterans is a program under BHA that collaborates with the VA Maryland Health Care System, Maryland Department of Veterans Affairs as well as other state agencies and community providers. MCV assists veterans and their families with coordinating behavioral health services for the veteran, including mental health and substance abuse services- either with the VA or BHA. MCV also facilitates and covers transportation costs to behavioral health appointments for veterans and provides information and referrals related to employment, education, housing, and VA benefits. All MCV Regional Resource Coordinators are also Mental Health First Aid instructors. Maryland's Commitment to Veterans (MCV) is linking BHA Peer Support to VA Maryland Health Care Peers. Intent is to have peer training and collaboration among BHA peers in the community and VA peers working inside VA medical center. MCV Director, served as Maryland Delegation lead for SAMHSA's Service Member, Veterans and their Families (SMVF), SUD Virtual Implementation Academy May 20-21 2015. As part of the follow on working with SAMHSA SMVF TA Center to develop military cultural competency training for BHA peer supports – this would be a first for the state of Maryland.

MCV is assisting VA Maryland Health Care with getting the word out about the VA's Veterans Choice program. MCV is educating community providers on the program and encouraging them to become a Veterans Choice provider by registering with Health Net. The more community providers that register with Health Net, the more choice veterans will have to access care directly in their community instead of going to a VA Medical Center or VA Community Based Outpatient Clinic.

Maryland is home to nearly 430, 000 veterans. Roughly half of that those veterans are enrolled in VA health care and of those, half actively seek treatment at a VA medical facility. This means a majority of Maryland's veterans are seeking treatment through their local provider. Military culture is unique and by screening for veteran status is critical.

Since October 2008 (program inception) through June 2014 6,971 veterans and their families have worked with MCV.

- FY 2014 had a program record – 1,401 calls from veterans, families, VA, community providers.74% of callers to MCV were veterans. MCV RRCs met 2,859 needs for 1,161 individuals – 2 needs per caller
- 113% increase linking veterans to DHMH behavioral health services 109 FY 2013 / 234 FY 2014
- 114% increase in linking veterans to VA behavioral health services 341 FY 2013 /792 FY 2014
- 132% increase in providing transportation to behavioral health appoints 341 FY 2013 /792 FY 2014
- Top FY 2014 caller needs: 33% housing, 22% behavioral health and financial assistance, 19% medical, 18% VA Benefit Claims

Military Cultural Competency Training:
In spring of 2012, DHMH signed a MOU with UMD School of Public Health to provide training. That fall nearly 3,300 behavioral health and primary care providers completed an online needs assessment survey. Found majority of community providers do not have experience working with veterans and nearly half do not screen for veteran status.
Based on needs assessment responses developed five training programs throughout the state with a total attendance of more than 1,000 Maryland behavioral health and primary care providers.

Services to the Homeless - Project for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care funds will be used to continue to meet the needs of homeless individuals and those coming from detention centers. This year, BHA will continue to work with courts, detention centers, public safety, and correctional services to better address the mental health needs of individuals entering or exiting these systems, as well as the needs of individuals in MHA facilities who are court-involved and ready for discharge.
Recovery is a goal for every individual. PATH services are essential in assisting individuals with accessing recovery support.   PATH providers often serve as advocates that assist individuals with navigating supports to assist in their recovery. PATH services link individuals to behavioral health treatment and recovery supports , transitional housing, and permanent housing through

bridge subsidies, the Continuum of Care Program (formerly called Shelter Plus Care Housing), and supportive housing. Additionally, PATH providers link individuals to local Wellness and Recovery Centers, which are consumer run behavioral health and recovery drop-in centers, and to Supported Employment Programs.

Systemic and clinical issues barring individuals who are homeless who have a mental illness or co-occurring substance related disorders from accessing recovery support are discussed during quarterly PATH meetings. These issues are brought to the attention of the Deputy Director, Clinical Services Division by the State PATH Contact. Additionally, the Deputy Director works collaboratively with BHA's Offices of Consumer Affairs, Adult Services, and Child and Adolescence to address barriers facing individuals identified as special populations. In April 2015, BHA submitted a CABHI grant application to support access to recovery. The proposed program is called the Maryland Collaboration for Homeless Enhancement Services (CHES). It's designed to increase capacity of both the permanent housing and service treatment systems. This program will provide coordinated and integrated evidenced-based treatments to individuals with mental and/or substance related disorder who are experiencing homelessness or chronic homelessness including veterans. We are awaiting for SAMHSA's approval of the grant application.

Priority is given to those PATH providers who provide street outreach and case management services. Many of the providers provide outreach to the most vulnerable adults who are literally and chronically homeless. BHA projects 1,921 individuals will be enrolled in PATH in FFY 2015 of which 1,875 will be literally homeless. Also, BHA projects 4,375 persons will be contacted by Maryland's PATH providers.   To better educate the public, PATH funded outreach workers conduct forums about PATH services, as well as distribute pamphlets in libraries, hospitals and to individuals in the community. Outreach and in-reach services are also provided in the streets, in shelters, and in local detentions to those adults who are most vulnerable. Case management services are combined with outreach efforts and include linkages to supported employment, community and behavioral health services, permanent housing, public entitlements which includes a portion of the efforts being dedicated to SSI/SSDI Outreach, Access and Recovery (SOAR).

Planning Steps

Quality and Data Collection Readiness

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

Maryland's Public Behavioral Health Data Collection/Reporting System

Maryland's primary public behavioral health system (PBHS) data system is currently managed by an Administrative Services Organization (ASO). In September 2014, ValueOptions Inc. was selected to continue their contract as the ASO for the PBHS. Prior to the merger of the administrations for mental health and substance related disorders (MH and SRD), the ASO historically gathered all mental health client level data (MH CLD). The implementation of a combined MH/SRD data system went live January 1, 2015. The ASO collects required data for all SRD services, whether or not it manages or reimburses those services. All required mental health and substance related disorders Treatment Episode Data Set (TEDS) data elements are built into ValueOptions (VO). Data will be collected and reported according to grant requirements. Currently, Maryland feels that its reporting system is sufficiently robust, but we are seeking ways to encourage discharge reporting, especially in light of the system changes and the TEDS requirements.

The data system collects information on those who receive services in the PBHS. The majority of community PBHS services are funded through a managed fee-for-service system. Both services that are eligible for MA reimbursement and services that are not eligible for MA (e.g., residential rehabilitation services, level III SRD services, and some supported employment services) are funded through this mechanism.   Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS.   This system serves over 220,000 people annually through a network of over 3,500 individual, group, agency, and institutional service providers.

The system is driven by a combination of authorizations and claims for behavioral health services. Inherent in the implementation of the PBHS is a series of extremely comprehensive data sets. Data sets on clients' service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files. Expenditures for services funded by this managed fee-for-service system represent nearly 92% of the BHA community services budget when it is adjusted for administrative costs. Administrative costs include the cost to operate the BHA, the cost of the ASO, and the cost of local administration. Data that is maintained on the consumers using these services are extracted from enrollment, claims, authorization, and Outcomes Measurement System (OMS) data systems.

The OMS for the public mental health system has been operational since September 2006. Under the newly established Behavioral Health Administration (BHA), the OMS was expanded beginning January 1, 2015 to include recipients of Level 1 outpatient Substance-Related

Disorder (SRD) services. The OMS is a very rich source of outcome data that can be viewed using OMS Datamart at http://maryland.valueoptions.com/servcies/OMS_Welcome.html

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

- service authorizations and referrals;
- services utilized by level of care and service;
- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Currently over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Currently, access to the PBHS data is monitored by the ASO/BHA. Based on content and appropriateness, these are available to BHA administrators, to administrators of local systems known as Core Service Agencies (CSA), to providers, and in near future to Local Addiction Authorities (LAA). Requests for access must be submitted to the BHA along with signed and approved data user agreements. There are set licenses for administrative executive level staff as well as for over 20 Core Service Agencies (CSA)-county specific behavioral health entities who, in collaboration with BHA, develop and manage a coordinated network of Maryland public behavioral health services. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC) where a parallel data repository is maintained. The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts. SEC staff aid in the reporting capabilities of the BHA. In addition to the processed data, BHA personnel have access to all of the person/claims level data from the ASO data warehouse. Access to the PBHS ASO data reporting platform is disabled after 45 days of inactivity. Password reset protocol is implemented every 90 days. Staff utilizing the PBHS data reporting platform are trained either by the ASO or BHA MIS staff. A user guide is provided, and policies are outlined in the data use agreement. Periodically, information regarding HIPAA policies and Protected Health Information (PHI) are distributed to all licensees.

Implemented in July 2007, a system enhancement was made that facilitated coordination of medication services between somatic and psychiatric prescribers. Information on Medicaid (MA) drug prescriptions filled by consumers in the PBHS are available through the ASO. A Medicaid prescriber can now find the recent medication history of an individual whom he or she is treating. These prescriptions are for all medications other than HIV medications

regardless of prescriber. This information is accessible to providers of behavioral health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy data is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this module has enhanced service quality and provided a rich resource to enhance data analysis efforts.

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

BHA is currently receiving grants through SAMHSA/Synectics to help support Behavioral Health Services Information System (BHSIS) related activities**.** The required Basic and Developmental Tables will be submitted in December 2015 along with a Client Level Data (CLD) file that will contain client specific data for all served in the PBHS and State Psychiatric facilities in FY 2015. The BHA will continue to submit quarterly all TEDS required files. A few tables required are NOMs- based data tables. All tables will be submitted this year, including developmental tables. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS), all of which are within the ASO system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Perception of Care Survey for many National Outcome Measures (NOMs).

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

Data from state-operated inpatient facilities are obtained from a Hospital Management Information System (HMIS) implemented in 1986. The HMIS system tracks all admissions and discharges in and out of the state facilities. There are various modules that capture basic demographic and diagnosis data, as well as federally mandated National Outcome Measures (NOMs). Access to HMIS is granted at the facility level, as well as limited access by BHA. HMIS is monitored and maintained by DHMH-Office of Information Technology (OIT). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS), NOMs and CLD reporting. While this

system does not use the same consumer identifiers at the ASO data system, there are elements common to both which BHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. Data is used at the Executive, facility, and CSA level to track facility usage, forensic population, and length of stay. Data is designed to be used to complete ad hoc requests.

In addition to the ASO, BHA contracts with the Systems Evaluation Center (SEC), a component of the Behavioral Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Psychiatric Services Research to assist with evaluation and data infrastructure activities. As BHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. In this coming year the SEC will continue to collaborate with BHA and key stakeholders to identify areas of interest related to the PBHS that could be analyzed using multiple databases. These databases include claims, authorization, consumer perception of care survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

Like other states, Maryland does not collect any of the data that would be required to report the proposed draft measures exactly as defined. There are cases in which data that responds to a part of the measure is collected. The proposed measures that require not only client identification, but also whether some action was taken for identified clients, and, in some cases, the outcomes of the action, are particularly problematic. These are generally items extracted from HMOs/MCOs electronic health records on a sample basis by an external quality review organization (EQRO). To expect states to be able to report such elements on its entire client population is very unrealistic and is unlikely to be workable at any time in the near future.

The proposed measures for which Maryland has a similar data item, but usually with a differing timeframe, include individuals smoking cigarettes (without an indication as to whether an intervention was performed), teens screened for ANY alcohol use (CRAFFT screening item), prescription drug/marijuana misuse (as collected and reported currently through TEDS), employment status of all clients, arrests in the past six months, homelessness in the past six months, and current living situation (which can be compared to status at last authorization in the episode of care).

There are multiple barriers to collecting these data elements as proposed. Most would require providers that are operating on very limited budgets either to acquire or to expand an electronic health record; it is unlikely that individual and/or group practitioners would be able to afford the required software with needed modifications. Requiring reporting on all of these data elements would discourage current providers from continuing in service and prospective providers from entering the public behavioral healthcare sector. The time required to collect many of the elements and perform the required interventions and the relatively strict

requirements for specific interventions would interfere with the therapeutic process. The expense involved in adjusting provider, state, and national data systems would be extraordinary and untenable; for the behavioral health system, it is estimated that implementation would cost more than the total value of the mental health block grant. Additionally, these data elements largely ignore the collaborative work that has done over the last thirty years between SAMHSA and the states in deriving meaningful behavioral health outcome indicators. Finally, data collection on everyone in treatment using public funds does not address the population actually treated by block grant funding. Services funded by the block grants are most often those that do not lend themselves to individual data collection and reporting and for services that require a certain amount of anonymity or that occur in a climate that is not conducive to data collection processes, such as peer support/WRAP services and mobile crisis intervention services.

Additionally, Data Shorts, a new project released by the BHA in collaboration with the SEC, provide concise behavioral health data and analysis that can be used by the various stakeholders. The aim of Data Shorts is to provide the reader with data related to behavioral health efforts scheduled throughout the fiscal year. Issues include data on suicide, smoking, legal matters, Medicaid Expansion, substance use, and consumer perception of care and wellness. Distribution of the Data Shorts is available via the MHA and Department's Website, and Tweeter account. http://bha.dhmh.maryland.gov/

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

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

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

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by *31,000. This average loss is approximately 6,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 5% each year (117,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

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

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

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

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

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

County	Under 18 Population	Low Prevalence 6%	High Prevalence 12%
Allegany	16,396	984	1,968
Anne Arundel	138,424	8,305	16,611
Baltimore County	199,550	11,973	23,946
Calvert	24,995	1,500	2,999
Caroline	8,930	536	1,072
Carroll	44,493	2,670	5,339
Cecil	27,411	1,645	3,289
Charles	42,461	2,548	5,095
Dorchester	7,715	463	926
Frederick	64,805	3,888	7,777
Garrett	7,243	435	869
Harford	65,182	3,911	7,822
Howard	81,267	4,876	9,752
Kent	4,367	262	524
Montgomery	256,535	15,392	30,784
Prince George's	234,640	14,078	28,157
Queen Anne's	12,293	738	1,475
St. Mary's	30,799	1,848	3,696
Somerset	6,016	361	722
Talbot	7,999	480	960
Washington	36,823	2,209	4,419
Wicomico	26,544	1,593	3,185
Worcester	10,249	615	1,230
Baltimore City	153,545	9,213	18,425
Statewide Total	**1,508,682**	**90,521**	**181,042**

Source: Census 2010 Modified Race data (MR(31)-CO.txt) prepared by the U.S. Census Bureau, May 2012.

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

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

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

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

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

Priority population includes:

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

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

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

County	Over 18 Population	Prevalence 5.4%
Allegany	58,296	3,148
Anne Arundel	405,979	21,923
Baltimore County	610,391	32,961
Calvert	64,261	3,470
Caroline	24,055	1,299
Carroll	122,795	6,631
Cecil	74,283	4,011
Charles	106,669	5,760
Dorchester	24,925	1,346
Frederick	171,940	9,285
Garrett	22,808	1,232
Harford	181,307	9,791
Howard	211,875	11,441
Kent	15,837	855
Montgomery	733,259	39,596
Prince George's	636,593	34,376
Queen Anne's	36,061	1,947
St. Mary's	76,685	4,141
Somerset	20,323	1,097
Talbot	30,026	1,621
Washington	111,380	6,015
Wicomico	72,646	3,923
Worcester	41,265	2,228
Baltimore City	465,948	25,161
Statewide Total	**4,319,607**	**233,259**

Source: Census 2010 Modified Race data (MR(31)-CO.txt) prepared by the U.S. Census Bureau, May 2012.

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

The PBHS services both Medicaid recipients and the uninsured population**.** The total number of individuals served in the fee-for-service PBHS has increased from 145,581 in FY 2012 to 165,534 in FY 2014, a 14 percent increase. Tables on the following pages provide data on consumers served by age group in FY 2012, 2013 and 2014. FY 2014 data shows 165,534 individuals had claims submitted for mental health services through the fee-for-service system. Of the total, 104,695 are adults, and 60,839 are children. This total has increased by 8% during the same time period from FY 2013. In FY 2014, 8,866 uninsured individuals utilized PBHS services who meet specific eligibility criteria. This is a 21% decrease from FY13 (n=11,260).

Demographics of Consumers Served in the Fee-For-Service System - The number of children and adolescents aged 0-21 grew over 7 percent while adults 22 and older experienced growth, increasing the numbers served by 19 percent over the same time period between FY 2012-2014.

Access to services is critical for any behavioral health system. In recent years and as an ongoing strategy in the FY 2016 State Plan, BHA will "continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PBHS". Data relevant to this national indicator on access to services continue to support the achievement of this target.

The Administrative Services Organization's Management Information System (ASO MIS) was utilized to produce most of the data. Data for FY 2014 are based on claims paid through June 30, 2015. Since claims can be submitted up to twelve months following the date of service, the data for FY 2014 may be incomplete. Specific diagnoses were used to define SMI. An individual was categorized as Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.
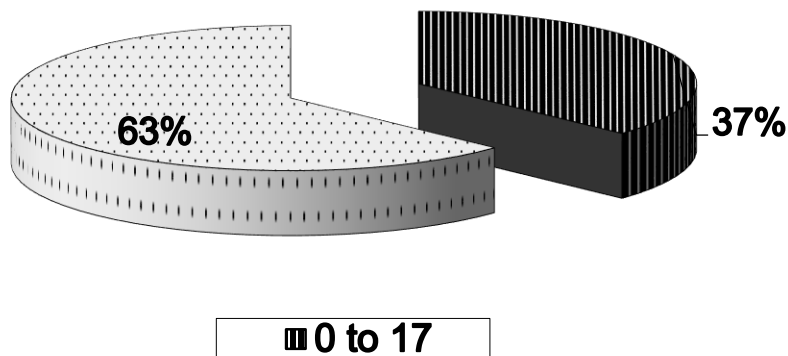
Based on claims paid through 06/30/2015, the number of individuals served in the fee-for-service PBHS has increased 14% from FY 2012. The number of child and adolescents increased by 8.4% while the number of adults served in FY 2012 increased by 17% since FY 2012. Many of these increases result from preparing for implementation or implementing some of the components of the Affordable Care Act, which provided funding allowing states to cover more people with Medicaid. The expansion of Medicaid, especially the extension of Medicaid to the parents of children in Maryland's Children's Health Program (MCHP), improved access to health care and services. It is estimated that an additional 25,000 Marylanders will be eligible for Medicaid and 15-17 percent of that population will use PBHS services within the coming fiscal years.

Total PMHS Consumer Counts for FY 2012-2014 by Age Group

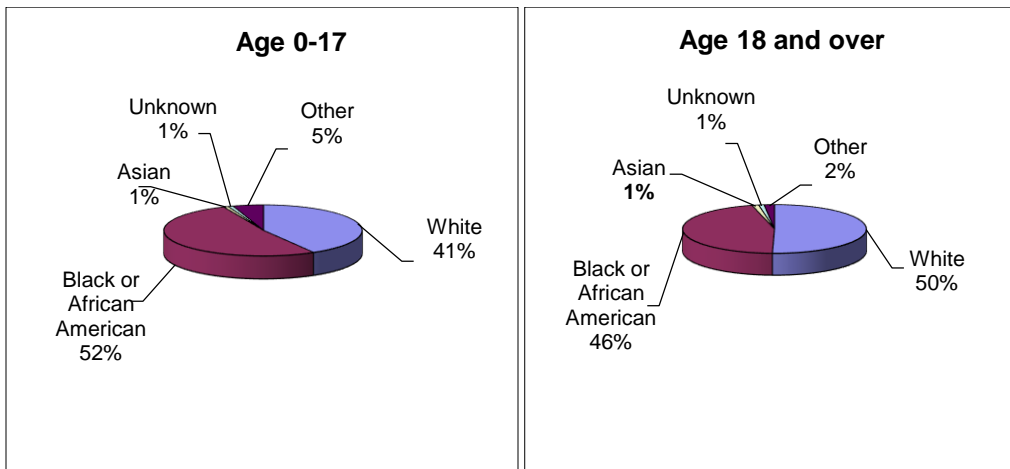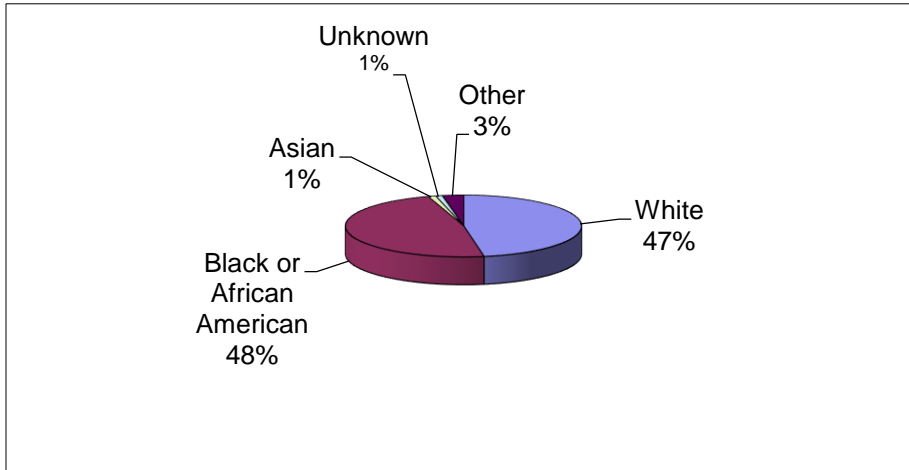|	FY 2012	FY 2013	FY 2014
□ 18 and Over	89,463	95,028	104,695
▊ 0 to 17	56,118	58,780	60,839
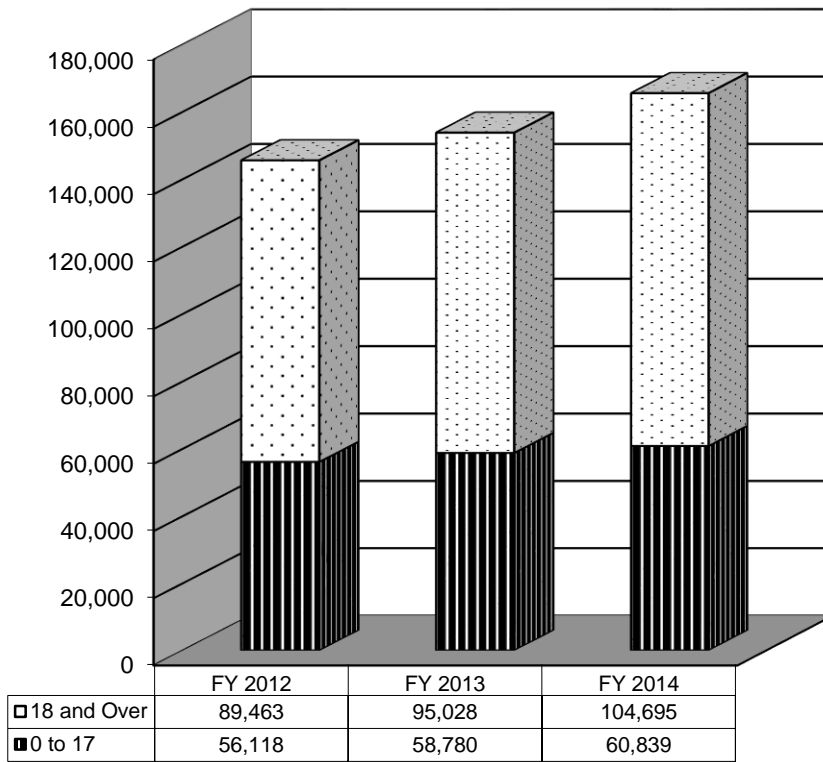
Source: VO-MD Data report MARF0004   Based on Claims Paid through 06/30/2015. FY2014 data may be incomplete as claims may be submitted upt to twelve months from date of service.

Percentage of PMHS Consumer Counts for FY 2014 by Age Group

63%   37%

▊ 0 to 17

Source: VO-MD Data report MARF0004. Based on Claims Paid through 06/30/2015. FY 2014 may be incomplete as claims may be submitted up to twelve months from date of service.

Currently, 63 percent of the people served are adults and 37 percent are children. The racial distribution of PMHS population is 49% Black, 47 % White, 1% Asian, 2% other and 1% unknown.

Unknown
1%
Other
3%
Asian
1%
White
47%
Black or
African
American
48%

Age 0-17

Unknown
1%
Other
5%
Asian
1%
White
41%
Black or
African
American
52%

Age 18 and over

Unknown
1%
Other
2%
Asian
1%
White
50%
Black or
African
American
46%

Source: FY 2014 URS Table 2A
Note: Other includes: Amerian Indian, Native Hawaiian, Pacific Islander and those individuals with more than one race.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #:   1

Priority Area: Public Awareness and Education - Mental Health First Aid

Priority Type: MHS

Population(s):   SMI, SED, Other (Students in College, Community at large)

Goal of the priority area:

> Increase Public Awareness and Support for Improved Health and Wellness

Objective:

> Continue to work with the behavioral health community to initiate educational activities and disseminate, to the general public, current information related to psychiatric, substance-related, and addiction disorders.

Strategies to attain the objective:

> Strategy 1: 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) initiative for adults and youth in Maryland and throughout the United States.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Number of individuals trained/certified in Mental Health First Aid

Baseline Measurement: 5000 Marylanders trained and 200 certified instructions

First-year target/outcome measurement: Minimum of 1,750 individuals ae trained in MHFA/ minimum of 100 Credential Instructors

Second-year target/outcome measurement: Minimum of 1,750 individuals ae trained in MHFA/ minimum of 100 Credential Instructors

Data Source:

> Training Activity Reporting - MHFA Web Instructor Management System (WIMS)

Description of Data:

> Data on completed general training sessions; data/reporting on instructor training and certifications - Instructors across the state and nation input data in WIMS each time they teach an eight (8) hour course or youth MHFA class. WIMS is also used to track compliance of annual requirements, such as teaching a minimum of three (3) times per year.

Data issues/caveats that affect outcome measures::

> Training cancellations due to low registration numbers

Priority #:   2

Priority Area: Prevention and Early Intervention

Priority Type: MHS

Population(s):   SED

Goal of the priority area:

> Promote Prevention and Early Intervention of Behavioral Health Disorders across the Lifespan.

Objective:

Develop, implement, and evaluate screening, prevention, and early intervention services.

Strategies to attain the objective:

1). Plan a system of integrated behavioral health promotion, prevention, and treatment services for children, youth, and young adults and adults who are at risk for or have mental health and/or substance-related disorders.
2). Continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Monitor access to intensive behavioral health services for youth and young adults with SED

Baseline Measurement: Projected number of unduplicated individuals to be served annually

First-year target/outcome measurement: Number enrolled for 1915(i) and targeted case management programs

Second-year target/outcome measurement: Number enrolled for 1915(i) and targeted case management programs

Data Source:

Medicaid/PBHS Data/Administrative Services Organization (ASO) for behavioral health system.

Description of Data:

Review enrollment data reports of actual number of unduplicated individuals served for 1915(I) program; Enrollment data for targeted Case management program

Data issues/caveats that affect outcome measures::

Low enrollment due to hospital admisson

Indicator #: 2

Indicator: Implementation of First Episode Psychosis Program (FEP)

Baseline Measurement: Minimum of 25 youth enrolled with or at risk of experiencing a psychosis disorder

First-year target/outcome measurement: Number of youth enrolled in FEP

Second-year target/outcome measurement: Number of youth enrolled in FEP

Data Source:

Administrative data collection - including collections from PBHS, by service type, payor source. Also a roster of individuals served/enrollment information

Description of Data:

Administrative data collection - unduplicated count of individuals. . Programs will also utilize a Critical Time Intervention (CTI) approach that sets an expectation for a two year length of stay, as evidenced by a step-down to a lower level of care, as clinically indicated, within two years of program enrollment.

Data issues/caveats that affect outcome measures::

n/a

Priority #: 3

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Military Families)

Goal of the priority area:

Promote Prevention and Early Intervention of Behavioral Health Disorders across the Lifespan.

Objective:

Promote efforts to address suicide and overdose prevention.

Strategies to attain the objective:

Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern. Continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Enhance the use and capacity of suicide prevention hotlines, implement evidence based and promising practices; Establish a baseline listing of existing services and supports across prevention, intervention and post-vention (attempters and survivors)
Baseline Measurement:	Maryland Suicide Rate (number of deaths due to suicide in a year) In FY 2013 - 559
First-year target/outcome measurement:	Number of Suicides
Second-year target/outcome measurement:	Number of Suicides

Data Source:

Maryland Vital Statistics, U. S. Census Bureau, Maryland Suicide preventions Hotlines, StateStat

Description of Data:

The Department of Health and Mental Hygiene use StateStat performance management sources to emphasize results and accountability. This approach links biweekly, monthly, quarterly and annually measures of program performance with core outcomes to critical public health areas. Throught StateStat we are able to track progress on some of the public health challenges facing Maryland. Data will be examined on recent Maryland and National suicide rates.

Data issues/caveats that affect outcome measures::

Priority #:	4
Priority Area:	Integrated/Coordinated Care
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Promote a System of Integrated Care to Increase Access, Reduce Disparities and Support Coordinated Care and Services across Systems.

Objective:

Enhance the competency of clinical behavioral and somatic care practitioners to provide treatment for behavioral health disorders and the capacity for integrating these skills into existing treatment practices.

Strategies to attain the objective:

1) 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.

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.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Monitor access to services for Children and Adults

Baseline Measurement:	Number of children and adults served in the public behavioral health system - FY 2014 - Children: 60,841 (SED-45,231); adults: 104,697(SMI-64,283)
First-year target/outcome measurement:	Number of children with SED served; number of adults with SMI served
Second-year target/outcome measurement:	Number of children with SED served; number of adults with SMI served

Data Source:

Maryland Public Behavioral Health System/Value Options - Administrative Services Organization, PBHS Quarterly Reports

Description of Data:

The PBHS/ASO data systems combine MA eligibility, service authorizations and claims payment data.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Number of BHIPP consultations provided statewide
Baseline Measurement:	Consultation calls 2014-2015 - 342
First-year target/outcome measurement:	Number of BHIPP consultation calls 427
Second-year target/outcome measurement:	Number of BHIPP consultation calls 427

Data Source:

REDCap, a secure web based database.

Description of Data:

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

Data issues/caveats that affect outcome measures::

n/a

Priority #:	5
Priority Area:	Tobacco Cessation
Priority Type:	SAP, SAT, MHS
Population(s):	SMI, SED

Goal of the priority area:

Promote a System of Integrated Care to Increase Access, Reduce Disparities and Support Coordinated Care and Services across Systems.

Objective:

Enhance the competency of clinical behavioral and somatic care practitioners to provide treatment for problem gambling, mental health, and substance –related disorders and the capacity for integrating these skills into existing treatment practices.

Strategies to attain the objective:

Enhance and sustain tobacco use quit rates among individuals in the behavioral health system and staff in behavioral health treatment services settings.

┌─ Annual Performance Indicators to measure goal success ─

Indicator #:	1
Indicator:	Reduce tobacco use among individuals with behavioral health disorders

Baseline Measurement:	Percentage of adults receiving outpatient behavioral health treatment who report smoking during their most recent interview
First-year target/outcome measurement:	By end of FY 2016, the average of adults receiving outpatient behavioral health treatment who report smoking will be less than 50%
Second-year target/outcome measurement:	By end of FY 2017, the average of adults receiving outpatient behavioral health treatment who report smoking will be less than 50%

Data Source:

> Outcomes Measurement System (OMS). Additionally there are a number of sources that provide both national and state level data for prevalence for tobacco use. These reports include: Maryland DHMH Reports, Maryland Cessation Data, Maryland Initiative Data, Youth Tobacco Use, Adult Tobacco Use.

Description of Data:

> The Outcomes Measurement System (OMS) Public Web-based Datamart provides outcomes data at the Statewide and county-specific level for individuals ages 6-64 in the public mental health system outpatient treatment services. Clinicians conduct OMS interviews, which include various life domains, at intake and approximately every six months. The OMS process is required for authorization of outpatient services. In the OMS Datamart, two types of aggregated data analysis are presented:
> • Results of individuals' most recent interview (point in time); and
> • Comparison of the individuals' initial and most recent interviews (change over time).
> *Rolling 12 months data are reported monthly and are based on OMS data that includes the previous 12 months with a 30 day lag

Data issues/caveats that affect outcome measures::

> None at this time

Indicator #:	2
Indicator:	Reduce tobacco use among adolescents with behavioral health disorders
Baseline Measurement:	Reduce tobacco use among adolescents with behavioral health disorders
First-year target/outcome measurement:	By end of FY 2016, the average of adolescents receiving behavioral health treatment who report smoking will be less than 10%
Second-year target/outcome measurement:	By end of FY 2017, the average of adolescents receiving behavioral health treatment who report smoking will be less than 10%

Data Source:

> Outcome Measurement System (OMS). Additionally there are a number of sources that provide both national and state level data for prevalence for tobacco use. These reports include: Maryland DHMH Reports, Maryland Cessation Data, Maryland Initiative Data, Youth Tobacco Use, Adult Tobacco Use.

Description of Data:

> The Outcomes Measurement System (OMS) Public Web-based Datamart provides outcomes data at the Statewide and county-specific level for individuals ages 6-64 in the public mental health system outpatient treatment services. Clinicians conduct OMS interviews, which include various life domains, at intake and approximately every six months. The OMS process is required for authorization of outpatient services. In the OMS Datamart, two types of aggregated data analysis are presented:
> • Results of individuals' most recent interview (point in time); and
> • Comparison of the individuals' initial and most recent interviews (change over time).
> *Rolling 12 months data are reported monthly and are based on OMS data that includes the previous 12 months with a 30 day lag

Data issues/caveats that affect outcome measures::

> none at this time.

Priority #:	6
Priority Area:	Evidence-Based Practices
Priority Type:	MHS
Population(s):	SMI

Goal of the priority area:

Provide coordinated approaches to Increase Recovery Supports.

Objective:

Promote the implementation of models of evidence-based, effective, promising, and best practices for behavioral health services in community programs and facilities.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #:	1

Indicator: Evaluate outcome and fidelity data collection on Supported Employment evidence based practice (EBP) across the State

Baseline Measurement: Number of individuals who received Supported Employment (SE) services - FY 2014 - 3,431

First-year target/outcome measurement: Number of indivduals receiving EBP-SE services

Second-year target/outcome measurement: Number of indivduals receiving EBP-SE services

Data Source:

Public Behavioral Health System (PBHS) Data, Uniform Reporting System (URS) Tables

Description of Data:

PBHS Claims data on supported employment

Data issues/caveats that affect outcome measures::

n/a

Indicator #:	2

Indicator: Evaluate outcome and fidelity data collection on Assertive Community Treatment (ACT)-evidence based practices (EBPs) across the State

Baseline Measurement: Number of individuals who received mobile treatment in FY 2014 - 3,667

First-year target/outcome measurement: Number of individuals receiving EBP ACT

Second-year target/outcome measurement: Number of individuals receiving EBP ACT

Data Source:

Public Behavioral Health System (PBHS) data, Uniform Reporting System (URS)Tables

Description of Data:

PBHS claims data

Data issues/caveats that affect outcome measures::

n/a

Priority #: 7

Priority Area: Workforce Development/Co-Occurring Dual Diagnosis Capability

Priority Type: SAP, SAT, MHS

Population(s):   SMI, SED

Goal of the priority area:

Promote an Integrated, Aligned, and Competent Workforce.

Objective:

Develop and disseminate workforce training and education tools as well core competencies to address behavioral health issues.

Strategies to attain the objective:

Continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) within the behavioral health workforce.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Ongoing trainings and consultations provided on screening and assessment tools to behavioral health providers and local behavioral health authorites on

Baseline Measurement: n/a

First-year target/outcome measurement: Number of trainings and consultations provided to jurisdictions/programs on integrated care; number of behavioral health providers/participants recieved training

Second-year target/outcome measurement: Number of trainings and consultations provided to jurisdictions/programs on integrated care; number of behavioral health providers/participants recieved training

Data Source:

Tracking grid of DDC training, Bi-annual reports

Description of Data:

Quarterly and Bi-annual reporting on COD/DDC activities

Data issues/caveats that affect outcome measures::

n/a

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015   Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$58,778,927	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$97,101,267	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		$853,207	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$305,158	$0	$0	$0	$0	$0
11. Total	$0	$1,158,365	$0	$0	$155,880,194	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Column C: These expenditures relate to Fee For Service (FFS) expenditures budgeted for 7/1/2015 - 6/30/2016. Maryland's Medicaid expenditures were transferred to the Department of Health and Mental Hygiene's Medicaid, Office of Finance Agency in FY 2015.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015   Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$923,000
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$59,148
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$2,550
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$308,999
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$240,760
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	$213,082
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$4,069,579
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$3,215,370
Total	$9,032,488

Footnotes:
Other includes: Trauma Informed Care Training, Learning Collaborative, Transitional Housing, Transition Age Youth, Diversion, School-Based Mental Health Evidence-Based Practices Implementation, System Evaluation, Consumer Quality Improvement Teams, Five Percent (5%) Set-Aside - First Episode Psychosis/Early Intervention

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015   Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	$1,355,014
MHA Planning Council Activities	
MHA Administration	$351,755
MHA Data Collection/Reporting	$39,444
MHA Activities Other Than Those Above	
Total Non-Direct Services	$1746213
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- Regular screening with a carbon monoxide (CO) monitor

- Smoking cessation classes

- Quit Helplines/Peer supports

- Others_____

11. The behavioral health providers screen and refer for:

- Prevention and wellness education;

- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,

- Recovery supports

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

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[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[49] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The Health Care System and Integration

As part of the State FY 2012 budget (for the fiscal year July 1, 2011-June 30, 2012) the Maryland General Assembly asked the DHMH to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues". In making this request, the General Assembly recognized the current need for improved coordination in Maryland's approach to individuals with behavioral health conditions. In response, the Department undertook a three-phase initiative to develop a model for integrated behavioral health service delivery and financing system. Each phase included significant input from a diverse group of stakeholders, representing individuals with behavioral health needs, providers and advocates.

- Phase 1 - began in 2011 and involved collaborative work between the Department, a consultant and stakeholders to assess the strengths and weakness of Maryland's current system.
- Phase 2 – began in early 2012 as the Department and stakeholders set out to develop a broad financing model to better integrated care across the service domains.
- Phase 3 – 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).

Department of Health and Mental Hygiene (DHMH) Behavioral Health Integration Activities

The Maryland Department of Health and Mental Hygiene (DHMH) serves as the State Mental Health Authority, the Single State Agency (SSA) for Substance Abuse Services, and the State Medicaid Agency. DHMH has four divisions—two of which have significant roles in the administration of Maryland's public behavioral health system: the Behavioral Health Administration (BHA) and Health Care Financing (HCF).

In July 2014, Maryland's Mental Hygiene Administration merged with the Alcohol and Drug Abuse Administration to form BHA. BHA is responsible for all publicly funded specialty mental health and substance use disorder (SUD) services. BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes the public health and safety of patients, participants, families, and communities in all jurisdictions throughout Maryland.

Health Care Financing (HCF)**:** HCF implements and manages the Maryland Medicaid program, which serves more than 1.3 million Marylanders. In fiscal year (FY) 2015, funding for Medicaid services for behavioral health was moved from BHA to HCF, which created a specialized unit for behavioral health services that works in close partnership with BHA to administer behavioral health services for individuals funded by Medicaid. BHA handles clinical and system issues, whereas HCF is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan. BHA and HCF worked closely together to design integration of mental health and substance use services. In partnership with BHA, HCF contracts with ValueOptions, Maryland's Administrative Services Organization (ASO) that administers

integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

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 Mental Hygiene and Alcohol and Drug Abuse Administrations, the Office of the Attorney General, the Office of Health Care Quality, the Office of Health Care Financing, as well as providers of behavioral health services.

The Workgroup was guided by these principles:
- Reflect and encourage both system and service integration
- Promote administrative simplicity
- Facilitate and support the use of evidence-based interventions
- Support a person-centered approach

Further, given the direction of behavioral health care's role vis-à-vis medical health care, the workgroup used the regulatory structure of somatic health care as a touchstone. This meant a new regulatory structure was viewed through the lens of how medical services are regulated, which are highly reliant upon the scope of a professional's license. Although the charge was to develop an integrated regulatory structure, there were inevitable discussions about the financial structure and how this workgroup's activity both impacted upon, and would be impacted by, the future financial model for behavioral health services. Those issues would be under consideration during Phase 3 in the development of the financial model for behavioral health services.

As a result of the workgroup's activities to date, the workgroup is recommending that the Department of Health and Mental Hygiene (DHMH) require that treatment programs currently covered through mental health regulations (COMAR 10.21) or substance use disorder regulations (COMAR 10.47) apply for and become accredited by a State-approved accrediting organization by July 1, 2015. The State will require that programs be approved for licensure through DHMH in order to provide behavioral health services. Receiving accreditation is one step in the process to becoming licensed to provide behavioral health services. This approach, then, requires accreditation as part of the application for licensure to operate in Maryland as a behavioral health provider.

The Behavioral Health Integration (BHI) process included the development of the Request for Proposal (RFP) to select an Administrative Services Organization (ASO) to administer the new MA financing model. On September 3, 2014, Value Options (VO), an Administrative Services Organization (ASO) was awarded a new performance based contract for the carve-out for mental health and substance use services. The DHMH will be facilitating integrated care across the healthcare service delivery system. VO will operate as a single point of entry to the public behavioral health system for individuals with substance use and mental health disorders.

Medicaid Eligibility
The new behavioral health model did not present any changes to the eligibility to the Medicaid program beyond what was planned based on the implementation of the Affordable Care Act (ACA). Beginning in January, 2014, under the ACA, Medicaid eligibility expanded for adults under the age of 65. The income eligibility threshold for parents increased from 116 % of the federal poverty level (FPL) to 138% of the FPL. Additionally, childless adults are covered up to 138% of the FPL. Some individuals who gained this new, expanded eligibility status had already been active in the public behavioral health system under either the Primary Adult Care (PSC) Medicaid (MA) waiver program or the uninsured benefit.

Maryland Health Benefit Exchange
According to Maryland Health Benefit Exchange Enrollment Report, August 18, 2015, 600,000 Marylanders have enrolled in health insurance through Maryland's state based insurance marketplace, Maryland Health Connection. This includes 123,673 people enrolled in private Qualified Health Plans (QHP) and 482,553 people enrolled in Medicaid through the marketplace since open enrollment for the year began on November 15, 2014.[i]

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

capacity of primary care providers (PCPs) to identify, refer, and/or treat child and adolescent mental health problems. There are currently over 375 providers enrolled in BHIPP statewide. The BHIPP program offers the following services:

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

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

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

[i] Maryland Health Benefit Exchange, Media Release/Enrollment Report/marylandhbe.com

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the _HHS Action Plan to Reduce Racial and Ethnic Health Disparities_[52], _Healthy People, 2020_[53], _National Stakeholder Strategy for Achieving Health Equity_[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

5. Is there state support for cultural and linguistic competency training for providers?

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Health Disparities

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

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

The funding for this initiative was place in the budget of the Maryland Community Health Resources Commission (CHRC) consistent with their charge to direct resources to communities where poor health persists despite ongoing services provided by public and private sectors. In January 2013, based on recommendations from CHRC, the DHMH, designated Maryland's first five HEZs: Anne Arundel County, Dorchester and Caroline Counties, Dorchester Health Department, Prince Georges County, St Mary's County and Baltimore City. The HEZs covered areas such as efforts to reduce diabetes-related and smoking illnesses, obesity, cardiovascular disease, promotion of school-based wellness programs, crisis response teams, access to primary and behavioral health services, and increases in community resources.

Additionally, through Maryland's DHMH Office of Minority Health and Health Disparities, technical assistance and guidance was provided to HEZ Coordinating Organizations and partners. The BHA also participated in activities coordinated by the Maryland Health Disparities Collaborative, which was established in 2008 and is comprised of more than 200 state health experts, health care organizations, academics and health advocates. The Collaborative was fully engaged in assisting the Department with the implementation of the Maryland Health Improvement and Disparities Reduction Act of 2012. The Collaborative established five workgroups (Awareness, Leadership and Capacity Building, Health and Health Systems, Cultural and Linguistic Competency and Research and Evaluation) to address the core aspects of the Act and develop recommendations.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

5. Which value based purchasing strategies do you use in your state:

    a. Leadership support, including investment of human and financial resources.

    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

    c. Use of financial incentives to drive quality.

    d. Provider involvement in planning value-based purchasing.

    e. Gained consensus on the use of accurate and reliable measures of quality.

    f. Quality measures focus on consumer outcomes rather than care processes.

    g. Development of strategies to educate consumers and empower them to select quality services.

    h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

    i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

[59] Ibid, 47, p. 41

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

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

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

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

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70][71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

5. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

"*...the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis*".

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. With consultation with NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their plan revision request proposal into the FY 2016-2017 Block Grant Application under the following section:

Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis.

The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.

2. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

3. A budget showing how the set-aside and additional state or other supported funds, if any, will be utilized for this purpose.

4. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

5. Any foreseen challenges.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidence-Based Practices for Early Intervention (5 Percent)

The State of Maryland was a site in the NIMH-funded study of the treatment of early psychosis called RAISE-Implementation and Evaluation Study (RAISE-IES). As part of this project, investigators developed a Coordinated Specialist Care (CSC) program located in West Baltimore that continued to be funded by the State of Maryland after the completion of the research. Maryland has used the 5% Set-Aside Federal Block Grant (FBG) funds to create two additional CSC teams based on the RAISE-IES model: OnTrack Maryland at Family Services in Montgomery County (http://www.fs-nc.org/services/programs/ontrack-maryland) and Johns Hopkins Early Psychosis Intervention Clinic/Maryland EIP (EPIC/MEIP) in East Baltimore (http://www.hopkinsmedicine.org/psychiatry/bayview/medical_services/child_adolescent/early_psychosis.html).

The 5% set aside funding has supported infrastructure and management activities, as well as time spent in training and outreach/education to the broader community in order to identify as many in need of these services as possible. The funding is used to provide the critical support needed to structure the teams to maximally provide the appropriate support to those with early psychoses.   Each team is comprised of a Team Leader, a Supported Employment and Education Specialist, a Recovery Coach, and a Team Psychiatrist who work collaboratively to assess and treat youth with early psychosis and their families. Both teams have received extensive and ongoing training from investigators and trainers from the Department of Psychiatry at the University of Maryland, School of Medicine (UM SOM) and the Maryland Early Intervention Program, a collaboration between UMSOM and the Maryland Department of Health and Mental Hygiene (DHMH) that offers specialized programs with expertise in the early identification, evaluation, and comprehensive treatment of adolescents and young adults experiencing early psychosis and their families.

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

The OnTrack team started training and providing services to one young person in December 2014. They are currently providing services to 17 young adult clients and families. Four of these young people have obtained employment, one has graduated from high school, and two are currently enrolled in college while working with the team. The Supported Employment and Education Specialist (SEES) is actively working with twelve (12) young people, nine (9) of whom are pursuing competitive employment, while six (6) are pursuing college graduation. This team has also reached out to agencies, schools, and service providers in counties in Southern Maryland (Montgomery, Price George's, Anne Arundel) and to some nearby in counties to the north (Frederick, Howard) to educate them generally about CSC for early psychosis and

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specifically about how to make a referral to their team. These types of outreach have resulted in referrals as well as in enhancing awareness about services for young people with early psychosis and their families.

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

The Behavioral Health Administration's Office of Adult Services collaborates with the University of Maryland Behavioral Health Systems Improvement Collaborative (BHSIC) to implement training, management and evaluation of the two (2) teams which include:
    a. psycho-education about psychosis
    b. assessment and diagnosis of early psychosis
    c. prescribing and management of recommended pharmacological treatments
    d. engaging young people and their families in care
    e. use and implementation of evidence-based practices for improving social functioning, reducing substance abuse, re-engaging in work or school or pursuing new educational/work opportunities, working with families, and assessment of and planning for safety.
    f. use of supported education and employment geared towards young adults
    g. safety planning
    h. providing care within a model of mental health recovery.

Current Budget:
Maryland's 5% set – aside allotment is $453,808. The spending plan is as follows:
- Start –up/Implementation of two Teams: $161,904 x 2=323,808
- Data Collection/Reporting, Evaluation: $115,000
- Financial management:$15,000

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Evidence-Based Practices for First Episode Psychosis (FEP)

Maryland's Mental Health Block Grant Revisions for the Ten (10) percent set-aside for FEP

In FY 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) required states to set aside five (5) percent of their Mental Health Block Grant (MHBG) allocation to support evidence-based programs that address the needs of individuals with early serious mental illness, specifically first episode psychosis. States were encouraged to address these needs by enhancing existing program activities or development of new activities.

In FY 2016, SAMHSA provided States a 10% set aside in their allotment, a 5% increase from the previous set aside, to further support evidence-based programs that specifically address first episode psychosis (FEP).

Background:

The State of Maryland established an early psychosis intervention program in Baltimore in July, 2009 as a key element of the NIMH Project entitled Recovery after an Initial Schizophrenia Episode (RA1SE) – Implementation and Evaluation Study (IES). Maryland's RAISE Connection Program is an intensive outpatient treatment with weekly sessions of wrap-around services including medication management with a psychiatrist, talk therapy with licensed social workers, substance abuse treatment, and education and employment supports. The goal of the RAISE Connection Program is designed to provide community-based recovery-oriented individualized services to persons who are within the first one to two years of developing psychosis and schizophrenia. The program goal is to prevent the development of long term disability and to promote independent, integrated community living. As part of this project, investigators developed a Coordinated Specialist Care (CSC) program located in West Baltimore that continued to be funded by the State of Maryland after the completion of the research project.

Five (5) percent Set-Aside Initiative

Maryland, through the Department of Health and Mental Hygiene's (DHMH), Behavioral Health Administration (BHA) has used the 5% Set-Aside Federal Block Grant (FBG) funds to establish a new team utilizing the the RA1SE-IES Coordinated Specialty Care (CSC) model at OnTrack Maryland at Family Services, Inc., (FSI) in Montgomery County and expand the Johns Hopkins Early Psychosis Intervention Clinic/Maryland EIP (EPIC/MEIP) in East Baltimore. The 5% set aside funding has supported infrastructure and management activities, as well as time spent in training and providing outreach/education to the broader community to identify as many individuals in need of these services as possible. The funding provides the critical support needed to structure the teams to maximally provide the appropriate support to those with early psychoses.

Each team is comprised of a Team Leader, a Supported Employment and Education Specialist, a Recovery Coach, and a Team Psychiatrist who work collaboratively to assess and treat youth with early psychosis and their families. Both teams have received extensive and ongoing training from investigators and trainers from the Department of Psychiatry at the University of Maryland, School of Medicine (UM SOM) and the Maryland Early Intervention Program, a collaboration between UMSOM and the Maryland Department of Health and Mental Hygiene (DHMH) that offers specialized programs with expertise in the early identification, evaluation, and comprehensive treatment of adolescents and young adults experiencing early psychosis and their families.

The OnTrack MD team started training and providing services to one young person in December 2014. They are currently providing services to 17 young adult clients and families. Four of them have obtained employment, one has graduated from high school, and two are currently enrolled in college while working with the team. The Supported Employment and Education Specialist (SEES) is actively working with twelve (12) young people, nine (9) of whom are pursuing competitive employment, while six (6) are pursuing college graduation. This team has also reached out to agencies, schools, and service providers in counties in Southern Maryland (Montgomery, Prince George's, Anne Arundel) and to some nearby in counties to the north (Frederick, Howard) to educate them generally about the value of CSC for individuals experiencing early psychosis and specifically about how to make a referral to their team. These types of outreach activities have resulted in an increase in referrals as well as in enhancing awareness about services for young people with early psychosis and their families.

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

Evidence-Based Practice for the Ten (10) Percent Set Aside Initiative

Maryland continues to refine strategies to achieve a collaborative process that will transform behavioral health service delivery and fully support recovery and resilience. Plans for the additional funding for the 10% set-aside initiative for first episode psychosis (FEP) include efforts to further promote recovery support services such as person-centered planning, peer involvement, as well as a combined model of evidence-based supported employment and supported education for individuals served by these two teams. These support services enable

individuals to choose, obtain, maintain or advance within a community-integrated work and education environment consistent with their interests and preferences.

The additional 5% set-aside will further support Outreach and Education activities. These efforts would enhance enrollment in services, expansion of potential referral resources, provide education and awareness to reduce stigma associated with behavioral health diagnoses and treatment. Increased trainings and communications with middle and high school support teams on identifying the early signs of psychosis in students through implementation of screening and assessments for early psychosis will be conducted.

Peer Involvement

The strength of Maryland's public behavioral health system (PBHS) comes mainly from its long-term, well-organized, and effective consumer, family, advocacy, and provider organizations. BHA has partnered with these organizations since their inceptions and, in fact, fostered their development.

To further develop the peer supports available to individuals served by First Episode Psychosis (FEP) teams, FEP leadership and trainer-consultants are working with stakeholders including representatives from Transition-age Youth (TAY) serving programs (Maryland Healthy Transitions (MD-HT), the Maryland Early Intervention Program (MEIP), University of Maryland Evidence-Based Practice Center, Maryland Collaboration for Homeless Enhancement Service (MD-CHES), Mental Health Association of Maryland (MHAMD)), peer and family run advocacy and service groups (On Our Own of Maryland (OOOMD), Maryland Coalition of Families for Children's Mental Health (MCF), National Alliance on Mental Illness (NAMI)) and existing peer support infrastructure (Maryland's certification board for Certified Peer Recovery Specialists – Maryland Addictions and Behavioral Health Professionals Certification Board (MABPCB) and the Behavioral Health Administration's Office of Consumer Affairs).

To build on Maryland's peer support workforce, this group is working to develop training curricula for peer support specialists tailored to meet the needs of youth and young adults experiencing or at risk for FEP, guidelines for FEP team leaders providing supervision to peer support workers, resources for dual supervision so that peer support workers can get guidance from more experienced peer recovery support specialists and resources and guidelines for organizations housing FEP teams. To date, efforts have included consultation with an expert on the supervision of peer support workers and with the leader of a FEP team in New York who has been drafting a manual for peer support implementation specific to FEP teams. The plan is to incorporate peer support specialists on each of the FEP teams.

Collecting and Reporting Data

The Maryland Behavioral Health Administration has been collaborating with the University of Maryland Systems Evaluation Center and Evidence-Based Practices Center to develop a plan for collecting client outcomes from those Maryland programs involved in the 5% set aside initiative. Services for early psychosis have historically been offered through academic institutions. Evidence-based practices for early psychosis community mental health clinics have been developed; however, strategies for assessing adherence to treatment models and associated outcomes vary widely across clinics. This reporting period, the implementation team has focused on evaluating existing tools for treatment fidelity and outcome assessment, and establishing strategies for collecting this information moving forward.

In an effort to ensure fidelity implementation of the First Episode Psychosis (FEP) Coordinated Specialty Care program model, BHA has established an ongoing training and consultative relationship with Donald Addington, MD, Professor of Psychiatry, University of Calgary and co-developer of an internationally-recognized fidelity assessment scale for First Episode Psychosis. Dr. Addington provided direct technical assistance and consultation for BHA Clinical Services and University of Maryland School of Medicine staff involved in program development, implementation, training, and fidelity assessment and evaluation of Maryland's FEP programs. This consultation included the administration of a mock fidelity review with one of the FEP programs. Developing competency with the FEP assessment scale will enhance Maryland's ongoing ability to evaluate its implementation efforts to prevent any unintended departure from established evidence-base practices.

For treatment outcomes, the goal is to create an evaluation plan that is consistent with other outcome initiatives in Maryland, while still ensuring that it is tailored to the unique needs of individuals and families served by these programs as well as enhances quality of care. Individuals generally experience psychosis onset between the ages of 16 and 25, when they are often covered through their parents' private insurance. This factor affects the types of outcome to measure that should be utilized as well as data collection strategies to be employed. Thus, existing outcomes measurements for adults may have to be modified or replaced to effectively assess outcomes for transitional-aged youth, such as supported education. Another factor for consideration is that the existing state outcome measurement systems may or may not collect outcomes for individuals receiving treatment through private insurers.

An initial step in identifying outcomes of interest was evaluating the existing outcome systems

used in the state for adults and transitional-aged youth, as well as evaluating early psychosis outcome measurements used by researchers and outpatient treatment centers in other states. Other outcome initiatives in Maryland were identified and reviewed, such as the statewide Outcomes Measurement System (OMS), the Assertive Community Treatment (ACT) outcomes system, the Healthy Transitions evaluation [for transitional aged youth], and the Maryland Individual Placement Service Study. To ensure that outcomes specific to early psychosis were also evaluated, the team reviewed outcome initiatives used by existing early psychosis programs, such including Recovery After an Initial Schizophrenia Episode, Maryland Early Intervention Program, and On Track New York (OnTrackNY).

The BHA, SEC, and EBPC created a cross walk comparing these and other outcome initiatives in Maryland to identify the life domains, specific items, frequency, and mode of data collection for each. The outcomes planning team has met several times to review the crosswalk and has selected outcome elements appropriate to the population and implementation strategy. This included narrowing the list down to a preferred set of life domains and items that will maximize utility of the data collected while minimizing burden upon providers.

At this time the group is very close to finalizing the list of items to be collected. They include demographics, housing (homelessness, current living situation), basic clinical information (diagnosis, clinic status, estimated onset, discharge), employment (employment status, hours worked, start/end dates, other variables), education (status, enrollment in education/training program), legal system involvement, service utilization (hospitalization, detox/residential substance-related disorder treatment, and somatic/health issues. Additionally, the group has been exploring software options for data collection.

Planned Activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
Planned activities for 2016 and 2017 include the following priority area:
Prevention and Early Intervention
Objective: Develop, implement and evaluate screening, prevention and early intervention

services.

Strategy: Plan a system of integrated behavioral health promotion, prevention and treatment

services for children, youth and young adults who are at risk for or have mental health and/or

substance-related disorders.

Indicator: Implementation of First Episode Psychosis (FEP) Programs

Baseline Measurement: Minimum of 25 youth enrolled with or at risk of experiencing a

psychosis disorder.

Budget:

Maryland's 10% set-aside allotment is $853,207
- Implementation of two CSC Teams: $339,595 x 2= $679,190

➢ Each program shall:
1) Serve annually a minimum, unduplicated count of twenty-five (25) to thirty (30) youth and young adults, ages 15-30, with a diagnosis of a schizophrenia spectrum disorder, diagnosed in accordance with DSM-5 criteria, for whom the current episode of psychosis is within two years of the first onset of psychotic symptoms.
2) Utilize a Critical Time Intervention (CTI) approach which sets an expectation for a two year length of stay, as evidenced by a step-down to a lower level of care, as clinically indicated, within two years of program enrollment, and the development of an individualized, graduated plan to facilitate the eventual transition to an outpatient level of care.
3) Incorporate the following program model ingredients:
   a) Assessment, diagnosis, and psychopharmacological treatment of early psychosis in accordance with empirically-supported standards and guideline-based use of medication;
   b) Primary care coordination;
   c) Outreach and education;
   d) Engagement of youth and young adults in treatment;
   e) Engagement of families;
   f) Family psychoeducation and support;
   g) Empirically-supported psychotherapy based on cognitive and behavioral treatment principles and focused on resilience training, illness and wellness management and general coping skills;
   h) Substance use disorder counseling;
   i) Evidence-Based Practice (EBP) Supported Employment and empirically-supported supported education;
   j) Multidisciplinary treatment team meetings;
   k) Comprehensive person-centered assessment and treatment planning, to include documentation of a written narrative summary for each participant;
   l) Shared decision-making;
   m) Social Skills Training;
   n) Crisis and safety planning, to include documentation of a written crisis and safety plan for each participant; and
   o) Mobile outreach and crisis intervention
   p) Peer support specialists
4) Employ a .25 FTE psychiatrist to provide psychopharmacological and psychotherapeutic treatment interventions, in combination with psychoeducation, within the context of a shared decision-making model that maximizes the individual's autonomy and control over treatment decisions. In addition, the psychiatrist shall facilitate coordination of care with the primary care physician

5) Employ a 1.0 FTE team leader who is a licensed mental health professional to facilitate overall coordination of services and continuity of care, to provide administrative and clinical supervision of staff, and to conduct individual mental health and substance use disorder counseling and therapy, crisis intervention, information gathering, crisis and safety planning, outreach and education.

6) Employ a 1.0 FTE Master's prepared recovery coach to conduct social skills training, weekly participant groups, monthly family education and support groups, family psychoeducation, school coordination, case management ,and outreach and education.

7) Employ a two 1.0 FTE Bachelor's prepared supported employment and supported education specialists to deliver supported employment services in accordance with the principles and practices of Evidence-Based Practice supported employment and empirically-supported supported education.

8) Ensure 24 hours a day, 7 days a week crisis intervention availability. For acute emergencies, a member of the team must be available at all times by phone or to meet with participants, either alone or with their family members.

9) Ensure that services and, supports are provided at times that are convenient to the participant and the family member, to include evenings and weekends.

10) Ensure that all services and, supports are delivered in accordance with the content of the First Episode Psychosis training manuals that have been developed by the University of Maryland, School of Medicine, Department of Psychiatry and fidelity to the program model referenced in Item 3a-o.

11) Submit to an annual review of program fidelity to be conducted by the Behavioral Health Administration (BHA) or its designate.

12) Commit program staff to attend training, technical assistance, and consultation– related activities, as requested by the BHA, the University of Maryland Evidence- based Practice Center, or their designate.

13) Enact structural, operational, and practice changes, as recommended by BHA, the University of Maryland Evidence-based Practice Center, or their designate, to conform to the program model in item 3a-o.

14) Seek reimbursement from the Public Behavioral Health System (PBHS) and the Division of Rehabilitation Services (DORS) for reimbursable services and supports for individuals who otherwise meet eligibility criteria for the PBHS or DORS. A claim for the EBP rates for Supported Employment and Family Psychoeducation services rendered to eligible program participants will not be submitted for PBHS or DORS reimbursement unless and until the program has received an on-site fidelity assessment and evaluation, specific to the First Episode Psychosis Program, for any BHA-identified EBP services and has been determined to meet the required fidelity standards on the corresponding fidelity scale for the identified EBP

15) Submit to the BHA, Office of Adult Services, by the 21st of the month immediately following the end of each quarter, a report that includes the following elements:
   a) A roster of designated program staff, to include the full name, credentials, roles, responsibilities, date of hire, and training received during the reporting period, for each staff;

b) A roster of individuals served, to include full name, health care coverage type, age, DSM-5 diagnosis, date of enrollment in the program, employment status (including job title, placement date, start date, average hours per week, and average wage); educational status, and services received during the reporting quarter; and

c) A narrative description of the progress achieved during the reporting period in meeting contract deliverables, barriers encountered, and program goals and objectives for the next reporting period.

16) Submit to BHA annually an itemized detail of program expenditures and revenue generated to include collections from the PBHS, DORS, or other funding streams by individual served, by service type, and by payor source

17) Participate actively in quarterly conference calls with designated BHA staff, Baltimore City, and Montgomery County Core Service agency staff to coordinate and to monitor program implementation.

- Data Collection/Reporting, Evaluation/Training: $115,000
- Personnel – Program Administrator – Grade 16 - $44,017
  - The Program Administrator position will provide oversight to the two CSC teams in the implementation of outreach and education activities and associated evaluation efforts, contract monitoring.
- Financial management:$15,000

Environmental Factors and Plan

6. Participant Directed Care

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

7. Program Integrity

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

   a. Budget review;

   b. Claims/payment adjudication;

   c. Expenditure report analysis;

   d. Compliance reviews;

   e. Client level encounter/use/performance analysis data; and

   f. Audits.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

8. Tribes

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.

2. Describe current activities between the state, tribes and tribal populations.

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

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.

- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.

- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.

- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.

- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning

- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.

- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;

2. Build capacity to address prevention needs;

3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;

4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and

5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:

   • The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);

   • The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and

   • The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. Please describe if the state has:

   a. A statewide licensing or certification program for the substance abuse prevention workforce;

   b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and

   c. A formal mechanism to assess community readiness to implement prevention strategies.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

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

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach". [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

2. Describe the state's policies that promote the provision of trauma-informed care.

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Maryland's BHA is committed to ensuring the promotion and implementation of efforts that the workforce and communities receive education, training and consultation on trauma informed care, and that individuals impacted have access to needed trauma informed behavioral health services. The State's trauma education project, has existed for more than 12 years providing services to individuals 18 and older who are detained in participating detention centers. Individuals with a history of abuse, a recent treatment history for a mental health condition or treatment for an alcohol or drug disorder are eligible for participation. The Trauma, Addictions, Mental Health and Recovery Program (TAMAR) education program is in nine detention centers and one state hospital reaches nearly 500 consumers annually. In addition to treatment in the detention center, four of the eight jurisdictions provide trauma treatment to inmates re-entering the community.

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

Additionally, the trauma specific training included the Adverse Childhood Experience (ACE) trauma screening tool. A consultant was retained to recommend workshops on sexual assault/ sexual harassment prevention. In addition to training, policies were revised to create uniform response and report procedures with regard to sexual assault and harassment.

As a result of recommendations and training, a pilot program was of a single gender unit was launched to provide a greater sense of comfort and safety for women who did not wish to share a unit with men. This unit was launched in on the Eastern Shore facility. When asked about why they preferred the single-gender unit, many women made similar comments reflecting that it was more peaceful without men and without men you can learn to be on your own. The discussion generated goals, such as, learning about trauma education, having more group discussions, and moving to Stepping Stones, a transitional unit focused on independent living. Some of the women suggested that the group discussions include topics, such as, medication management, interacting with others who have a mental illness, nutrition/diet, and first aid. The group was interested in having peer specialists co-lead groups.

Behavioral Health Disaster Services: The BHA 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. The goal is to establish a synchronized, comprehensive, integrated, inclusive and coordinated plan to respond to environmental and man-made disasters in Maryland. The purpose of planning is to minimize the adverse effects of traumatic events affecting all individuals in Maryland communities. The Plan identifies necessary administrative and clinical activities, supports, and resources that can be mobilized quickly when a disaster occurs. It is well recognized that disaster services require rapid, integrated, flexible, collegial and collaborative responses. To that end, the Plan concentrates on four areas of activities: (1) Mitigation; (2) Preparedness; (3) Response; and (4) Recovery. For each activity the responsibilities of the BHA Executive Director, BHA Facilities Directors**,** Core Service Agencies (CSA), and local health departments (LHD) are addressed. Where appropriate, other partner responsibilities are delineated.

Chrysalis House Healthy Start Program: Chrysalis House Healthy Start is a program developed for pregnant women who are incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW). The Chrysalis House Healthy Start Program is funded with State dollars and a small PATH grant. This holistic program aims to provide appropriate treatment and mother/child intervention to women with mental health, substance use, and trauma related disorders. The program provides services at a 16-bed residential/transitional facility during the pregnancy and for up to one year post delivery.

National Collaboration on Trauma Informed Care Training

In Baltimore City, the local health department (LHD) begin efforts to address tragic events that have impacted the communities. The City's Health Commissioner is collaborating with SAMHSA and the National Center for Trauma Informed Care to host a series of trainings on trauma informed care. Sessions will start with LHD employees and other community workers. The TIC trainings are a part of the City Commissioner's public health recovery efforts and the Mayor's OneBaltimore Initiative after the City's recent unrest.

Additionally, the local behavioral health authority in Baltimore City, Behavioral Health Systems Baltimore (BHSB), receives mental health block grant funding to promote education, training and TA to providers on trauma informed care. Efforts have included consultation from the National Council to implement the Trauma Informed Care Learning Community with behavioral health providers. The Learning Community, comprised of a variety of mental health organizations, was designed to take teams from each organization through an intensive implementation process to adopt the principles and practices of Trauma Informed Care. Teams gained a strong and better understanding of what it meant to be trauma informed and developed sustainability plans to maintain momentum to continue to provide TIC services.

In FY 2016 – 2017, the BHSB will support the provision of consultation through the National Association of State Mental Health Program Directors (NAMHSPD) to provide technical assistance to city-based trauma-informed care (TIC) teams that will implement TIC policies and practices. It is anticipated that the TIC teams will develop the skill sets necessary to evaluate organizations on their adherence to trauma-informed principles, identify policies and practices within organizations that do not meet trauma-informed principles, and implement changes that bring the organizations up to trauma-informed care standards.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80][81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

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[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum.* David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

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[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Medication Assisted Treatment

Overdose Prevention in Maryland

Drug overdoses have become a serious public health challenge in Maryland and across the county. In Maryland, the total number of overdose deaths has risen steadily since 2010, mainly due to the increase of heroin related deaths. Maryland's state agencies have engaged in comprehensive, cross-agency efforts to reduce overdose deaths. These efforts include educating the public and implementing new medical practices. The FY 2016 State Behavioral Health Plan includes strategies that promote increase in public awareness, encouraging naloxone distribution, clinician education on opioid prescribing practices and the use of Prescription Drug Monitoring Program, as well as enhancing overdose related data sharing and analysis.

On February 24, 2015, the Governor and Lt. Governor announced the establishment of both the Heroin and Opioid Emergency Task Force and a separate Inter-Agency Coordinating Council. Both groups will work and support efforts to address Maryland's growing heroin and opioid crisis. According to the Governor, the purpose of the inter-agency council and task force is to connect the dots of prevention, treatment, and recovery and maximize our resources and expertise.

Prevention efforts are robust particularly in areas of the state that have the highest rates of opioid-related issues and emergency room visits. Maryland applied for and received a three-year federal grant in the amount of $815,745 to expand medication –assisted treatment and enrollment in substance use treatment in Baltimore City and Anne Arundel County. The funds will also be used to support direct outreach to recruit individuals into medication-assisted treatment.

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

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

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

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning

- Psychiatric Advance Directives

- Family Engagement

- Safety Planning

- Peer-Operated Warm Lines

- Peer-Run Crisis Respite Programs

- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)

- Open Dialogue

- Crisis Residential/Respite

- Crisis Intervention Team/ Law Enforcement

- Mobile Crisis Outreach

- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis

- Peer Support/Peer Bridgers

- Follow-Up Outreach and Support

- Family-to-Family engagement

- Connection to care coordination and follow-up clinical care for individuals in crisis

- Follow-up crisis engagement with families and involved community members

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Crisis Services

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

There is considerable variability of the services offered from jurisdiction to jurisdiction. As an example, currently there are 12 Mobile Crisis Team (MCT) programs operating in Maryland, and only 25% are available 24/7. Many of the jurisdictions in the more rural areas are just focused on obtaining access to urgent care. The current continuum of crisis response services is:

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

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

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

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

Environmental Factors and Plan

16. Recovery

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

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

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported

- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)

- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. RECOVERY

Maryland's commitment to the principles of recovery and resiliency is long standing. Since the mid-1990 the state has focused on recovery concepts in State and local planning efforts, particularly through the development of local mental health authorities, core service agencies. Embedded in BHA (formerly MHA) vision and mission statement, this commitment led to efforts to further define a recovery-oriented system through policy definitions and changes in the regulations. In 2008, regulations governing the provision of outpatient mental health and psychiatric rehabilitative services (PRPs) were amended to include language that outlined strengths and recovery as well as expectations that treatment services were to be provided that focused on facilitating individual recovery and resiliency. Guided by SAMHSA's Working Definition of Recovery - 2012, "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential", the Administration continued to promote recovery in all aspects of the behavioral health care system. In keeping with this philosophy, the Public Mental Health System (now the Public Behavioral Health System) incorporated recovery approaches such as person centered planning, self-directed care, peer recovery support, and consumer/participant/family education, as well as the promotion and expansion of access to employment, education wellness, and affordable housing. Over the years, the system has promoted and/or provided access to training for behavioral health providers in step with these concepts.

The public behavioral health system in Maryland offers continuum of care including prevention, intervention, treatment, and recovery services in all jurisdictions across the state. With the merger of the Mental Hygiene and the Alcohol and Drug Abuse (ADAA) administrations, the most significant strengths are the existing recovery systems for both mental health and substance-related disorders. In the FY 2016 State Behavioral Health Plan, several strategies were developed that promote expansion of recovery support services, peer workforce development through peer specialists certification process and, peer leader training opportunities.

BHA is strengthened through the leadership efforts of the Office of Consumer Affairs and the Office of Treatment and Recovery as they continue to promote recovery strategies and initiatives for these two Offices. The Office of Consumer Affairs (OCA) gives oversight to 25 Wellness and Recovery Centers (peer-operated centers located in the community, which offer linkages to many resources such as workshops, support groups, opportunities for friendship, socialization, and advocacy) and works in collaboration with consumer/participants across the state to promote new initiatives that facilitate recovery in treatment and community living, shape peer recovery approaches as these resources become more wide-spread, promote trainings and workshops that enhance a life style in recovery. OCA also conducts venues and projects that enhance decision making, leadership, and self-direction such as, the Self-Directed Care (SDC) program which began as a pilot in Washington County and continues to assist individuals with the development and implementation of their personal "recovery" plans which include directing the use of their benefits to access public behavioral health services, education goals, and non-traditional support services. Most recently the OCA has focused on peer certification and is coordinating efforts with the offices of Treatment and Recovery; Forensic

Services, Maryland's Commitment to Veterans, and Workforce Development and Training to widen the availability of peer support services to various populations across the state.

The Office of Treatment and Recovery is responsible for the development and monitoring of effective behavioral health treatment and substance recovery services and the implementation of evidence-based practices (EBPs) and standards statewide. It monitors access to clinical services including Half-way Houses and recovery support services such as Recovery Housing, Continuing Care, Care Coordination, Recovery Community Centers, Peer Support/Recovery Coaching, and Maryland Recovery Net (which develops partnerships with service providers statewide and funds access to clinical and recovery support needs for individuals with substance-related disorders). Additionally, the promotion of the Recovery-Oriented System of Care (ROSC) approach, carved out a more integrated role for Peer Recovery Support Specialists. The principles of the ROSC approach have been carried forward to include availability of training opportunities for workforces that address recovery-oriented services and supports through efforts such as the establishment of an integrated ROSC Learning Collaborative that involves state agencies, faith-based service providers, behavioral health treatment and recovery support service providers, criminal justice professionals, individuals and their family members.

Recovery Community Centers (RCCs) are very similar entities for individuals with substance-related disorders conveying a sense of shared identity and mutual support for persons in recovery. Peer Support/Recovery Coaching services have also been established in the RCCs to assist participants in developing healthy living skills and in the enhancement of recovery self-management skills. Many of the WRCs and RCCs address co-occurring issues of mental health and substance-related disorders within their programming.

RECOVERY-BASED APPROACHES
Person Centered Care

As Maryland's Public Behavioral Health System has evolved, it has become more important for programs and providers to re-orient their services to be congruent with what has been found to be effective, in terms of organizational and clinical practices, both nationally and within the state. Toward that end, the BHA's Office of Adults and Specialized Behavioral Health Services moved forward with the goal to promote and actively support consumer recovery, personal growth, independent living, and improved quality of life through the development of person centered planning.

Person centered planning (PCP) or person centered care (PCC) is designed to enable individuals to direct their own plan for services and supports and is in concert with BHA's emphasis on a recovery-oriented system of care. The Plan of care is intended to create a detailed roadmap – a personalized, highly individualized health management approach – to actively drive appropriate treatment and supports that are oriented toward recovery and resilience. Training on Person Centered Planning, supported by the BHA, began prior to the call for systems transformation from the federal and state levels. Person Centered Planning along with a variety of initiatives began to foster the evolution of a more cohesive, integrated, and seamless system of services and supports for individuals with mental illness. Four two-day trainings for direct service

providers were offered. Particular emphasis was be placed on demystifying the process of treatment and rehabilitation planning, debunking the myths surrounding the incompatibility of person-centered planning and managed care medical necessity criteria, and assuring the compliance of documentation and planning documents with regulatory and administrative requirements. The goal for participants was to demonstrate competency in developing a recovery-oriented treatment or rehabilitation plan that reflected the goal of the individual, and simultaneously illustrate the need for treatment and rehabilitation services, where appropriate.

Additionally, a series of train-the-trainer sessions were conducted. One set was conducted in by a national expert in person centered care for a core group of master trainers. These designated master trainers who in turn were charged with assisting selected provider agencies with whom they have existing training and consultative relationships to promote the adoption and implementation of person-centered planning within their respective specialty domains (aging, co-occurring mental illness and substance use disorders, traumatic brain injury (TBI), co-occurring mental illness and intellectual disability, assertive community treatment (ACT), and supported employment) as the cornerstone of treatment and rehabilitation planning. As a complement to training of the supported employment master trainers, a more focused, targeted training was be offered to the Evidence-based Practice Supported Employment supervisors on the implementation and adaptation of person-centered planning principles and practices within the context of the delivery of a non-clinical service.

Also, in FY 2012, the Peer Support Specialists and the BHA Office of Consumer Affairs coordinated PCC training with consumer trainers who worked with participants on Assertive Community Treatment (ACT) teams to prepare them to be active participants in their treatment planning processes. Altogether, 328 participants were trained in PCC from a variety of agencies, ACT teams, and Supervisor Collaborative (consisting of participants in the areas of supported employment and ACT). PCC continues to expand and be promoted statewide.

Plans are underway to sponsor five full-day regional trainings for mental health and substance abuse providers to explore the clinical and administrative issues involved in implementing person-centered planning within their programs as a first-step toward expanding the reach of this initiative.

Maryland is a state where quality peer recovery support services are universally accessible, flexible, person-centered, sustainable, and valued. BHA strives to strengthen and expand the available peer-based services and supports through certification, eligibility for Medicaid reimbursement, and workforce development. Within the BHA, the Office of Consumer Affairs (OCA) and the Office of Workforce Development and Training have been collaborating to successfully implement the process of training and certification for Peer Support.

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

implementation of recovery supports including peer health reform education efforts and projects to promote best and emerging practices in peer services. During the same year, as a result of the policy academy, a work group on peer certification was convened in order to evaluate any existing addiction and/or mental health core curricula that might potentially be able to be used towards a Peer Recovery Support Specialist certification. Elements for the developed curricula were taken from two main existing curricula - the Connecticut Community for Addiction Recovery (CCAR)'s Recovery Coach Academy core training for Substance Use Disorder (SUD) Specialists and a corollary mental health core curriculum used to train Wellness Recovery Action Plan (WRAP – a self-recovery management system) facilitators.

The group also worked on identifying elements from other courses that would help bridge the deficit of the two main core curricula in order to satisfy the requirements of the International Certification and Reciprocity Consortium (IC&RC)'s required core competencies for Peer Mentor credentialing. Moving forward, along with CCAR and WRAP, four other domains were targeted and implemented as training requirements for the Peer Recovery Support Specialist certification. This training was developed by the Addiction Technology Transfer Center Network (ATTC) and The DAYNA Institute to include the four domains of knowledge, skills and abilities for peer certification: Advocacy; Ethics; Mentoring and Education; and Recovery and Wellness. 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 OCA held its first annual Peer Summit of all Certified Peer Recovery Specialists (CPRS) and those seeking certification. 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.

In September, 2015, the Office of Consumer Affairs (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.

OCA also conducts venues and projects that enhance decision making, leadership, and self-direction such as, the Self-Directed Care (SDC) program which began as a pilot in Washington County and continues to assist individuals with the development and implementation of their personal "recovery" plans which include directing the use of their benefits to access public behavioral health services, education goals, and non-traditional support services.

Efforts are underway to begin the development of endorsement training for Certified Peer Recovery Specialists in specialized areas, such as forensics, child, youth and adolescents, aging, family, and veteran peer support services. Additionally, the OCA is working in partnership with Maryland's Commitment to Veterans to develop cultural competency training and support for veterans/military and their families.

Evidence-Based Practices

Evidence-Based Practices (EBPs) refers to a specific practice or service that consists of a set of standardized, replicable interventions for which rigorous scientific research exists to demonstrate the effectiveness of the interventions when implemented as designed in achieving meaningful, positive outcomes for individuals who have received the service. The successful implementation of EBP program fidelity is measured by a scale which assesses the degree to which the services adhere to the core principles and essential program elements of the practice which have been shown by research to be critical to the effectiveness of the service. EBP programs that have been rated high in fidelity on an empirically-validated fidelity scale by trained fidelity evaluators have been shown to achieve superior outcomes relative to those programs that have been rated low in fidelity.

Maryland's BHA, in partnership with the University of Maryland School of Medicine, Department of Psychiatry, Evidence-Based Practice Center promotes, monitors, and evaluates the development and implementation of EBP programs and services. The EBPC, which is funded through the federal mental health block grant, is in the 13th year of active implementation of Evidence-Based Practices (EBPs) for adults. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Additionally a Co-Occurring Disorders Specialist is working to move the system towards Dual Diagnosis Capability, and is also monitoring the activities of two programs implementing Integrated Dual Disorders Treatment. Recently, efforts have been implemented to improve services for Transition Age Youth and Older Adults. Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by the BHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score minimum thresholds on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate. Training, technical assistance and consultation is also provided to programs interested in implementing one of the models.

Supported Employment: Supported employment (SE) services provide job development and placement, job coaching, and ongoing employment support to individuals with serious mental illness (SMI) or emotional disturbance for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences, and skills. This level of service is available for individuals ages 16 and above.

BHA's relationship with the state Division of Rehabilitation Services (DORS) is another example of Maryland's collaborative strengths and commitment to supported employment. Outstanding integration between BHA and DORS at the state level and among CSAs, programs, and local DORS offices, has been recognized as exceptional by national leaders in implementation of evidence-based practices. DORS and BHA jointly applied for and were awarded a grant from the Johnson and Johnson – Dartmouth Community Mental Health Program (J & J – Dartmouth

Program), designed to further promote EBP SE services. The number of SE programs grew considerably and as of 2015, there are 61 approved community mental health provider sites across Maryland that provide SE services and supports to customers with SMI, 16 of which have received training and technical assistance in EBP SE implementation, and 26 of which currently meet EBP SE fidelity standards in order to demonstrate eligibility for an enhanced EBP rate in recognition of the additional services provided. The EBP SE Implementation Initiative in Maryland has enhanced the quality of SE services, increased competitive employment outcomes for SE consumers (average of 57% in competitive employment among EBP sites since inception of initiative.   In FY 2014, 3,431 consumers were served in Supported Employment.

Additionally, BHA partners with the National Alliance on Mental Illness of Maryland (NAMI MD) to implement the Johnson & Johnson – Dartmouth College Community Mental Health Program, Family Advocacy Team Project. The purpose of the project is to increase awareness of Evidence-Based Practice (EBP) Supported Employment (SE) among family members of persons with serious and persistent mental illness. Armed with information about the positive impact of employment and the incentives in place to protect benefit loss, families will be better prepared to provide necessary supports when their loved ones move into the work force.

The 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. This free, voluntary program is a statewide administrative employment structure, sponsored by the Behavioral Health Administration, which connects selected supported employment programs, and the CSAs within which the supported employment programs operate, into a single Employment Network consortium.

Assertive Community Treatment /Mobile Treatment: Assertive Community Treatment/Mobile Treatment is an intensive, community-based service which provides assertive outreach, treatment, rehabilitation, and support to individuals with severe and persistent mental illness (SPMI) who may be without a home or for whom more traditional forms of outpatient treatment have been ineffective. Services are provided by a mobile, multidisciplinary team in the individual's natural environment. Of the 29 mobile treatment (MT) teams in Maryland, twenty (20) are EBP ACT. In FY 2014 3,667 individuals with mental health disorders received mobile treatment services. Maryland has expanded Assertive Community Treatment (ACT) assessment tool developed through initial funding by the Washington State Mental Health Division, Department of Social and Health Services, Health and Recovery Administration. Named the *Tool for Measurement of Assertive Community Treatment* (TMACT), this instrument will eventually replace the current mechanism for gauging adherence to the established ACT model. The *Dartmouth Assertive Community Treatment Scale* (DACTS) has been the assessment tool used to monitor Maryland ACT services since 2002, and to which reimbursement rates are tied.

The TMACT, based on the DACTS, expands the assessment to include qualitative information along with team structuring. TMACT measures six subscales: (1) Operations and Structure, (2) Core Team, (3) Specialist Team, (4) Core Practices, (5) Evidence-Based Practices and (6) Person Centered Planning and Practices, integrating team structure, staffing and practices. Monitoring of these subscales will improve ACT service delivery. Currently piloted in several states, TMACT is still undergoing revisions and refinements. This tool will be used for quality improvement purposes until the research is completed. Fidelity scoring for ACT teams will rely solely on the DACTS until TMACT research is completed.

BHA fidelity monitors are utilizing TMACT during fidelity assessments. ACT providers receive both a DACTS score and a TMACT score as well as qualitative analysis and recommendations for enhance service quality. Results are shared with the EBPC's ACT consultant who provides technical support to teams to implement TMACT recommendations.

Family Psycho-education (FPE): FPE is an approach for partnering with individuals and families to treat serious mental illnesses. FPE practitioners develop a working alliance with individuals and families in the recovery process by providing information on mental illness; assisting helps to build social supports; and enhancing problem solving, communications and coping skills. Three sites are currently implementing FPE. Efforts are underway to explore implementation of EBP-FPE with transition age youth (TAY) programs supported through the Healthy Transitions (HT) and Maryland Early Intervention Program.

Consumer's Role in Quality Improvement
Consumer Quality Team (CQT)
Consumer feedback in service delivery is valued throughout Maryland's system of care. One approach is through the Consumer Quality Team (CQT). CQT is a consumer-run program dedicated to improving quality oversight of the public behavioral health system. Through the Mental Health Association of Maryland, CQT is staffed by consumers and family members, and funded in part through the mental health block grant, to conduct regular site visits (announced and unannounced) to public mental health facilities and psychiatric rehabilitation programs (PRPs) in the public mental/behavioral health system. In FY 2014, efforts were implemented to begin site visits to Residential Treatment Centers (RTCs) for youth. Interviews were conducted with young people and their families. CQT obtains first-hand information from consumers about their experiences in programs and state hospital settings and takes an active role in addressing issues directly at the program level and, as needed, at other system levels. Through monthly and quarterly meetings, information is shared via Site Visit Reports ad regular Feedback Meetings. Both consumers and program staff have recognized significant program changes made as a result of the reports. In FY 2015 more than 500 individual requests were addressed through the CQT process. Site visits included: Ninety-five (95) psychiatric rehabilitation programs (PRPs), thirty-three (33) inpatient adult units, and all the units in eight (8) youth RTCs

CQT also began conduction Housing Surveys with consumers in PRPs during FY 2014 as part of the State's Hospital Discharge Initiative. These surveys were conducted with consumers to

address feedback on housing and living preferences in the community. Highlights of what consumers across Maryland identify as key trends and issues are reported in CQT's Annual Report: www.cqtmd.org .

Client Perception of Care Survey
A statewide client perception of care survey of adults and parents/caretakers of children and youth, regarding their experiences with PBHS services, is conducted annually. Evaluation of consumer perception of care, including satisfaction with and outcomes of mental health services is a requirement of the PBHS and Code of Maryland Regulations. The survey rating are in areas of treatment success, satisfaction with services, coordination of care, referral and access to substance use services, and satisfaction with family support services.   Findings provide the BHA with valuable input that may be used to improve the PBHS.

INVOLVEMENT OF INDIVIDUALS AND FAMILIES
Partners in Recovery and Resilience
The strength of Maryland's Public Behavioral Health System (PBHS) comes mainly from its long-time collaboration with consumer, family, advocacy, and provider organizations. BHA has partnered with these organizations since their inceptions and, in fact, fostered their development. Maryland's strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PBHS. Additionally, BHA's partnerships include academic institutions and federal, state, and local agencies.

Youth & Family Involvement - BHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PBHS. The value placed on youth and family member participation continues as a major priority of the child and adolescent behavioral health system of care. The Maryland Coalition of Families (MCF) for Children's Mental Health, a statewide child and family advocacy group, continues to raise awareness and develop local family support activities.

A highly successful project of MCF, jointly with the Mental Health Association of Maryland (a volunteer nonprofit citizen's organization that brings together consumers, families, professionals, advocates, and concerned citizens for unified action), is the "Children's Mental Health Matters" public awareness campaign. This annual project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, provide an overview on issues such as bullying, and garner public support for innovative system development through a major public awareness campaign. The campaign is a partnership with local broadcast affiliates. A major media blitz occurred during Children's Mental Health Week during this past May and will be continued in the upcoming year. (www.childrensmentalhealthmatters.org).

On Our Own of Maryland (OOOMD) is a statewide consumer organization that has created its own network of support groups to provide alternative types of services to the traditional

mental health system. The organization provides opportunities for peer-operated supports and has local affiliates across the state. MCF and On Our Own of Maryland promote councils/groups that allow the opportunity for youth who receive or have received services in the PBHS to come together as peers for mutual support and systems change. BHA, in partnership with other federal grants, has supported *Taking Flight*, a program of MCF for youth and young adult leadership development. It is a youth council comprised of youth advocates ranging in ages from late teens to early twenties. Members are a diverse group of individuals with different backgrounds (mental health, foster care, lesbian, gay, bi-sexual, transgender [LGBT], etc.). A goal is to draw upon experiences to advocate toward making positive system changes.

Additionally, Maryland's former administration for substance related disorders (Alcohol and Drug Abuse Administration –ADAA) funded the establishment of eight adolescent clubhouses in FY 2013-14 that invite youth ages 12-17 who are in treatment or have been in treatment for substance-related disorders or co-occurring (mental health and substance-related) disorders to participate in peer groups that provide activities regarding educational/vocational, family events, life skills, recovery planning, and social/recreational opportunities. The BHA continues to support these eight venues in seven jurisdictions and looks forward to eventual expansion statewide.

Maryland maintains an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. BHA maintains this focus to assure that services are continuously examined and redesigned to best support recovery and resiliency. MCF established a Family Leadership Institute (FLI) which has continued graduating families every year for the last 11 years to become advocates in their communities and in the state. FLI provides this training for six weekends over a three-month period. The eleventh Family Leadership Institute was held this year with 24 graduates, increasing the number of trained family advocates to more than 300 over the period of the Institute's existence.

BHA along with the local Core Service Agencies and Local Addiction Authorities (CSAs/LAAs), the local behavioral health authorities, have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. BHA, in collaboration with the CSAs /LAAs has supported On Our Own of Maryland's (OOOMD) initiatives to transform its consumer network toward a wellness and recovery-oriented system and to enhance peer support activities and the use of best practices within the community. These collaborations include:

- The Empowerment Partnership Project is dedicated to helping transform the lives of consumers in the mental health system through offering training to consumers that provide a variety of resources and tips to individuals to help them build and maintain a recovery centered life. The workshops include topics such as wellness, employment and creativity, and recovery. The most recent workshop is *Achieving Health & Wellness Together* designed to engage consumers to take an active approach in managing their physical wellness through a series of workshops over a six-week period. The workshops are free to behavioral health programs, clinics, or hospitals that receive full or partial public funding from the state of Maryland. Another important component of this

program is Peer Employment Coaching. OOOMD has partnered with Harford County's Maryland Mental Health Network to provide benefits counseling with five of Maryland's Ticket-to-Work agencies as a tool of self-empowerment. Additionally, the program promotes *Recovery Conversations*, a new digital library of audio and video interviews about various facets of recovery. The public is able to visit the OOOMD Web site and learn and be inspired by individuals across the state as they share their thoughts, stories, and wisdom.

- OOOMD and BHA continue to collaborate to fight stigma within the behavioral health system through the Anti-Stigma Project (ASP), which helps participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Four themed workshops are available: *Stigma… in Our Work, in Our Lives; An Inside Look at stigma; Stigma: Language Matters; and Stigma: It Doesn't Discriminate*. These workshops may be tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, or the reduction/elimination of seclusion and restraint. They are presented in a wide spectrum of venues, such as local Wellness & Recovery or Recovery Community centers, housing authorities, homeless shelters, and statewide conferences and universities. OOOMD continues to receive requests for two teaching videotapes, "Stigma...In Our Work, In Our Lives" and "Distorted Perceptions: How Stigma Impacts Recovery". ASP has recently collaborated with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool.

- BHA, in collaboration with OOOMD, will continue statewide delivery of the Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement, and incorporate WRAP within community mental health programs. WRAP also addresses BHA's increasing efforts to actively involve consumers and families in quality improvement and evaluation activities. There are more than 240 WRAP facilitators trained statewide.

Maryland provides support to the statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. NAMI adheres to the concept that empowering family members and consumers is a critical factor in recovery and provides education and outreach programs, trainings, advocacy, and support. BHA worked successfully with NAMI MD in promoting a kick-off event for NAMIWALKS, a successful annual event that promotes *MAY MENTAL HEALTH MONTH.* NAMI MD has developed a strong Family-to-Family Education presence in the state. The "In Our Own Voice" program is an informational outreach program on recovery. "Peer-to-Peer" is a unique, experiential learning program for people with serious mental illness, who are interested in establishing and maintaining their wellness and recovery. Also, NAMI MD has two initiatives to support the integration of physical and mental health – NAMI MD's "Healthy Hearts and Minds" education program as well as an information dissemination project. Additionally, NAMI MD (as do the other advocacy organizations mentioned above) presents an annual education conference for families, consumers, and providers. Significantly, NAMI is an approved trainer of the Maryland Addiction and Behavioral-

health Professionals Certification Board (MABPCB) for the four domains of Peer Support certification - Advocacy, Ethics, Mentoring and Education, Recovery and Wellness. In FY 2016 BHA will continue to support NAMI MD's public education and training efforts.

The BHA Office of Consumer Affairs (OCA) participates in systems level activities at all pertinent BHA meetings. The OCA conducts a project known as LEAP (Leadership Empowerment Advocacy Project), which trains individuals to advocate for policy change, become educated in advocacy, direct peer groups, while learning to develop communication and leadership skills at a systems level. Since its inception in 1990, LEAP graduates continue to: serve on committees, federal and state advisory boards; as well as participate in the state planning process for the Public Behavioral Health System (PBHS).

Health and Wellness
As part of Maryland's commitment to wellness and prevention, BHA promotes and maintains strategies to enhance tobacco-use quit rates among individuals in the behavioral health system as well as staff in behavioral health treatment services settings. Guidance and technical assistance is provided to the consumer/peer run programs to promote implementation of smoking cessation initiatives.   Expanded training of behavioral health treatment agency staff and treatment providers continues in order to promote and facilitate the provision of smoking cessation classes and guidance for nicotine reduction to individuals with mental health and substance-related disorders. Smoking cessation services and pharmacotherapies are being provided as a component of providers' therapeutic services. BHA continues its collaboration with MDQuit to utilize tools and resources such as use of nicotine replacement therapy (NRT), medications, and referrals to Maryland Quitline. BHA collaborates with the DHMH Prevention and Health Promotion Administration (PHPA), the Center for Tobacco Prevention and Control (CTPC), other public health and somatic care agencies, and community-based organizations to expand public awareness of available smoking cessation services for individuals with behavioral health disorders.

The BHA FY 2016 Behavioral Health Plan also includes efforts that promote integration of behavioral health and somatic care.   Strategies highlight continued activities that foster collaboration with the DHMH -Coordination of Care Committee, through monthly meetings, to determine barriers and strategies for integrated care and to identify universal outcomes. Activities also support the provision of outreach, training on obesity in children, and other chronic somatic issues in adults, as well as technical assistance to providers participating in Health Home implementation to further integrate somatic and behavioral health services. Additionally, access to registered somatic health providers has been increased through Webinars and trainings that are available through the ValueOptions®Maryland Web site. Training events are posted on the ASO site, which can be viewed by all providers, as well as the public. Regional forums have been held by the ASO on Integration of Care. Trainings are also available on how to access the Outcome Measurement System (OMS) data.

Housing
Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the well-being and stability of persons with serious mental illnesses residing in the

community. Toward this end, BHA actively collaborates with both the Maryland Department of Housing and Community Development (DHCD) and the federal Housing and Urban Development (HUD) to promote access and receipt of affordable housing through specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

To assure that consumers of mental health services have a range of housing and other residential options, BHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable, safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing with accompanying support services as requested and needed by the consumer. Several CSAs have supported local housing authorities in applications for HUD Mainstream Section 8 vouchers and Flexible Housing Choice Vouchers. However, due to changes in the Federal budget priorities and the increase in the cost of all housing, access to new housing vouchers for individuals with disabilities is limited. Despite this, BHA will continue to work with CSAs to expand mainstream rental opportunities that enhance affordable housing options for individuals with serious mental illnesses. At the provider level, many mental health providers have also helped consumers successfully pursue HUD Housing Choice programs including the Housing Choice Vouchers and other rental assistance services. Additionally, BHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. BHA has identified housing as its priority for receipt of these bond monies. Several of this year's Capital Program awards addressed this priority.

The Public Behavioral Health System encompasses an array of services within a continuum of care. Maintaining capacity along this continuum is key to facilitating movement along this route of services leading from diversion from inpatient (or incarceration in the forensic system), urgent care, crisis services, psychiatric inpatient care, partial hospitalization, outpatient care, residential rehabilitation care, case management, all the way to supported living and supported employment. Diversion of individuals from admissions and/or discharging individuals from the hospitals assist in further reductions in the hospitals' census.

BHA funds residential rehabilitation programs (RRPs) as part of psychiatric rehabilitation services to assist in serving persons who are discharged from state psychiatric facilities, those court ordered to such services, and other persons who meet the medical necessity criteria for this level of care. All persons in RRPs have a severe and persistent mental illness. The goal of the RRPs is to assist individuals to integrate back into the community as they graduate through and out of RRPs and into permanent supportive housing. The BHA has recently taken the following actions to ensure that individuals move as quickly as possible through the continuum of residential treatment and rehabilitation options, relying on such options for their treatment and rehabilitative milieu rather than as a form of de facto housing placement: 1) Transfer of the locus of authorization for the RRP service from the local Core Service Agency (CSA) to the Administrative Services Organization in order to more strictly and uniformly apply the Medical

Necessity criteria for the service; and 2) Reduce the length of the authorization for the service, thereby increasing the frequency of utilization review and further ensuring that available clinical documentation justifies the continuing need for the service.

As important as the discharge planning process, is the access to urgent care, respite care, and crisis services and all services that help to reduce the risk of re-admission to the hospitals or to the jails and detention centers. Additional community-based services and resources, such as Wellness & Recovery Centers/Recovery Community Centers are key components supported by the BHA to help sustain an individual in the community.

BHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies, as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized federal and state government-supported housing opportunities, as well as local county resources and private foundations.

In 2009, Maryland's DHMH and Department of Housing and Community Development (DHCD) developed a strategic plan for the development of affordable housing for persons with mental illnesses and/or developmental disabilities. An earlier report by the Technical Assistance Collaborative (TAC) outlined the barriers to available affordable housing for individuals with mental illness, including that many who were on SSI faced rent payments that were at least one third more than their total monthly income and that rental subsidies were necessary if the large numbers awaiting housing were to be served. The 2009 Plan recommended:

- Continued expansion of the production of affordable units and utilization of existing affordable housing units
- Targeting rent subsidies to the highest priority target populations served by the system
- Strengthening planning and advocacy efforts at the local, state, and federal levels and collaboration with the private sector to increase affordable housing opportunities
- The generation of more than 1800 rent subsidies in the next 5 years

The plan encouraged the use of supportive housing, tenant-based and project-based rent subsidies. BHA continues to update and expand on the components in this plan that include Integration of housing that is scattered throughout the community, in buildings without unusual concentrations of people with disabilities and affordable housing, such as independent 1-2 bedroom apartments or single family homes are prioritized in concert with the ADA community integration mandate.

Maryland's Behavioral Health Administration has the unique opportunity to partner with the Department's Office of Capital Planning, Budget and Engineering Services to prioritize the Administration-Sponsored Capital Program grant (Community Bond) financing for the development of affordable housing projects as well as projects that move individuals from RRPs into the community so that state psychiatric facilities can transition eligible individuals ready for discharge into RRPs. Through this program, BHA continues to encourage the expansion of permanent supported housing through which individuals with psychiatric disabilities may access

an array of flexible service delivery programs, including psychiatric rehabilitation programs (PRPs), case management, and other supports to enable them to live in housing of their choice. This Program may also include projects that provide transitional housing models (often time limited) with specific supports that often serve a specific population, such as veterans or individuals with forensic backgrounds, whose needs can be better met in the community rather than an inpatient setting. Community Bond projects are often leveraged with HUD housing vouchers or DHCD, county, or other funding sources that provide rental subsidies to the tenants.

BHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. These efforts have resulted in extensive partnerships that have provided consumers with affordable housing and rental subsidies along with accompanying support services as needed and requested by the consumer.

BHA also supports a continuum of care which includes a continuum of residential and housing models. Rates in the fee-for-service system for supportive housing services help providers to support individuals' abilities to live in their own homes. BHA also gives grants to ACT teams through the CSA to afford subsidies for persons leaving the State Hospitals. These are for individuals or those with families. BHA funds residential rehabilitation programs (RRPs) as part of psychiatric rehabilitation services to assist in serving persons who are: discharged from state psychiatric facilities; court ordered to such services, and/or other persons who meet the medical necessity criteria for this level of care. The goal of the RRPs is to assist individuals who have a severe and persistent mental illness to integrate back into the community as they graduate through and out of RRPs and into permanent supportive housing.

This year, as a result of the behavioral health integration and creation of the Behavioral Health Administration (BHA), the substance-related and mental health disorders' Community Bond Application processes were combined. The priority for substance-related projects was Recovery Housing. The BHA Offices of Planning and Treatment and Recovery Services worked in concert to review all projects and submit pertinent information to BHA leadership as a unified package.

Maryland has a strong track record of entering into partnerships to develop creative approaches to addressing the housing needs of low income persons with disabilities. Maryland has convened committees with representation from state governmental agencies, service providers, housing organizations, and consumer groups to address the housing needs of the Medicaid population that have led to cooperative agreements, program and policy changes, resource development and implementation of demonstration projects that further the state's affirmative efforts to implement the Olmstead Decision. These efforts have resulted in the following successes:

- Implementation of the *DDA/MFP Bridge Subsidy Program* in 2010 through an agreement between DHCD, the Developmental Disabilities Administration (DDA) and certain PHAs using $1 million in MFP rebalancing initiative funds. This program assisted 20 people with up to 5 years of rental assistance.

- Implementation and maintenance of an internet-based affordable housing registry through a DHCD contract with Social Serve, Inc. at www.mdhousingsearch.org.
- Convening a MDOD Statewide Housing Task Force to assist PHAs to apply for Non Elderly Disabled (NED) Category 1 and 2 HCVs with the support and collaboration of disability service organizations. This partnership resulted in awards of 260 Category 1and 112 Category 2 vouchers to Maryland PHAs. To date, all Category 1 and 2 vouchers were issued to qualified households.
- Creation of the "Affordable Rental Housing Opportunities for Persons with Disabilities" project in 2011. This $1 million grant from the Weinberg Foundation will develop apartments for people with disabilities at 15-30% AMI through a partnership between the Foundation, MDOD, DHCD and DHMH. Units will   remain affordable for 40 years.
- Convening of a HUD 811 Steering Committee in April 2011 to discuss strategies for responding to an anticipated NOFA for a new Section 811 program.
- Implementation of the *Maryland Partnership for Affordable Housing* project in October 2011 through funding from a Real Choice Systems Change grant from the Centers for Medicare and Medicaid. This project has furthered Maryland's efforts to create the infrastructure necessary to apply for and implement a HUD 811 Project Rental Assistance Demo program. Partners include DHMH, DHCD, and MDOD. Maryland Center for Developmental Disabilities (MCDD), Centers for Independent Living, consumer organizations and housing developers.
- In February, 2013, HUD (along with 13 other states) awarded The Maryland Department of Housing and Community Development (DHCD) in partnership with the Department of Health and Mental Hygiene and the Department of Disabilities $10,917,383 in funding to administer Maryland's Section 811 PRA Demo program, which will serve 150 individuals. Recently, in FY 2015, a second award was made allowing for an addition l 150 individuals to be served. Section 811 PRA Demo funds will be leveraged with federal and state resources such as Low-Income Housing Tax Credits, private activity bonds used for multifamily development, FHA Risk Share Lending, and HOME Investments Partnership Program, Maryland's Rental Housing Production Program, Maryland Housing Rehabilitation Program-Multi-Family, the Partnership Rental Housing Program and other resources.

Community Living Supports - Older Adults

The PASRR Program (Pre-Admission Screening and Resident Review) is a federal program governed by the Centers for Medicare and Medicaid Services. This program screens individuals seeking nursing facility care for a history of mental illness and identifies the most appropriate and least restrictive services that will meet the individual's needs. The required evaluations are conducted by Adult Evaluation and Referral Services (AERS) professionals at the local health departments and approved by the Office of Adult Services.

Outreach and specialized services to support older adults with behavioral health issues: BHA funds specialized programs and resources through state grants to certain jurisdictions to support the behavioral health needs of older adults. These programs may include outreach,

education, engagement, home-based treatment, or specialized older adult RRP or behavioral health assisted living services.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

2. How are individuals transitioned from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. COMMUNITY LIVING AND THE IMPLEMENTATION OF OLMSTEAD

Implementation of Olmstead Related Activities
The Behavioral Health Administration works collaboratively with key State agencies to cultivate efforts that support Olmstead related activities. The Maryland Department of Disabilities (MDOD) develops a cross-disability plan that addresses housing, employment, transportation and consumer rights. Planning efforts continues to provide direction for Olmstead – related activities for the State and calls upon units of State government to cooperatively engage in a variety of activities to promote consumer self-direction and consumer-centered services. The Maryland Department of Disabilities has become increasingly involved in the housing issues for persons of all disabilities, in order to streamline cross-disability efforts and maximize State and federal resources.

Additionally, Maryland was selected to participate in SAMHSA's *2013 Olmstead Policy Academy (PA) on Housing, Employment and Recovery*. The Maryland Olmstead PA team is part of a larger effort sponsored by SAMHSA involving multiple states and bringing to bear the efforts of subject matter experts in the topic areas of recovery, housing and employment. The hope is to see measurable improvements in policies, practices and numbers of people making successful transitions from institution to community. The Maryland Olmstead PA convened an ad hoc workgroup of the Maryland Affordable Housing Partnership (MAPH), formed under the Centers for Medicare and Medicaid, Real Systems Change Grant for Building Sustainable Partnerships for Housing, with the leadership support of DHMH, MDOD, and DHCD. MPAH has been a catalyst for coalescing the disability advocacy, state governmental agency, and housing development communities around a shared vision surrounding central importance of affordable, accessible housing to individuals with disabilities, included those with serious mental illness and co-occurring disorders.

Efforts in Maryland will build on the state's success in developing and targeting housing resources to people with disabilities, and take that success to the next level. Specifically, there is interest in crafting a statewide, coordinated approach to helping people with disabilities move into affordable housing. This might include:

- Standardized assessment of needs and preferences of prospective tenants, and creation of a method for matching needs and preferences with available units and supports. This could result in *system change* that becomes the Maryland approach to the housing needs of people with disabilities, across systems and applicable to all sorts of institutionalized situations.
- Staff and prospective tenant training and support: This might include efforts across systems to standardize outreach and 'in reach' to prospective tenants with disabilities; offer a set of tools and approaches designed to improve successful transitions; train staff and prospective tenants on step by step methods of matching housing needs and preferences to available units and available supports as well as finding and securing housing. These efforts are targeted to the people doing the work – the prospective tenants and caseworkers from all systems.

The resulting Maryland Olmstead Behavioral Health Initiative (MOBHI) is embedded within the context of a larger, cross-disability initiative designed to expand and extend the state's efforts to promote full community integration and to reduce the reliance on restrictive and segregated levels of care for individuals with disabilities, consistent with the implementation of Title II of the Americans with Disabilities Act (ADA) and *Olmstead v. L.C* (hereafter referred to as the Olmstead decision). This initiative addresses systemic and individual barriers to community integration through effective implementation of an integrated set of priority strategies as identified in the state's Olmstead Planning process:

1) Expansion of the role of the Consumer Quality Teams to administer a housing survey tool to identify the community housing preferences of individuals residing in restrictive mental health care settings;
2) Expansion of targeted case management services on a time-limited basis at the point of transition to facilitate the transition of individuals from restrictive residential settings to permanent supported housing
3) Establishment of regional housing specialists. Regional housing specialists provide expert consultation and access to mainstream community housing resources within their regions, and work in partnership with the local housing development community and public housing authorities to leverage state, federal, local, and private resources to expand the supply of affordable housing units. Case managers or other behavioral health practitioners who are seeking to locate and secure affordable, accessible housing work with regional housing specialists to identify community resources.   Regional housing specialists do not carry dedicated caseloads, but serve as coordinated access points at the local level for cross-system level resources including but not limited to bridge rental subsidies, Section 811 demonstration funds, Weinberg Foundation Units, Non- Elderly Disabled (NED) vouchers, and housing tax credit units,
4) Provision of enhanced, individualized mental health and support services not otherwise reimbursable within current fee-for-service behavioral health system which are necessary and sufficient to support the individual's transition to integrated community-based settings.

Olmstead Community of Practice
Post Olmstead Policy Academy efforts build on many of the activities around the state that promote supportive housing and the continued partnerships that contribute to an inclusive planning process. The SAMHSA Olmstead Community of Practice (COP) is designed as a voluntary technical assistance effort to assist state governments in assessing and maximizing their system's ability to support consumers living in their own communities. The COP encourages each state to bring a cross section of staff with relevant expertise and responsibilities. BHA's Office of Adult Services Director and the Coordinator of Case Management and Housing along with MPAH representation collaboratively participate on the COP, which is enclaved regionally across the country. Maryland is part of the northeast group and actively participates in conference calls and Webinars with the other states, learning the latest outcomes of various approaches to diversion from hospitalization, and efforts to promote permanent supported housing.

Olmstead Related Initiatives
Maryland Hospital Discharge Project
In FY 2013, to facilitate the discharge of long-stay State hospital residents, the former Mental Hygiene Administration (MHA), now the BHA, began an initiative 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. 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 (SGH). As a result of the committee efforts, several recommendations were identified and implemented. These included the development of a real time process for identification of patients ready for discharge, collaboration of SGH and the CSAs for communication and planning community services and discharge; implementation of a process to identify patient preference in treatment for mental health advance directives; increase efforts to support transition groups and provide 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; encouragement of improved process of Medicaid enrollment; referral process to include multi-jurisdictional options, availability of wraparound and other types of funding; services for individuals in need of medication administration; and increased number of housing subsidies. 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.

SGHC's catchment area includes Harford, Baltimore, Anne Arundel, Prince George's counties and Baltimore City. The CSAs from these jurisdictions agreed to develop services for patients identified by the hospital and regional services are being contracted with community providers. A variety of services and supports were recommended, based on an identified general need of SGHC patients, such as: expansion of assertive community treatment (ACT) team service capacity; increased housing and residential rehabilitation program (RRP) beds; and upgrading RRP beds from general to intensive status. This project resulted in a total of eighty (80) new community resources for patients discharged primarily from Spring Grove Hospital and some from Springfield Hospital. The project was implemented in 2 Phases. Phase 1 was 70 new services and Phase 2 was 10. The Discharge Initiative was completed in FY 2015. Services included ACT with housing, Assisted Living, and Residential Rehabilitative Programs (RRP) intensive level.

Maryland's Behavioral Health Capitation Project
Since FY 1994, the Baltimore City CSA, has operated a capitation project. The Capitation Project is a unique program in Baltimore City that provides a comprehensive range of coordinated services to individuals with a serious mental illness who are able to live in the community, but have difficulty managing their various treatment and service needs independently. Individuals enrolled in Capitation have access to staff 24 hours per day, 7 days a week. Individuals receive psychiatric evaluation and treatment; clinical assessment; medication management,

administration, and monitoring; individual, group, and family therapy; support with daily living skills; assistance with locating housing; entitlements coordination; supported employment services; and case management. Through a procurement process, two vendors were selected, Johns Hopkins Bayview (Creative Alternatives) and Mosaic Health Services (Chesapeake Connections) to operate the program. The Capitation Project providers receive a predetermined amount of funding each month to manage and pay for all of an individual's psychiatric care, including inpatient care. Treatment teams use assertive outreach, treatment, and support to assist individuals to live successfully in the community. Caseloads are small and average eight to ten individuals per clinician. When consenting to Capitation services, individuals are agreeing to a limited benefit package within the PMHS. This means that individuals still have access to the full range of services, but the Capitation provider authorizes and pays for services instead of the administrative services organization. In FY 2014, 354 individuals were served.

Peer Support Project

BHA also, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also WRAP facilitators, facilitate consumer discharges and provide ongoing support during the consumers' transition into the community from three state facilities: Springfield, Eastern Shore, and Finan Hospital Centers. In FY 2015 more than 110 consumers in state hospitals were seen by the PSS staff. PSS staff also provided help and referrals to Wellness & Recovery centers (22 of the 25 Centers are OOOMD affiliates), CSAs, and other organizations that work to enhance recovery. Within the BHA, the Office of Consumer Affairs (OCA) and the Office of Workforce Development and Training have been collaborating to successfully implement the process of training and certification for Peer Support.

The Lisa L Program

Maryland is not involved in any litigation or settlement due to an Olmstead suit at this time. However, BHA does provide case service coordination to the Multi-Agency Review Team (MART), charged with tracking the Lisa L population of Maryland. This population consists of children (up to age 20) who are in the custody of a state agency (DJS, DSS, DHMH) and admitted to a state or private psychiatric hospital. MART's goal is to remove barriers to treatment and discharge for these youth while ensuring that they are discharged to their recommended placement in a timely manner. To achieve this goal, Mart convenes bi-weekly, holds emergency conference calls (as needed), and utilizes Web-based automated tracking systems to stay abreast of every reported psychiatric hospitalization and residential treatment center placement.

18. Children and Adolescents Behavioral Health Services

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;

- improve emotional and behavioral outcomes for children and youth;

- enhance family outcomes, such as decreased caregiver stress;

- decrease suicidal ideation and gestures;

- expand the availability of effective supports and services; and

- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

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[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

The Behavioral Health Administration's Office of Child and Adolescent Services (OCAS) is responsible for planning, monitoring for program compliance and building partnerships to ensure the delivery of behavioral health services to children and their families within the public behavioral health system (PBHS). The Office works closely with other child-serving agencies and the core service agencies to improve access and coordination of care for the child and adolescent population.

The Office, with its partners and stakeholders, provides leadership, expertise and guidance to promote wellness, prevention and resiliency in all child and adolescent behavioral health. These efforts range from universal prevention programs to the most intense levels of care in every jurisdiction. Maryland continues to make progress in growing its system of care, imbued with core values of being child-centered, family and youth driven, community-based and culturally and linguistically competent.

As stated earlier in this document, Maryland merged its previously separate substance use and mental health administrations on July 1, 2015. This merger prompted a reorganization that has allowed the state to begin the process of improving all behavioral health services offered Statewide. The Office of Child and Adolescent Services assumed responsibility for adolescent and youth substance use service delivery in this reorganization.

A Multi-System of Care Approach: An Array of Services and Supports: Maryland's Coordinated Network of Community-Based Behavioral Health Services and Supports
SAMHSA has funded initiatives to build the system of care approach in states and communities around the country. Maryland's Behavioral Health Administration has worked diligently to bring this approach to scale creating meaningful partnerships for children with serious emotional disorders (SED) receiving mental health services and assistance. Maryland's system of care approach framework relies on several projects and programs to improve delivery systems, services and outcomes for children, youth, and young adults with mental health and/or substance related, and co-occurring disorders as well as support to their families and caregivers.

Maryland was one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration that was based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. A major component of the implementation of the waiver was the statewide development of a Care Management Entity (CME). The Statewide CME provided care management to youth in the PRTF waiver, youth placed at the group home level by both DHR and DJS, and youth enrolled in two SAMHSA funded system of care grants. Another similar demonstration that fostered efforts to improve the quality and cost of care for children with serious behavioral health challenges was the implementation of CHIPRA (Children's Health Insurance Program Reauthorization Act, Quality Demonstration Grant). Maryland applied successfully to CMS for the CHIPRA Quality Demonstration grant as the head

of a consortium of states that included fellow PRTF demo partner, the State of Georgia, and the State of Wyoming. The grant was the only behavioral health grant among all 10 awarded by CMS that focused on the implementation, expansion and sustainability or Care Management Entities (CMEs). As a result, the five year CHIPRA Quality Demonstration became an anchor in the sustainability planning for CME and System of Care efforts started up under the 1915(c) and SAMHSA SOC grants.   In brief, the CHIPRA grant supported a number of projects, these included the following:

- Finance project- Development of a financial sustainability plan, including the development of a Section 1915(i) state plan amendment
- Psychopharmacological Project--Developing State of the art mechanisms to assure appropriate uses of medications with children and adolescents in the Medicaid program.
- Somatic health—Strengthen CMEs to expand their focus to include coordination of somatic care such as access to well child visit, EPSDT, dental, smoking cessation , obesity, poor nutrition, and health care consumer skills, and other critical health care coordination issues as they arise.
- Peer Support--Refining and strengthening Maryland's approach to family to family peer support and developing appropriate reimbursement mechanisms to support peer support as a Medicaid service. Possible examination of the difficult area of developing youth peer support services and developing infrastructure to support this service.

Additionally, as one of the states awarded the System of Care (SOC) Expansion grants, BHA's Office of Children and Adolescents developed the Maryland Behavioral Health Collaborative (MHBC). The MHBC 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 MHBC 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.

Intensive Behavioral Health Services for Children and Youth State Plan Amendment
In developing a more robust system of care, Maryland also recognized specialized intensive behavioral services must be coordinated in a delivery system that reaches the broadest number of people in need. In FY 2013, the former MHA submitted to Maryland Medicaid a proposed 1915(i) State Plan Amendment (SPA) to support services delivered under the sunsetting PRTF Demonstration Waiver that provides PTRF diversion services for children adolescents and Transition Aged Youth. The Section 1915(i) SPA amendment entitled "Intensive Behavioral Health Services for Children, Youth and Families" was approved by CMS effective October 1, 2014. 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 services not otherwise available to Medicaid recipients.   Eligible enrollees include youth at the PRTF level of care and those who have experienced multiple hospitalizations. Financial eligibility is limited to those below 150% of the Federal Poverty Level (FPL) 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. Maryland is required to offer these services statewide within a five year period. Implementation of this program will be incremental based on jurisdictional readiness as determined by the numbers and types of providers that are enrolled as are deemed ready to commence service delivery in a manner that assures the health and safety of participants. The new Targeted Case Management program and 1915(i) service package are specifically designed to both divert and to transition youth from Residential Treatment Centers (RTC's) that are currently the primary institutional setting used for children and adolescents with SED in Maryland. In our past experience it has proven advantageous to divert a child from going to such a facility in the first place rather than to require their admission as a criterion for getting special services for discharge.

Interagency Partnerships
Departments of the Children's Cabinet
Maryland has a well-established Children's Cabinet that is staffed by the Governor's Office for Children and addresses high level policy issues related to coordination, with DHMH as an interagency partner, among integrated service efforts serving children and youth across the state. DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan. The numerous, jointly- funded, and integrated service efforts – for services offered to children and youth for substance abuse, developmental disabilities, and mental health problems - that come from the Children's Cabinet are guided by an Interagency State Plan. Ongoing coordinating mechanisms within DHMH allow the department to fulfill its role as an interagency partner with the other agenciesThe existence of such an enduring interagency structure (the initial cabinet level body was created in 1978), creates a highly effective venue for interagency policy development and implementation. Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

Additionally, the Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet.   A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes Deputy Secretaries and other key members from the same

agencies as the Cabinet. . The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address priority needs.

Department of Human Resources - Child Welfare Services

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, and formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. BHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PBHS as a performance indicator.

- *"Place Matters"*- A prevailing policy direction of DHR is the "Place Matters" campaign. The agency joined with the Annie E. Casey Foundation's Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading an effort to bolster new foster family homes so that children live in closer proximity to their family members and their communities. Key Performance Measures for Place Matters include: (1) reducing the number of children in out-of-home care; (2) reducing the number of children in group homes; (3) increasing the number of children placed in their home jurisdiction; (4) increasing the number of children who reunite with their family; and (5) increasing the number of adoptions. According to DHR's Place Matters October, 2014 Fact sheet, there has been 50% reduction in out of home placements (from 10,330 in July 2007 to 5,151 in September 2014). There has also been a decrease in the percentage of youth under 18 in group home placements by 8%, and an increase in the percentage of family home placements for youth under age 18 to 81%.

- *"Other DHR"* - Other DHR social services, outside of child welfare, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). Child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education and will be discussed in conjunction with early childhood education. For those in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.

- **Department of Human Resources (DHR) -** The Mental Health Supportive Services (MHSS) is funded through the DHR to local jurisdictions for Mental Health Mobile Crisis and Stabilization Services. DHR and BHA monitor these services that are designed to support foster care youth in their placements, and to avoid hospitalizations. Improved outcomes have been documented in the areas of a reduction in acute admissions, and disrupted placements. Due to these successes, some of the funding through MHSS has now been able to be used for family support services, prevention of foster care placements, and education. This has also allowed mental health to provide early intervention services for identified youth, while still being able to respond to mobilize services during times of crisis.

- **Maryland's Title IV-E Waiver Demonstration Project** – Title IV-E are federal funds that are matched by State dollars to pay for specific child welfare activities. Historically, Title IV-E funds have been used primarily for children and youth while in foster care. The Title IV-E Waiver Demonstration Project provide states flexibility in their use. Maryland's DHR, the lead agency, intends to utilize the Title IV-E Waiver Demonstration Project to create a responsive, evidence and trauma informed system to promote well-being, using standardized assessments, building capacity of evidence-based and promising practices, strengthening families, and serving children in their homes. These efforts will be achieved through building on the success of Place Matters, leveraging statewide Children's Cabinet initiatives; utilizing EBPs, and creating a trauma informed system of care.

Targeted and Specialized Services

Maryland's system of care approach is comprised of a spectrum of effective community-based services and supports including services for children in homeless families and homeless youth. BHA has funded and provided technical assistance to a project for young children who are homeless, children living with their mothers and other family members in family shelters throughout Baltimore City. This outreach focuses on family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Services for Runaway and Homeless Youth

The unmet needs of youth that are homeless are extensive, particularly the needs runaway and homeless adolescents or otherwise unaccompanied minors with serious emotional disturbance.

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. BHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using this System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level.

DHR gathers and reports information only on people and families who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

Maryland State Department of Education (MSDE)

MSDE and the BHA have worked on integrating School Based Mental Health (SBMH) services since the 1990's. There was a long standing Education Mental Health Leadership Committee, that is now the Community of Practice (CoP) in Maryland. The Center for School Mental Health (CSMH – located at the UMD), is the nationally funded center for TA and excellence and is a key part of the CoP. These efforts also include a focus on early childhood mental health and school readiness. Through these partnerships the CSMH, MSDE, and BHA has been supported in successfully applying for a number of grants that serve to improve SBMH services across Maryland. There has also been the development of a number of Children's MH on-line modules that are geared to school personnel. As systems become more integrated, there is the recognition that substance use services, along with mental health, need to be available through local school districts. Planning and decision making efforts are now in process regarding the components of an integrated behavioral health SOC as it relates to educational settings. Two examples of more recent state and local partnerships supported by the CoP is a grant MSDE received through SAMHSA for Advancing Wellness and Resilience in Education (Project Aware), that are in Baltimore, Somerset and Dorchester Counties and a grant provided by MSDE, with in-kind support from the OCAS, for the Eastern Shore School Mental Health Coalition (ESSMHC), a 9 county regional project created in 2009 to improve the academic outcomes of youth with behavioral health needs on the Shore.

School-Based Behavioral Health Interventions

To address the need for multi-system involvement due to the high number of children and youth who are frequently involved in more than one specialized system, the state is working to strengthen the connection between available behavioral health services, and recovery support services and educational services in the Maryland public school system. The BHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA).   BHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. Additionally, the mental health block grant supports school-based mental health initiatives that foster diversion to hospitals and RTC's, as well as funding that address school expulsion and bullying.

Additionally, school-based behavioral health interventions are available in Maryland along with more comprehensive School Wellness Centers that provide somatic and behavioral health services to students will be expanded and made available in school settings across the State. The University of Maryland, School of Medicine will partner with the BHA and provide technical assistance for the development of school mental health services. In addition, Maryland has made a significant investment in early childhood mental health by focusing on mental health

programs placed in Head Start Centers that will provide mental health consultation to day care center staff around the State. The day care mental health services efforts were developed to prevent the unnecessary expulsion of young children from child care settings because of perceived behavioral problems.

Early Childhood Mental Health Services
Maryland supports programs and activities for children with SED by applying available funding for prevention and treatment for SED's in early childhood, as most mental health disorders have their roots in childhood. The main strategy is to incorporate mental health services into existing early childhood programs and other community settings for infants and children up to 5 years of age. The mental health component of the Maryland Infant and Toddler Program provides services for young children is continually strengthened by activities part of the Early Childhood Mental Health Initiative which supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

Maryland Project LAUNCH
Maryland continues to implement of the LAUNCH (Linking All Unmet Needs in Children's Health) a five-year grant awarded to DHMH and the BHA by SAMHSA is a comprehensive early childhood intervention strategy designed to coordinate key-child-serving systems and integrate behavioral and physical health services to ensure that children are able to thrive in safe, supportive environments and enter school ready to learn in the pilot community of Prince George's County. The population served by this grant are children from birth to 8 years living in Prince George's County within an identified Transforming Neighborhood Initiative Area. Maryland LAUNCH will establish State and Local Young Child Wellness Councils promote infrastructure develop at the local and state level. In addition, Maryland LAUNCH will provide training on developmental screening and assessment tools for primary care providers, early childhood educators, and home visiting programs. The project has successfully placed mental health consultants in early child care and education settings through a partnership with community Counseling and Mentoring Services. The Maryland LAUNCH grant provides support for the following efforts:

- To enhance the collaboration among State and local child-serving agencies;
- Increase the use of early screenings, assessments, and mental health consultations in a range of early child care and educational settings;
- Increase integration of behavioral health and primary care;
- Enhance home visiting with an emphasis on social and emotional development supports;
- Provide family strengthening and parent skills training to parents and families;
- Provide training on developmental screening and assessment tools for primary care providers, early childhood educators, and home visiting programs; and
- Mental health consultation capacity will be enhanced by hiring master's level early childhood mental health consultants to work in a variety of settings. Primary care providers will be trained in identifying and referring children with

developmental concerns to appropriate services to better coordinate behavioral and primary care.

- Family strengthening programs will be expanded to reach families receiving mental health consultation services to those involved with or at risk for involvement with the child welfare system.

In the previous year LAUNCH efforts have included placing four mental health consultants in twenty-seven schools as a result of partnerships with community services such as the Counseling and Mentoring Services, the Maryland Coalition of Families, Fatherhood Buzz, MCF, University of Maryland, Center for Infant Study, and the National Fatherhood Clearinghouse. Through these partnerships, outreach and marketing events and activities have been hosted and county-wide. Events and evidenced based parenting training programs such as the Social Emotional Foundations of Early Learning Parent Workshop series, the Week of the Young Child and the Mental Health Matters Campaign, Strengthening Families, the Family Leadership Institute, the Family Connectors Program, a BHIPP Check Up event, and Dynamic Dads. Maryland continues it collaboration of the State Wide Early Childhood Mental Health Steering Committee. Additionally, through the BHA's Office of Children and Adolescent Services continued partnerships with MSDE, there is expanded recognition of the importance of intervening with young children (0-5), therefore, efforts have been extended to a number of centers and consultative services in Maryland to provide this resource to day care and Head Start programs as a way of assisting individual children, classroom supports and decreasing the large number of young children being expelled from preschool programs.

Juvenile Services

The Behavioral Health Administration (BHA) of DHMH and the Department of Juvenile Services (DJS) have a history of cooperation at State and local levels to support behavioral health services to DJS youth in need of these services.   These behavioral health services focus on the needs of youth in the care of DJS both before and after adjudication and disposition by the juvenile court.

Current collaboration: BHA promotes behavioral health services by supporting substance use counseling within the juvenile detention centers. The BHA Child and Adolescent (C&A) staff provide training for DJS direct care staff on an as needed basis. The BHA Psychopharmacology Learning Collaborative continues working with psychiatrists who provide services to youth in the juvenile justice system to assess the use and administration of psychotropic medication to youth in DJS custody.

Proposed collaboration: Given the prevalence of behavioral health problems in youth with DJS contact, as well as concerns youth with behavioral health problems may be at higher risk for DJS contact, BHA proposes extending the partnership with DJS to expand current DJS and BHA services to effectively and efficiently address the behavioral health needs of these youth. DJS and BHA will develop and implement additional treatment and related recovery supports, for individuals with DJS involvement, including early diversion from juvenile justice and criminal justice systems as appropriate. These developments will be planned, monitored and evaluated collaboratively by DJS and BHA in phases over the next three years.

Substance Abuse Services Including Co-occurring Disorders

Maryland's BHA, has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals across the lifespan needing both mental health and substance abuse services.   Maryland's behavioral health integration process moved forward in developing an integrated system of care for youth with mental health and substance related disorders. This structure has allowed for coordinated behavioral health workforce development and integrated service delivery. The Office of Child & Adolescent Behavioral Health will support more effective access to services and improved outcomes for youth and young adults with behavioral health needs and their families. The BHA has implemented several initiatives for to address the needs of youth with substance use disorders (SUD). Each county in the state of Maryland has prevention funding to prevent underage drinking as indicated in the Behavioral Health Plan and efforts are ongoing to identify the needs of children and families through the prevention grants at the local level. They include the following initiatives:

- **SAMHSA Funded Maryland Strategic Prevention Framework (MSPF) 2008-2014**
  MSPF grants have been provided to 24 local jurisdictions to address underage drinking, youth binge drinking, and alcohol-related accidents involving youth. The MSPF process requires conducting a needs assessment, develop a plan for capacity building and strategic planning.
- **Maryland Collaboration to Reduce College Drinking and Related Problems**
  A partnership with the University of Maryland and Johns Hopkins University provides expert training and technical assistance directed as reducing excessive alcohol use on college campuses. A team works to mobilize campus and community leaders in their efforts to reduce alcohol and increase safety in the college environment.
- **Opioid Misuse Prevention Program (SAMHSA SAPT Block Grant)**
  This grant provides funds to Maryland's local jurisdictions to support a local opioid misuse coalition, the development of a data-driven opioid misuse strategic plan, and local Over-Dose Prevention Plans. The plans allow for the coordinated Implementation of evidence-based prevention and intervention strategies across the state. Evaluating the impact of activities focused on opioid misuse and overdoses in each jurisdiction also occurs under this grant. A local media Campaign to address the opioid misuse and community education has been launched. Additionally, community medication drop-box locations have also been implemented.
- **Partnership for Success Grant** (**SAMSHA Funded**)
  This is a recently awarded $1.6 Million yearly grant that supports efforts to strengthen the work of specific local coalitions in preventing and reducing underage and youth binge drinking in their communities. Its measurable objectives are (1) to reduce underage drinking in the 10 selected jurisdictions and statewide, as measured by the Maryland YRBS and NSDUH data and (2) to reduce binge drinking by youth, ages 18-25, in the 10 jurisdictions and statewide, as measured by NSDUH and jurisdictional survey data. The interventions to attain this goal will primarily be evidence-based environmental prevention strategies addressing key intervening variables for underage and youth binge drinking, including retail access to alcohol, social access, perception of

harm and risk, community and social norms, enforcement of alcohol laws, alcohol pricing, and promotions. Coalitions may augment these environmental strategies with information dissemination, prevention education, and community based processes to strengthen community awareness of and support for their prevention efforts.

Another goal of this initiative is to strengthen state and local community prevention capacity and infrastructure. Its measurable objectives are (1) to increase the capacity of sub recipient prevention coalitions through the provision of guidance, training and technical assistance, as measured by program performance indicators and (2) to strengthen the state and local prevention infrastructure by leveraging, redirecting and realigning the SABG resources administered by the BHA to exclusively support evidence-based programs and strategies that are determined through the SPF process, as measured by grant program and fiscal records.

Adolescent Treatment Grant
A CSAT Adolescent Treatment grant was awarded to the State for FY15. This grant will be used to pilot evidence-based substance use prevention, treatment, and recovery services. There will be substance use services placed in school mental health programs in Baltimore County and Baltimore City, Maryland.

Maryland Behavioral Health for Adolescents and Young Adults (MD-BHAY)
The Maryland Department of Health and Mental Hygiene, Behavioral Health Administration is sponsoring, with a four-year Substance Abuse and Mental Health Administration (SAMHSA) grant, the Maryland Behavioral Health for Adolescents and Young Adults (MD-BHAY) project which is designed to bring innovative treatment services to adolescents and transition-age youth (TAY), ages 12-24, with either a substance use or co-occurring disorder (COD). The project will initially be piloted in two schools and two community-based health clinics, and then expand to at least two additional schools and clinics by the completion of the grant.

The project will also enlist stakeholders and critical partners as it seeks to develop integrated approaches to sustainable financing, and also to support the dissemination of evidence-based practices to treat these populations. The project is located at The University of Maryland's School of Medicine's Center for School Mental Health. Additional project partners include the University of Maryland, Department of Psychiatry, the Epoch Counseling Center, Harbel Community Organization, Chestnut Health Systems, and Maryland Coalition of Families for Children's Mental Health. MD-BHAY is designed to increase access to and improve the quality of treatment for youth, ages 12-24, with substance use and co-occurring substance use and mental health disorders. Due to chronic systemic gaps in care and recovery supports for this population, MD-BHAY this project is enhancing statewide infrastructure, delivering evidence-based treatment in school and community settings, and developing funding and delivery mechanisms to sustain these changes.

Project LIFT (Launching Individual Futures Together)
Another effort to address TAY with co-occurring disorders who are below a residential treatment level of care is LIFT (Launching Individual Futures Together) project. LIFT is a SAMHSA Systems of Care grant that utilizes the Wraparound service delivery model infused with SOC values to engage youth and families in community-based care. This project is closely tied to the above-referenced 1915(i) SPA and efforts to expand that project to include those with co-occurring substance disorders. The goals of the project included several infrastructure goals:

- The development of Maryland's Health Home model and Target Case Management (TCM).
- Efforts for strengthening Workforce Development & Training by training the children's behavioral health workforce in Alliance in 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 practices trough existing programs WrapTMS and PracticeWise, and web-based virtual training centers.
- Increased family and youth involvement through partnerships with Youth MOVE, Youth Council, On Our Own of Maryland youth adult projects, and Maryland Coalition of Families for Children's Mental Health (MCF). Also, enhanced areas of the Peer Support curriculum to include distinct components and TAY adaptation.

The Institute for Innovation and Implementation (The Institute) assists LIFT with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. Ongoing training and technical assistance is provided to:

- Wraparound Care Management Entity/Care Coordination Organization Staff,
- Wraparound Practitioners: Care Coordinators and Family Support Partners,
- Local and State Agencies,
- Public and Private Providers,
- Caregivers and Youth,
- Family/Systems Navigators, and
- Other team members or individuals involved in the Wraparound Process or individuals working at the state and local level within the children's systems of care.

Community Education and Stigma Reduction
The BHA will work with communities to change attitudes in Maryland so that people with a history of substance use disorders, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. Strategies are to target all Maryland communities, specifically, adults, youth, business owners, physicians and other prescribers and dispersers of narcotic medications, law enforcement, judges, legislators, educators, and substance users and their families. Additional strategies include, developing public awareness campaigns targeting adults and youth to help individuals to identify the signs of an overdose and steps to take to administer Naloxone, to promote the use of a state-wide hotline by

Marylanders to obtain a referral to treatment resources, to implement and sustain social media strategy to communicate with Marylanders interested in issues related to substance use disorders. The use of social media will also be used to attract Marylanders to events and gain immediate feedback/input on important issues. The BHA understands the additional benefit of strategies that can reduce stigma by promoting wellness, and the good mental health and resilience of individuals, families, and communities as an universal public health strategy. Collaborative efforts continue with On Our Own of Maryland's Anti-Stigma Project. Current activities include workshops tailored to address stigma issues with transition aged youth.

Transitional Age Youth
For youth and young adults, individuals between the ages of 16 and 25 years, transitioning into adult responsibilities, negotiating between the child-and adult serving systems requires additional coordination. Maryland had developed many partnerships between community agencies and mental services to make the process of transitioning between child and adult services more manageable. Transitional care and services provided by Maryland for children with SED in the following settings are available for those moving between institutions and the community, from one educational setting to another, in-home to out-of-home placements, as well as from out-of-state to in-state placements. As special efforts are underway with residential providers in state to reduce the utilization of out of state placements, which has been showing a downward trend over recent years. As stated earlier, Maryland's 1915(i) program is designed to help address transitions that youth, young adults and their families may encounter through an array of services developed to address the unique challenges for individuals who are not fully participants in adult programs. The specific needs of this population transitioning into adulthood can include co-occurring disorders, developmental disabilities, traumatic brain injury, somatic conditions, and also involves needs for LGBTQ youth and young adults; justice-involved youth and young adults; homeless youth and young adults; and youth and young adults in the deaf and hard of hearing community. The following programs and grant-funded efforts address issues related to supported services important for youth transitioning into the community.

Maryland Healthy Transitions (MD- HT) Grant
Maryland has received a Healthy Transitions grant from SAMHSA, building on considerable joint efforts between the offices of adult services and child and adolescent services to address the special needs of the emerging adult population. Current efforts within the Maryland Mental Hygiene Administration's will serve as the lead state agency for MD-HT. Several TAY initiatives part of strategic planning efforts for the Office of Child and Adolescent Services and the Office of Adult Services are state-wide efforts designed to expand and enhance TAY services. The Maryland Healthy Transitions (MD-HT) project will seek to raise awareness of the mental health challenges faced by transition-aged youth (TAY) age 16-25, increase the early identification of mental health conditions among TAY, and provide services and supports to meet the needs of TAY as they transition into adulthood.

The MD-HT project was developed in full partnership with two communities in Maryland, where two local laboratories will be located, Howard County and the Southern Maryland Tri-County region. Collaborative support will be provided by consumers, youth, and families and multiple local and state agencies and stakeholders. Additional partnerships have been established between The Behavioral Health Administration (BHA), located within Maryland's Department of Health and Mental Hygiene, The Howard County Mental Health Authority and the Charles County Core Service Agency (CSA), two provider agencies, Humanim, Inc. and Pathways, Inc., The University of Maryland School of Medicine, Evidence-Based Practice Center (EBPC), The University of Maryland School of Medicine, Department of Child and Adolescent Psychiatry, On Our Own of Maryland (OOO-MD); The Governor's Interagency Transition Council (IATC), and The Maryland Early Intervention Program (EIP). Other grant initiatives are Project AWARE and Systems of Care. The project will utilize collaborations and partnerships to leverage a solid infrastructure within Maryland's child and adult public health systems to meet project goals.

MD-HT will utilize Maryland's past and current TAY initiatives which include strategies such as family and youth involvement, evidence-based practices, several methods for improving access to care, as well as policy changes at the state and local level. Supported Programs that serve TAY in a successful transition into adulthood include: Supported Employment, Assertive Community Treatment, and Family Psychoeducation that. Through these supported services, the MD-HT will serve 60 youth in the FY20--, and approximately 80 youth per year thereafter for a total unduplicated count of 380 individuals.

Consumer and Family Collaborative Initiatives
As discussed earlier, a partnership with On Our Own (OOOMD) and the Maryland Coalition of Families (MCF) around young adult leadership development has been very successful in developing increased availability of peer support for young adults and opening channels for young adult voices to be heard. OOOMD's Director of Network and Peer Services provides oversight to the activities of the Statewide Consumer Network Grant Project, technical assistance to local Wellness & Recovery Centers, Transition Aged Youth outreach, and liaisons with local and state agencies. The Director was also a recipient of SAMHSA's Young Adult Advocate Voice Award (2013). In collaboration with BHA, OOOMD, implements the Transitional Age Youth Outreach Project. The TAY Project is an initiative of On Our Own of Maryland which introduces young adult peer with lived experience with mental health or substance use systems to the peer support, policy, and advocacy fields. The project coordinates and hosts events, support groups, leadership opportunities and trainings for and by young adult consumers throughout the state with the end goal of developing a sustainable young adult network within the peer education and advocacy network of
OOOMD. (http://www.onourownmd.org/projects/maryland-youth-outreach-project)

Upcoming efforts include a Young Adult Peer Support & Leadership Retreat. The goal of this retreat is to further support the young adult peer network within Maryland, and to provide leadership skill-building and training on advocacy and wellness issues of interest to young adults. The leadership retreat will host 40-50 young adults ages 18-29 who are peer advocates

within programs across Maryland including The Healthy Transitions Initiative, the OOOMD and MCF networks, Maryland YouthMOVE chapters, and others that support young adults with behavioral health experiences. The retreat center will provide a number of team-building activities including ropes courses, games, zip-lines, rock-climbing, yoga, and many other activities. Workshops and activities supporting topics such as Leadership Skills, Social Justice through Art, Becoming an LGBTQ Youth Ally, and Storytelling in Peer Support &Advocacy will be led and facilitated by peers in all of the participating programs.

Other collaborative efforts that support youth involvement and activities include:
Taking Flight: Maryland Coalition of Families for Children's Mental Health Young Adult Council
To cultivate a group of young adult leaders who work to empower and support young adult transition and to facilitate system collaboration in an effort to promote acceptance and education and reduce stigma. http://www.taking-flight.org/

What Helps What Harms Maryland Initiative
What Helps, What Harms Maryland is a year-long project initiative recently launched by OOOMD's T.A.Y. Project in partnership with Maryland Coalition of Families' Taking Flight, which will infuse the youth and young adult voice into strategic policy actions and planning structures for systemic change in the state of Maryland. As we have the full support of the Behavioral Health Administration (BHA), the project will use the information obtained during these groups to leverage the young adult voice and include its insight in service planning for the behavioral health service system in Maryland. Discussion forums will be held with young adults, ages 18-29 years old, who have and/or are receiving services in any Maryland service system.
What Helps What Harms is an initiative developed for young adults to spend time with one another in facilitated discussions that allow them to analyze their community network, resources, services, and environment. The discussion prompt will be simple so that the conversation remains truly directed by the young adult participants. It will ask "Of all the systems you have been involved with (education, mental health, physical disability services, juvenile justice, peer-run services, employment services, etc.) what about its set-up, services, and service delivery has helped you (move forward into adulthood, recovery etc.), what has harmed you or created barriers for you moving forward, and what changes would you make that would benefit you in reaching your goals and becoming who you want to be?

Family Partnerships
Family Partnerships and family collaboration are critical to effectively serving children and youth, as family involvement improves emotional and behavioral outcomes for children, youth, and their families. Maryland is working to ensure that parents and family members of children with SED are involved in the child's treatment and available services.

Child and Adolescent Advisory Committee (Blueprint)
The Child and Adolescent Advisory Committee to the overall MHA Advisory Council was formed in 2002 with the publication of the Blueprint for Children's Mental Health. That report was updated in 2009 and Blueprint (as that advisory committee is called), still serves to establish

priorities for children's services across state agencies in Maryland. In 2013 MHA received a SAMHSA System of Care (SOC) planning grant to develop an Integrated Behavioral Health System of Care for Children, Youth and Families. In that report is outlines strategies for components of an integrated system such as workforce development, quality improvement, wellness, family and youth involvement and the service array. Now that the administrations have merged under the BHA the timing is right to update the Blueprint within a co-occurring SOC approach. Given that children and families are often multi-agency involved the continued need for integration with other departments, whose children use many BH services, will also remain a priority within the updated Blueprint.

The state provides financial support to MCF for the provision of family navigation, peer support, and social marketing efforts. In addition, the 1915(i) program covers family peer support under Medicaid for families who are enrolled in the program. This service includes having a peer explain to a newly enrolled family member what to expect in the attending a child and family team meeting and how the process of developing a plan of care works. In addition, family peers provide support on the wide ranging everyday issues of being a parent of a child with special needs. The program provides for reimbursement of telephone contacts between peer support specialist and families in order to broaden access.

Resilience Training

Trainings and technical assistance on services that promote recovery and resilience efforts has been a focus in Maryland since 2006, particularly, with an ongoing Resilience Committee in Maryland operating since 2008. The Committee has created a number of documents that outline the core concepts of resilience, and how those can be used to promote a universal message of the benefits of positive mental health, and as a way of developing treatment goals that enhance strengths and (re)establish skills with youth and families. Multiple trainings have been provided over the years that have moved this from theory to implementation

Maryland's Behavioral Health Administration's has implemented various training efforts to enhance quality improvements for providers of behavioral health services. The Maryland Resilience Breakthrough Series Collaborative (BSC), a recent quality improvement initiative 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 mental 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. As a key strategy the BSC involves team members in diverse organizational roles to incorporate distinct perspectives and coordinate practice improvements across multiple levels at an agency. Additionally, key focus areas which help teams promote competencies among youths and families with whom they have worked in their communities are resilience-enhanced assessment and treatment, as well as family and community resilience.

In Maryland's FY16 Behavioral Health Plan there are multiple strategies that promote workforce development initiatives 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. These efforts include supporting the continued implementation of Maryland Linking Actions for Unmet Needs in Children's Health (LAUNCH), Project LIFT (Launching Individual Futures Together) and the Social and Emotional Foundations for Early Learning (SEFEL), as well as Early Childhood Mental Health Consultation (CMHC). Other strategies from the FY16 State Plan include efforts to develop and disseminate workforce training and education tools as well core competencies to address behavioral health issues. Included in collaborative effort to establish and disseminate evidence-based behavioral health core competencies for behavioral health, primary care, and peer providers are multiple training activities and other forms of support for the BHA's Workforce Development Committee's (WDC).

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)

    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)

    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

20. Suicide Prevention

Current initiatives have enhanced the recommendations identified through an Executive Order 01.01.2009.13, issued by Governor Martin O'Malley on October 7, 2009, establishing the Governor's Commission on Suicide Prevention (the Commission). Further, the work of the Governor's Commission is aligned with national suicide prevention efforts, such as Substance Abuse and Mental Health Administration's (SAMHSA) strategic initiatives. The continuing emphasis on youth suicide prevention will target the special and specific needs of populations known as high risk groups such as veterans, lesbian, gay, bisexual, transgender and questioning individuals, and persons who are unemployed in both the Commissioner's Plan (the Plan) and the Suicide Prevention Plan FY2015. There will also be strategies designed to provide additional services to individuals in special and specific populations with increased attention during critical high-risk periods, following an unsuccessful suicide attempt. The Commissioner's Plan, based on the Public Health Model, includes three overarching goals and eight related strategies operating at the following three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated subpopulation

Updating Maryland State Suicide Plan for FY 2015

The Maryland Governor's Commission on Suicide Prevention created a suicide prevention plan in 2012, listing strategies for suicide prevention efforts across the lifespan. Substantial progress has been made on that plan and the new FY2015 is currently in development for approval in September. One of the major goals of the plan was to create a social marketing campaign to promote the Maryland Crisis Hotline. The Maryland Crisis Hotline (formerly the MD Youth Crisis Hotline) is staffed and available 24 hours per day, seven days a week, and 365 days per year to Maryland residents experiencing a mental health crisis. A marketing campaign consisting of printed materials that include, brochure, t-shirts, posters, information cards, and pens was developed to raise awareness of the Maryland Crisis Hotline and to inform the public that the hotline is available to all Maryland residents, regardless of age (NSSP Goal 2). The goal of the campaign is to raise awareness of the general public to the change of the hotline from being youth-focused, to serving members across the lifespan. The materials are being distributed at local behavioral health events as well as local conferences, awareness walks, and to local schools. Each year, the Maryland Coalition of Families sponsors a "Children's Mental Health Matters" week where events take place across the state to promote children's mental health. This year, we contributed 2,500 promotional materials in packages on information to be sent to Maryland families.

Following the 2012 National Strategy for Suicide Prevention (NSSP), the Maryland State Suicide Prevention Plan FY2015 will highlight key initiatives. As the Maryland State Suicide Prevention Plan is currently being revised, with new areas of focus listed below. The new Suicide Prevention that will be completed by September, 2015 will focus many of its efforts on the following four areas:

- Disconnected Youth (NSSP Goal 3)
  - o Disconnected youth are youth who have either dropped out of school or have graduated high school and are not currently in school, working, or seeking active employment. With unemployment being a risk factor for suicide, we are targeting efforts to connect with these individuals and ensure positive mental health outcomes. Providing resources for these individuals, as well as their families, will be highlighted in the FY2015 plan.
- Bullying (Youth and Workplace) (NSSP Goal 5)
  - o The FY2015 plan will highlight bullying as a new target area for suicide prevention. The efforts will focus on increasing awareness of the negative mental health outcomes of bullying as well as connecting with the Maryland State Department of Education to combine efforts and resources to end bullying in schools K-12. Positive mental health will also be taught to younger students through the use of the evidence-based "Good Behavior Game."
- Substance Related Disorders
  - o The MD Mental Hygiene Administration has recently integrated with Addictions and has become the Behavioral Health Administration. The integration has allowed the two sides to focus on new ways to collaborate. The Administration is working to infuse suicide prevention into an existing SAMHSA grant targeting youth and transition-aged youth with substance-related disorders. We will also be working with the State Adolescent Clubhouses, after school programs designed to assist youth dealing with substance-related disorders, to provide a suicide prevention training as well as meeting with their directors quarterly to provide them with resources. The MD Crisis Hotline has also received funding to begin to answer calls related to substance use for the State. The hotline staff is receiving training on substance-related disorders and will be connecting callers to resources and providing them with a "warm hand-off" to the local addictions authorities during day time hours.
- Inclusion of those with Lived Experience (NSSP Goal 10)
  - o The FY2015 will have a targeted approach to provide resources to attempt survivors and loss survivors. The six hotlines who comprise the MD Crisis Hotline Network will begin to provide support groups for attempt and loss survivors. We Commission will create a working list of resources and supports for attempt and loss survivors throughout the State. An attempt survivor and loss survivor currently sit as Commissioners on the MD Governor's Commission on Suicide Prevention.

SAMHSA Strategic Initiatives were highlighted as goals in the FY2016 Behavioral Health Plan for Maryland. Promoting prevention and early intervention of behavioral health disorders across the lifespan is the primary SAMHSA goal under which efforts to address suicide prevention activities for youth, adults, and older adults are indicated by efforts to address and implement suicide prevention activities for youth, adults, and older adults. Several initiatives such as the Garrett Lee Smith Grant awarded to Maryland by SAMHSA in 2014, in an effort to reduce suicides in youth between the ages of 10-24 years in the state.

Maryland's Suicide Prevention and Early Intervention Network (MD-SPIN)
MD-SPIN is a five-year program located at the University of Maryland, School of Medicine's Center for School Mental Health sponsored by The Maryland Department of Health and Mental Hygiene, Behavioral Health Administration, with a grant from the Substance Abuse and Mental Health Administration (SAMHSA). MD-SPIN provides suicide prevention training, and technical assistance to advance a comprehensive suicide prevention and early intervention service system for youth and young adults, ages 10 to 24. The purpose of MD-SPIN is to reduce premature loss of lives from suicide by increasing the number of at-risk youth who are identified which include individuals in the following high-rick populations of focus: LGBTQ, transition age youth, veterans and military families, and youth with emotional and behavioral concerns. The project has developed partnerships between the Maryland Behavioral Health Administration, the University of Maryland, Department of Psychiatry, and Johns Hopkins University Bloomberg School of Public Health. Other partners include the Maryland Coalition of Families for Children's Mental Health, the Community Behavioral Health Association of Maryland, and the public education system (K to 12th grades, university/college/community colleges, and juvenile facilities programs).

The main goals of MD-SPIN are to enhance culturally competent, effective, and accessible community-based services and programs, broaden awareness of suicide, increase evidence-based training opportunities for professionals and others who work with high risk groups, and to assure effective services to those who have attempted suicide or others affected by suicide attempts or death. The programs key components are: technical assistance through a training center, screening, training and follow-up protocols in emergency departments and inpatient units to which they refer, and online gatekeeper training by Kognito's Training Games and Simulations for Health. The Kognito gatekeeper training is an interactive, avatar-based, suicide prevention training for the general public. With funds from the GLS grant, we have secured funding for the Kognito training through the next five years.

 The purpose of the Kognito At-Risk Training is to give individuals an opportunity to walk through a conversation with someone who may be having some type of psychological distress. The trainee is given a real-world scenario in which they are having a one-on-one conversation with a friend (student module) or a student (faculty module) who they believe to be experiencing some psychological distress. Options of what to say to the individual appear on the screen and the trainee decides what to say to help them assess the situation, assist the person with feedback, and refer the person to additional help, if needed. The individual

modules take approximately 60 minutes to complete. For the purposes of the grant, we have purchased the training modules for:
- Kognito for Elementary School
- Kognito for Middle School
- Kognito for High School
- Kognito On-Campus (Faculty and Student)
- Kognito LGBTQ On-Campus (Faculty and Student)
- Kognito Family of Heroes (Veterans)

We are working with partners at the Maryland State Department of Education to promote the Kognito training to teachers and staff K-12 throughout the State. Recently, we have gotten continuing education credits for teachers, social workers, school psychologist, counselors, and nurses who complete the training modules. We have initially partnered with four colleges and universities who are implementing Kognito on their campuses. We are expending to four additional colleges and universities during Year 2 of the grant.

In addition to the initiative to train school and higher education staff and students, MD-SPIN will connect with pediatric emergency departments to improve screening, assessment, and follow-up of youth who are identified to have a greater risk for suicide (NSSP Goal 7). Partners from Johns Hopkins and the University of Maryland will be implementing a comprehensive program composed of the following three components:

1. Standardized, evidence-based screening - The Ask Suicide Screening Questions (ASQ) is a recently developed, non-proprietary instrument to screen for suicide risk during the ED triage phase with patients ages 10-21 years. The ASQ demonstrated good sensitivity and specificity.
2. Training and brief Interventions- Standardized training will take place in person or through webinars lead by the grant team.
   - a) Safety Planning
   - b) Emergency Department Means Restriction
   - c) Emergency Room Intervention for Adolescent Females

   EDs will be provided with the following materials and a member of the grant team will provide outreach and technical assistance to encourage implementation:
   - 1) Is Your Patient Suicidal?" ED Poster and Clinical Guide
   - 2) After an Attempt series of guides for providers, youth and families in ED
3. Follow-up of high-risk youth- The grant team will work with EDs and the inpatient psychiatric units to develop a plan for following up with suicidal patients based on the caring letters and texts research. The phone calls, emails and/or texts would convey care for individuals, importance of care, and availability if in need of further support or resources.

The BHA has currently partnered with Johns Hopkins Hospital, Bayview Hospital (Johns Hopkins), and University of Maryland Medical Center to partner with us in adapting their screening and assessment protocols as well as create a system for follow-up of individuals who are found to be at a high-risk for suicide.

Environmental Factors and Plan

21. Support of State Partners

<u>Narrative Question:</u>

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

SUPPORT OF STATE PARTNERS

Collaborations **with Other State Agencies –** The Behavioral Health Administration (BHA) continues to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance use, and other services and community supports. The development of the State Behavioral Health Plan is a result of the existing collaborative/interagency efforts and cooperation, and public and private partnerships. Alliances have been strengthened and new partnerships have been formed to further build upon the infrastructure, to coordinate care, and improve service systems.

Collaboration with the other State agencies include, but is not limited to: Maryland Medicaid Office of Health Services, Maryland Department of Disabilities, Governor's Office for Children, Maryland State Department of Education, Department of Juvenile Services, Department of Human Resources, Department of Public Safety and Correction Services, Developmental Disabilities, Department of Housing and Community Development, Department of Rehabilitation Services, Office of the Deaf and Hard of Hearing, Maryland National Guard and Department of Veterans Affairs.

A chart of State Partners and BHA Liaisons are appended.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

2. What mechanism does the state use to plan and implement substance abuse services?

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Meeting with the Planning Committee of the Combined Councils:

**The Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council
(Joint Council)
and
The State Drug and Alcohol Abuse Council**

Review of the Draft FY 2016 Behavioral Health Plan

Thursday, June 25, 2015

Minutes

Planning Committee Attendance:
Joint Council – Robert Anderson, Chicquita Crawford, Julie Jerscheid, Dan Martin, Dennis McDowell, Cynthia Petion, Anita Solomon, Phoenix Woody
State Drug and Alcohol Council (SDAAC) – Gray Barton; Lynn Albizo (participation by phone)
Behavioral Health Administration Staff – Thomas Merrick, Robin Poponne, Hilary Phillips, Greta Carter

The Planning Committee of the Combined Councils met with the BHA Office of Planning staff to review, discuss, and offer feedback on objectives and strategies in the draft FY 2016 Behavioral Health Plan and components of the draft FY 2016-17 Block Grant application. The Combined Council's recommendations for the draft FY 2016 Behavioral were as follows:

- Work with community entities to support increased leadership roles for youth while reducing gang involvement
- Continue efforts to support suicide prevention and bullying prevention across the lifespan; increased partnerships in the schools such as activities under the Garrett Lee Smith grant for suicide prevention
- Increase awareness of resources in schools related to crisis intervention and other trainings
- Increase awareness of available user-friendly resources of modern, contemporary communication tools in use for suicide prevention as well as dissemination of campaign awareness information
- Continue reduction of housing barriers especially for individuals with forensic backgrounds who are ready to be integrated into the community
- Increase workforce development – need for more professional mentoring

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c/o Behavioral Health Administration
Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473
TDD for Disabled – Maryland Relay Service (800) 735-2258
Healthy People in Healthy Communities

- Facilitate real-time data sharing across systems, replacement of SMART with a format allowing availability of information (to the courts, etc.)
- Include strategies to address overdose prevention, awareness and training, particularly on Naloxone
- Increase awareness on stigma and substance-related disorders

The Committee commended the state's efforts to:
- Align goals with SAMHSA's Strategic Initiatives
- Promote an integrated behavioral health system of care, including partnerships with consumers, advocacy groups, providers, state agencies, and other stakeholders
- Continue emphasis on wellness, prevention, and recovery
- Promote collaborative efforts within the Behavioral Health Administration; inclusion of both the Core Service Agencies and Local Addiction Authorities as involved parties
- Continue to implement crisis response services as key components of the PBHS system
- Enhance partnerships with LAUNCH and LIFT (initiatives that support the coordination and delivery of high quality, behavioral health, prevention, early intervention, and treatment services for young children and their families)
- Continue funding of Wellness and Recovery Centers and Recovery Community Centers as they develop programs with relevance across the lifespan

Members of the Planning Committee understood the unique position of fostering an inclusive planning process that supported a broader participation from mental health and substance use communities. The Plan is inclusive of strategies that address needs in the areas of mental health, substance-related, and other addictive disorders. The Committee also supported the goals and strategies identified as priority areas in the FY 2016 – 2017 Mental Health Block Grant Application.

2

State Behavioral Health Planning Advisory Council and Input on the Mental Health/Substance Use Block Grant Applications

Maryland's Behavioral Health Councils
Currently, Maryland's Public Behavioral Health System, has two councils that serve in the advisory and advocacy capacity for individuals with serious mental illness and substance-related disorders. Since Maryland's Behavioral Health Integration, the two councils – Maryland Advisory Council on Mental Hygiene/P.L.102-321 Planning Council and the State Drug and Alcohol Abuse Council – have convened combined meetings and workgroups that have led to the development of legislation to establish a Behavioral Health Advisory Council. Effective October 1, 2015, through statute, a behavioral health advisory council will be established.

The Maryland Advisory Council on Mental Hygiene/P.L.102-321 Planning Council, referred to as the Joint Council, is comprised of individuals representing a broad range of groups, which are diverse in ethnic, cultural, linguistic, and socio-economic backgrounds and inclusive of behavioral health professionals, advocates, parents of young children, and consumer/participants, of various ages and living in urban, sub-urban and rural parts of the state.
The responsibility of the Joint Council is to review issues and services for people with mental health disorders as well as supported a collaborative approach through consumer, provider advocacy and state agency representation, to: advise the Behavioral Health Administration; discuss cultural issues related to access to services; to be informed of the Medicaid expansion progress; and review the state plan and the Mental Health Block Grant.

The Maryland State Drug and Alcohol Abuse Council (SDAAC), was initially established by executive order in 2008 and codified into law on October 2010 and is comprised of cabinet level representatives, professionals, consumer/participants, family members, and service providers representing various geographic regions of the state. This council has been key in the effort to develop a comprehensive, coordinated, and strategic approach to ensure efficient and effective use of state and local resources in order to deliver a full continuum of drug and alcohol abuse prevention, intervention, and treatment services for residents of the state. Through the enactment of the legislation to create the Behavioral Health Advisory Council, issues which are the current focus of these two councils and that impact the lives of individuals with serious mental illness (SMI), serious emotional disturbance (SED), and who have a behavioral health disorder, will be addressed more broadly.

Throughout this discussion you will see the term Combined Council. This term refers the Joint Council and the SDAAC meeting together. The combined meetings of the mental health and substance use councils afforded members the opportunity to have an integrated approach to planning and fostered a mechanism for meaningful input from individuals in recovery as well as a collaborative voice on issues of concern.

The Combined Councils have committee structures and workgroups to further enhance their abilities to monitor progress towards goals and strategies identified in plans and the federal Block Grant application applications. Members provide important input into the planning and policy development of the PBHS. These committee structures provide work that have impacted or influenced advocacy in the areas of consumer recovery and leadership, behavioral health

integration, health and wellness, coordination of care and systems of care for youth, older adults, criminal justice, prevention, and workforce development.

The Combined Council's Participation in the State's Planning Process
As discussed above, the Combined Council carry out their duties and responsibilities through various activities. This includes efforts provided through a meaningful planning process in the state's public behavioral health stakeholders meeting to develop the FY 2016 Behavioral Health Plan in April 2015. Recommendations for strategies were identified that supported the development of a behavioral health plan with goals that align SAMHSA's Strategic Initiatives. This broader stakeholder meeting afforded participants the opportunity to provide input on recommendations that impact policy and the development of initiatives that enhance a system that addresses the needs of individuals across the lifespan including the strategic goal areas of as prevention (overdose, suicide), early intervention, cultural competency, recovery supports, trauma, and workforce development.

In addition, the Planning Committee of the Combined Council met on June 25, 2015 to review the final draft of the FY 2016 Behavioral Health Plan. The committee reviewed strategies and priorities in the plan, which were also presented in the FY 2016 Mental Health Block Grant application (MHBG). The full Maryland Advisory Council on Mental Hygiene/ P.L. 102–321 Planning Council received the report of the Planning Committee's recommendation for adoption of the FY 2016 Plan along with comments and recommendations. For future Plan improvement, the Planning Committee's recommendations for the draft FY 2016 Behavioral Health Plan were as follows:

- Work with community entities to support increased leadership roles for youth while reducing gang involvement
- Continue efforts to support suicide prevention and bullying prevention across the lifespan; increased partnerships in the schools such as activities under the Garrett Lee Smith grant for suicide prevention
- Increase awareness of resources in schools related to crisis intervention and other trainings
- Increase awareness of available user-friendly resources of modern, contemporary communication tools in use for suicide prevention as well as dissemination of campaign awareness information
- Continue reduction of housing barriers especially for individuals with forensic backgrounds who are ready to be integrated into the community
- Increase workforce development – need for more professional mentoring
- Facilitate real-time data sharing across systems, replacement of SMART with a format allowing availability of information (to the courts, etc.)
- Include more strategies to address overdose prevention, awareness, and training, particularly on Naloxone
- Increase awareness on stigma and substance-related disorders

The Committee commended the state's efforts to:
- Align Plan goals with SAMHSA's Strategic Initiatives

- Promote an integrated behavioral health system of care, including partnerships with consumers, advocacy groups, providers, state agencies, and other stakeholders
- Continue emphasis on wellness, prevention, and recovery
- Promote collaborative efforts within the BHA; inclusion of both the Core Service Agencies (CSAs) and the Local Addictions Authorities (LAAs) as involved parties
- Continue to implement crisis response services as key components of the Public Behavioral Health System
- Promote areas of addictions that include problem gambling and tobacco cessation
- Enhance partnerships with LAUNCH and LIFT (initiatives that support the coordination and delivery of high quality, behavioral health, prevention, early intervention, and treatment services for young children and their families)
- Continue funding of Wellness and Recovery Centers and Recovery Community Centers as they develop programs with relevance across the lifespan

This information is also included in the appendix of this application as minutes from the review. Monthly Council meetings included information shared by BHA leadership on key issues. The Council stayed informed of Maryland's Medicaid expansion, effective January 1, 2015, including updates from the administrative services organization (ASO), which shifted its contract obligations from the BHA to Medicaid, as it expanded its operations and its role in administering the new financing model of an integrated system. The ASO now manages the delivery of integrated care across the system to include both mental health and substance-related disorders.

The members continued to gather and share pertinent information from people in recovery, families, and other involved stakeholders through presentations on a variety of topics throughout the year that focused on Overdose Prevention, Prescription Drug Monitoring Program, Program Gambling, Suicide Prevention, Tobacco Cessation, substance related disorders, Child and Adolescent initiatives, the MHBG 5% Set-aside for the First Episode Psychosis Initiative, among others. It is expected that these efforts will continue within the new Behavioral Health Advisory Council.

Also, in FY 2015, the Joint Council submitted letters of support on behalf of four grant proposals – a DHMH Planning Grant for certified community behavioral health clinics; two peer support training grants by the BHA Office of Consumer Affairs; and a BHA Adult Services proposal to enhance services for Transition-Age Youth. The Council also wrote letters advocating for increased availability of rental subsidies/housing vouchers for individuals with behavioral health disorders; a letter supporting a proposal to build a replacement hospital facility; and a letter to the Governor in response to published misinformation concerning treatment of persons with mental illness in Maryland's jails and prisons. Also, the Council represented the interests of BHA through testimony at the legislative budget hearings for the Administration in February and March.

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 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.

As a result of the forward movement of the legislation, the Joint Council and SDAAC planned and attended a retreat on March 17, 2015 in Columbia, MD to discuss key components of the by-laws, based on segments of the early draft of SB 174 and offer draft concepts for the committee structures as well as the overall structure for the Behavioral Health Advisory Council. The draft by-laws were discussed during the April and June meetings of the Combined Council and corrections and amendments were made. The bill was passed and the by-laws will receive final approval at the first meeting of the new Behavioral Health Advisory Council in the fall of 2015.

Three components of membership appointments for the new Behavioral Health Advisory Council, were established in legislation – Ex-officio, DHMH Secretary-appointed, and Governor-appointed. Since this will be a new Council current council members would have to re-apply through the Department of Health and Mental Hygiene Office of Appointments if they wish to continue to serve as members. The legislation and by-laws set forth a committee structure to enhance the Council membership's ability to monitor the system of care, to facilitate and inform the planning process and policy making decisions of BHA and to maintain the connection with local behavioral health entities. The membership and committee structure of the new Behavioral Health Advisory Council will meet the federal requirements for the behavioral health planning section, Title XIX, subpart 3 of the Planning Law 99-660.

PUBLIC COMMENT

Each year, official public notice of the State Behavioral Health Plan, Block Grant application, and Implementation Report is published in the Maryland Register for citizen review. The Register is published two times per month and provides information on state government activities. The notice in the Register also provides information regarding the availability of the documents. Due dates for the application and the implementation report are noted. Comments are requested in writing. Any responses received prior to finalization of documents are considered and incorporated, as appropriate. Comments are also accepted after submission of documents to the federal government. The notice provides the name of a Behavioral Health Administration contact person and phone number.

The opportunity to comment on the plan is provided at different stages in the state planning process. The most critical stages of this planning process, this year, involved the work of the Maryland Advisory Councils for mental health and substance use, also referred to as the Combined Council in earlier discussions. The development of the goals, objectives, and strategies for the annual state plan involves a series of meetings with active participation from key public behavioral health system (PBHS) stakeholders including representatives of consumer and family advocacy organizations, substance use and mental health advocacy groups, advisory council for special needs populations, (such as the deaf or hard of hearing, traumatic brain injury), provider organizations, Core Service Agencies, Local Addiction Authorities, and a wide range of groups, agencies, and individuals serving on the Councils.

During this public process, draft copies of the State Plan and key sections of the Block Grant application are distributed, through the Joint Council mailing and e-mail lists, for review and comment. The annual meeting for Planning Committee of the Joint Council to the review draft Plan and sections of the Block Grant application, with recommendations are summarized in "State Behavioral Health Advisory Council section of the application.

Each year, following the adoption of the State Plan, the document is distributed through the Joint Council mailing list consisting of over 200 members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, BHA's Division of Planning provides copies of the State Behavioral Health Plan to interested parties upon request. The review and comment on the annual Block Grant Implementation Report follows a somewhat similar process prior to the December submission deadline.

BHA's Division of Planning, in collaboration with the Division of Health Management Information Systems, places the approved State Plan on the Department of Health and Mental Hygiene-BHA Web site as a vehicle for notification of the availability and/or for wider distribution of the document. We expect this process to engender questions during the year, which will assist with the development of the Plan for the following year.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Lynn Albizo	Others (Not State employees or providers)	Maryland Addictions Director's Council (Behavioral Health) MADC	11869 Bright Passage Columbia, MD 21044 PH: 410-733-1098	LALBIZO@VERIZON.NET
Jan Desper Peters	Others (Not State employees or providers)	Black Mental Health Alliance, Inc.	733 West 40th Street, Suite 10 Baltimore, MD 21215 PH: 410-338-2642	
Karyn Black	Others (Not State employees or providers)	Maryland Association of Core Service Agencies	PO Box 1050, 10480 Theodore Green Blvd. White Plains, MD 20695 PH: 301-609-5757 FAX: 301-609-5749	karynm.black@maryland.gov
Vira Froehlinger	Others (Not State employees or providers)	Advocate	One Southerly Court, #608 Towson, MD 21286 PH: 410-828-8608	
Dan Martin	Others (Not State employees or providers)	Mental Health Association of Maryland, Inc.	Suite 505, 1301 York Road Lutherville, MD 21093 PH: 410-235-1178	DMARTIN@MHAMD.ORG
Linda Raines	Others (Not State employees or providers)	Mental Health Association	Suite 505, 1301 York Road Lutherville, MD 21093 PH: 410-235-1178 FAX: 410-235-1180	LRAINES@MHAMD.ORG
Laura Cain	Others (Not State employees or providers)	Maryland Disability Law Center	Suite 2000, 1500 Union Avenue Baltimore, MD 21211 PH: 410-727-6352 FAX: 410-727-6389	LAURAC@MDLCLAW.ORG
M. Sue Diehl	Others (Not State employees or providers)	Mental Health	6005 Lake Manor Drive Baltimore, MD 21210 PH: 410-377-4446	SUEDIEHLMSW@COMCAST.NET
Robert Pender	Others (Not State employees or providers)	Mental Health	Box 294, Terry Drive Port Tobacco, MD 20677 PH: 301-934-3145	RPENDER@CROSSLINK.NET
Sharon Lipford	Others (Not State employees or providers)	Mental Health	520 Upper Chesapeake Drive, Klein Ambulatory Care Center, Suite 405 Bel Air, MD 21014 PH: 410-638-3389 FAX: 410-803-0433	Slipford@healthyharford.org
Joanne Meekins	Others (Not State employees or providers)	Mental Health	1301 York Road, Suite 505 Lutherville, MD 21093 PH: 410-235-1314 FAX: 410-235-5102	JMEEKINS@CQTMD.ORG
Thomas E. Arthur	Others (Not State employees or providers)	Mental Health	98 Dewey Drive Annapolis, MD 21401 PH: 410-269-5263 FAX: 410-269-5263	ARTHURHOME98@COMCAST.NET

Naomi Booker	Others (Not State employees or providers)	Mental Health	2611 Manhattan Avenue Baltimore, MD 21215 PH: 410-207-3173 FAX: 410-367-6166	NAOMIBOOKERASSOC@YAHOO.COM
Dennis McDowell	Others (Not State employees or providers)	Mental Health	24308 Hipsley Mill Road Laytonsville, MD 20882 PH: 240-888-5649 FAX: 301-253-8839	STARKS4343@AOL.COM
John Turner	Others (Not State employees or providers)	Mental Health	225 Autumn Lane Centreville, MD 21617 PH: 410-739-1910	JOHN.TURNER225@GMAIL.COM
Crista Taylor	Others (Not State employees or providers)	Maryland Association of Core Service Agencies	One North Charles Street, Suite 1600 Baltimore, MD 21201 PH: 410-637-1900 FAX: 410-637-1911	crista.taylor@bhsbaltimore.org
Deirdre Davis	State Employees	Behavioral Health Administration (Substance Related Disorders)	55 Wade Avenue Catonsville, MD 21228 FAX: 410-402-8620	deirdre.davis@maryland.gov
Robert Anderson	State Employees	Maryland Department of Juvenile Services	One Center Plaza, 120 West Fayette Street Baltimore, MD 21201 PH: 410-230-3147	ANDERSR@DJS.STATE.MD.US
Michelle Stewart	State Employees	Maryland Division of Rehabilitation Services	2301 Argonne Drive, Suite A304 Baltimore, MD 21218 PH: 410-554-9109 FAX: 410-554-9412	MSTEWART@DORS.STATE.MD.US
Morgan Cole	State Employees	Maryland Medicaid	201 W Preston Street, 2nd Floor Baltimore, MD 21201 PH: 410-767-1687 FAX: 410-333-5154	MORGAN.COLE@MARYLAND.GOV
Dayna Harris	State Employees	Maryland Department of Housing and Community Development	7800 Harkins Road Lanham, MD 20706 PH: 301-429-7845	DAYNA.HARRIS@MARYLAND.GOV
Cynthia Petion	State Employees	Behavioral Health Administration (Mental Health Disorders)	55 Wade Avenue, Dix Bldg Catonsville, MD 21228 PH: 410-402-8473 FAX: 410-402-8309	CYNTHIA.PETION@MARYLAND.GOV
Kathleen Ward	State Employees	Social Services	Room 597, 311 W Saratoga Street Baltimore, MD 21201 PH: 410-767-7422 FAX: 410-333-0127	KWARD2@DHR.STATE.MD.US
Anita Solomon	State Employees	Mental Health	7517 Holiday Terrace Bethesda, MD 20817-6611 PH: 301-340-0999 FAX: 301-229-0833	SOLOANITA@AOL.COM
Phoenix Woody	State Employees	Maryland Department of Aging	301 W Preston Street, Suite 1007 Baltimore, MD 21201 PH: 410-767-4665 FAX: 410-333-7943	PLISS@OOA.STATE.MD.US
Anne Blackfield	State Employees	Maryland Department of Disabilities	217 East Redwood Street, Suite 1300 Baltimore, MD 21202 PH: 410-767-3635	anne.blackfield@maryland.gov
Michael Bluestone	State Employees	Developmental Disabilities Administration	312 Marshall Avenue Laurel, MD 20707 PH: 410-767-8691	MICHAEL.BLUESTONE@MARYLAND.GOV
			700 East Patapsco	

George Lipman	State Employees	Maryland Courts	Avenue Baltimore, MD 21133 PH: 410-878-8963 FAX: 410-878-8319	GEORGE.LIPMAN@MDCOURTS.GOV
Jacqueline Powell	State Employees	Maryland Department of Human Resources	311 W Saratoga Street Baltimore, MD 21201 PH: 410-767-6948	JPOWELL@DHR.STATE.MD.US
Nancy Feeley	State Employees	Maryland State Department of Education	200 West Baltimore Street Baltimore, MD 21201 PH: 410-767-0738	NFEELEY@MSDE.STATE.MD.US
John Kromm	State Employees	Maryland Health Benefit Exchange	750 East Pratt Street, 16th Floor Baltimore, MD 21202	
Herb Cromwell	Providers	Community Behavioral Health Association of Maryland	18 Egges Lane Catonsville, MD 21228 PH: 410-788-1865	MDCBH@VERIZON.NET
Joshana Goga	Providers	Medical Profession	1158 East MacPhal Road Bel Air, MD 21015 PH: 410-441-9999	JGOGA@SHEPPARDPRATT.ORG
Livia Pazourek	Providers	Mental Health	Unit #611, 930 Astern Way Annapolis, MD 21401 PH: 410-768-6777 FAX: 410-760-6811	LIVIAP@OMNIHOUSE.ORG
Gerald Beemer	Providers	Mental Health	6013 Newton Road Preston, MD 21655 PH: 410-228-5511	GBEEMER@SHOREHEALTH.ORG
Michael Finkle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	On Our Own of Maryland, Inc.	1521 S. Edgewood Street Baltimore, MD 21227 PH: 410-646-0262 FAX: 410-646-0264	mikef@onourownmd.org
Sarah Burns	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	On Our Own of Maryland, Inc.	1247 Newfield Road Baltimore, MD 21207 PH: 443-682-5012	SEB21228@AOL.COM
Charles Reifsnider	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	Unit F, 500 Heather Ridge Drive Frederick, MD 21702-1409 PH: 301-898-3044	
A. Scott Gibson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	PO Box 561 Frostburg, MD 21532-0561 PH: 301-777-2346 FAX: 301-777-2364	GODFATHER21532@HOTMAIL.COM
Julia Jerscheid	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	201 Federal Street, #33 Easton, MD 21601 PH: 410-822-4917	
Sheryl Lynn Sparer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health	1612 Hill Top Road Edgewater, MD 21037 PH: 443-716-5322 FAX: 410-956-8695	LUV2SING29@GMAIL.COM
Kate Farinholt	Family Members of Individuals in Recovery (to include family members of adults with SMI)	National Alliance on Mental Illness-Maryland	10630 Little Patuxent Pkwy., Suite 475 Columbia, MD 21044 PH: 410-884-8691	KFARINHOLT@NAMIMD.ORG
Ann Geddes	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy, Suite 234 Columbia, MD 21044 PH: 410-730-8267 FAX: 410-730-8331	AGEDDES@MDCOALITION.ORG
			5501 Summerfield	

| Chicquita Crawford | Parents of children with SED | Mental Health | Avenue
Baltimore, MD 21206-4313
PH: 410-448-2232 | KEE-KEE10@HOTMAIL.COM |

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	44	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	16	
Total Individuals in Recovery, Family Members & Others	25	56.82%
State Employees	15	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	19	43.18%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	7	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Mr. Brain Hepburn
Department of Health and
Mental Hygiene
55 Wade Avenue/ Dix Building
Catonsville, MD 21228

Dear Mr. Hepburn:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Behavioral Health is Essential To Health • Prevention Works • Treatment is Effective • People Recover

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
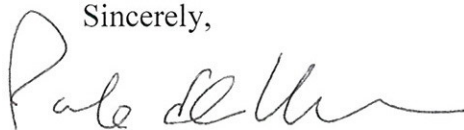Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Cynthia Petion
        Thomas Merrick
        Sarah Burns

Enclosures:
        2016 MHBG Prospective Allotments
        MHBG Project Officer Directory