

# Maryland

## UNIFORM APPLICATION

### FY 2016/2017 - STATE BEHAVIORIAL HEALTH ASSESSMENT AND PLAN

### SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018  
(generated on 09/22/2015 11.07.18 AM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

# State Information

## State Information

### Plan Year

Start Year 2016

End Year 2017

### State DUNS Number

Number 134104855

Expiration Date

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

Agency Name Maryland Department of Health and Mental Hygiene

Organizational Unit Behavioral Health Administration

Mailing Address 55 Wade Avenue

City Catonsville

Zip Code 21228

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

First Name Kathleen

Last Name Rebbert-Franklin

Agency Name Maryland Department of Health and Mental Hygiene

Mailing Address 55 Wade Avenue

City Catonsville

Zip Code 21228

Telephone 410-402-8610

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Email Address kathleen.rebbert-franklin@maryland.gov

### III. Expenditure Period

State Expenditure Period

From

To

### IV. Date Submitted

Submission Date

Revision Date

### V. Contact Person Responsible for Application Submission

First Name Erik

Last Name Gonder

Telephone 410-402-8669

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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  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
Section 1922	Certain Allocations	<a href="#">42 USC § 300x-22</a>
Section 1923	Intravenous Substance Abuse	<a href="#">42 USC § 300x-23</a>
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	<a href="#">42 USC § 300x-24</a>
Section 1925	Group Homes for Recovering Substance Abusers	<a href="#">42 USC § 300x-25</a>
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	<a href="#">42 USC § 300x-26</a>
Section 1927	Treatment Services for Pregnant Women	<a href="#">42 USC § 300x-27</a>
Section 1928	Additional Agreements	<a href="#">42 USC § 300x-28</a>
Section 1929	Submission to Secretary of Statewide Assessment of Needs	<a href="#">42 USC § 300x-29</a>
Section 1930	Maintenance of Effort Regarding State Expenditures	<a href="#">42 USC § 300x-30</a>
Section 1931	Restrictions on Expenditure of Grant	<a href="#">42 USC § 300x-31</a>
Section 1932	Application for Grant; Approval of State Plan	<a href="#">42 USC § 300x-32</a>
Section 1935	Core Data Set	<a href="#">42 USC § 300x-35</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

Title: Secretary, Department of Health and Mental Hygiene

Date Signed: \_\_\_\_\_

mm/dd/yyyy

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

Footnotes:

## State Information

### Disclosure of Lobbying Activities

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

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

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Name	<input type="text" value="Van T. Mitchell"/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="Department of Health and Mental Hygiene"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## Planning Steps

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

Narrative Question:

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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:

## Planning Steps

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

### **Executive Summary:**

During the 2014 Maryland legislative session, legislation was passed integrating the Alcohol and Drug Abuse Administration (ADAA) and the Mental Health Administration (MHA) creating the Behavioral Health Administration (BHA). The BHA is part of the Maryland Department of Health and Mental Hygiene (DHMH) and is responsible for overseeing the delivery of publicly funded addictions prevention and treatment services as well as responsibility for the oversight of public mental health services in Maryland. The BHA remains actively involved in activities to refine, enhance, and improvement management of the service delivery systems. The Deputy Secretary for Behavioral Health, Gayle Jordan-Randolph, M.D., oversees all aspects of the newly integrated Behavioral Health Administration, under the leadership of the DHMH secretary Van Mitchell. In addition, the BHA Deputy Secretary is responsible for the Developmental Disabilities Administration (DDA) and the Office of Forensic Services. The BHA is led by Executive Director Brian Hepburn, M.D.

The BHA preserves and strengthens the service system through various collaborative efforts and places high priority on access to services and the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. The BHA continues efforts to support the Department's mission of fostering an integrated process for planning and collaboration, and of ensuring that a quality system of care is available for individuals with behavioral health disorders.

Maryland is submitting separate applications for the FY16 -17 Mental Health Block Grant and Substance Abuse Block Grant.

### **Overview of Maryland's Public Behavioral Health System:**

The Behavioral Health Administration is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention, treatment and recovery support services. The Single State Authority (SSA) for Maryland resides within the BHA and is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families and communities. The BHA designates, approves, plans and coordinates programming within Maryland that offers

prevention, intervention, treatment and recovery support services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates “science to service” information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence, and support services to sustain the recovery beyond the treatment/rehabilitation episode.

### **Organization of Maryland’s Public Behavioral Health System:**

The BHA is organized into five separate “Pillars” each led by a BHA Deputy Director. The Deputy Directors report directly to the BHA Executive Director. The five pillars are: Population-Based Behavioral Health, Operations, Clinical Services, Children Services, and Facilities (see attached organizational chart). Each of the pillars contributes to the overall mission of the Administration through integrated planning and implementation of their respective component of the services. For example, the SSA function is the responsibility of the Deputy Director for Operations for fiscal management, procurement and compliance. The SSA also relies on the Deputy Director for Clinical Services for clinical oversight, quality assurance and treatment and recovery services. The Deputy Directors are responsible for services to substance use disorder as well as mental health disorder individuals and families.

### **The BHA and Maryland’s Public Substance Use Disorders System**

Maryland is divided into twenty-four subdivisions, including twenty-three counties and Baltimore City. Each subdivision has a Local Addiction Authority (LAA) within the local health department who is responsible for the delivery of publicly funded services in that jurisdiction. The BHA awards State and Federal funds to the twenty-four jurisdictions for substance use disorder prevention, treatment and recovery support services through grants that support the services infrastructure for Maryland’s uninsured or under insured patient population. Public funding through the BHA is therefore the “safety net” for individuals in need of services who would otherwise lack the ability to pay for services. This is a particularly important consideration in view of the number of court commitments and other justice system referrals.

Conditions of Award for these grants provide contractual parameters for the jurisdiction to ensure that SAPT-BG and other Federal and State requirements are met. Jurisdictions control the type and method of service delivery, including directly operated programs, sub-contracts with private providers, a preferred provider network, or a combination model. Access to programs within a jurisdiction may be restricted to residents within that jurisdiction or a designated region. Other programs have statewide capacity and are funded with State, Local and Federal dollars.

Maryland strives to provide a statewide continuum of care with all levels of treatment, in which individuals move among levels of care based on their individual needs. Within each of the twenty-four jurisdictions there are State and locally funded systems for assessment, referral and treatment of persons with substance use, abuse and dependence problems. Individuals may self-refer, or be referred from a primary care provider, other health care professional, the courts or other sources. Local Health Departments are generally designated for the initial contact with the un- or under- insured.

Programmatic functions in all public and privately funded treatment programs, from assessment through every level of care in the continuum, are governed by the Code of Maryland Regulations (COMAR). State laws and regulations require that all SUD treatment programs in Maryland be certified by the Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ). The continuum of certified treatment programs in Maryland consists of \_\_\_\_\_ certified treatment provider; \_\_\_\_\_ receive funding from the BHA and \_\_\_\_\_ are privately funded.

The BHA Substance Abuse Regional Managers are responsible to the SSA and are liaisons to local prevention, treatment and recovery support service providers working with the local jurisdictions to coordinate the provision of services. The Regional Managers provide on-site clinical development activities for programs, and leads technical assistance (TA) teams that provide both proactive (BHA initiated) assistance as well as assistance requested by jurisdictions and programs.

The BHA Quality Assurance (QA) responsibility lies within the Clinical Services pillar and is responsible for developing, implementing and maintaining service improvement strategies to enhance the quality of services provided in Maryland. The QA staff conduct compliance reviews on a random basis to assure the provision of quality services, and conduct investigations as needed in response to complaints by patients, families, or the public. The QA staff reviews various aspects of program operations to determine compliance with substance use disorder treatment program regulations and BHA Conditions of Award, and identifies relationships between program practices and the quality of care. Code of Maryland Regulations (COMAR), Code of Federal Regulations (CFR) and BHA Conditions of Award determine the basis for the reviews.

The QA staff work with programs to implement a number of possible solutions to non-compliance with COMAR, CFR, or BHA Conditions of Award. If there is a risk to the health and safety of the patient or the community, administrative action may be taken, including the possibility of program closure. In the case of less serious deficiencies, Corrective Action Plans (CAP) are developed with appropriate timelines for implementation. Follow-up reviews are conducted to ensure the CAP has been completed.

All publicly funded treatment (grant funded as well as Medicaid) is required to be reported through the data collection system of the Administrative Service Organization (ASO). This data reflect the status of substance treatment, services delivered and populations served.

All funded programs are required to provide a comprehensive assessment within ten days of initial contact with the patient. The exception to this requirement is for pregnant women and women with dependent children, who must receive priority assessment and admission to the appropriate level of care within twenty-four hours of initial contact. The assessment instrument for adults is the Treatment Assignment Protocol (TAP) and the Adolescent Drug and Alcohol Diagnosis (ADAD) for adolescents. All assessments must measure along several domains, including physical health, employment status, drug and alcohol use, family status, treatment history and mental health status.

Maryland regulations (COMAR) mandate the use of the American Society of Addiction Medicine Patient Placement Criteria – 2 Revised (ASAM-PPC-2R) for placement in the most appropriate level of care (LOC). Individuals are referred to programs with the corresponding LOC, based on bed or slot availability. Referrals and admissions are based on the ASAM-PPC-2R criteria and corresponds with various LOCs available throughout the state. Programs incorporate Evidenced Based Programs in the delivery of funded services and are evaluated on performance measurement standards which have been developed by the BHA and written into grant conditions of award.

**The Maryland Addictions Directors Council (MADC)** is a nonprofit organization that supports the prevention, intervention, treatment and recovery programs throughout the state. MADC members include public, private, nonprofit and for-profit programs. MADC initiates, facilitates, and supports advocacy, outreach, research, publication and educational activities that improve access to quality substance use disorder services. MADC's mission is to advocate for quality addictions services that promote healthy individuals, strong families and thriving communities. The BHA actively provides liaison to MADC.

**Maryland's Public Mental Health System (PMHS):**

The Single State Mental Health Authority (SSMHA) is located within the BHA. The delivery of services in the PMHS is managed in collaboration with local Core Service Agencies (CSA) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility to develop and manage a coordinated network of mental health services. The ASO is contracted to the BHA with the statewide responsibility for utilization management, access to services, data collection and management information services, claims processing and payment, evaluation services and stakeholder feedback. It is

the goal of the PMHS to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services with flexibility and choice.

The BHA and CSAs share responsibilities within the PMHS. There are nineteen CSAs covering all twenty-four jurisdictions. The CSAs are agents of county or city government and may be a part of the county government, quasi-government bodies, or private, non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluation appropriateness and effectiveness of services.

The CSAs are important points of contact for both consumers and providers in the PMHS and they develop partnerships with other local, state, and federal agencies. CSAs provide numerous public education events and trainings. They process complaints, grievances, and appeals, as well as monitoring the contract with the ASO and reporting findings to the BHA. The local Mental Health Advisory Committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PHMS and to participate in the development of local mental health plans and budget.

The Maryland Association of Core Service Agencies, Inc. (MACSA) was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and state priorities. The CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various BHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues.

The CSAs work closely with the BHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve. CSAs also serve as authorization agents for some specialized services and play key leadership roles in a number of federally funded local demonstration projects.

## **The Behavioral Health Administration and Other State Agencies:**

### **State Drug and Alcohol Abuse Council (SDAAC)**

The Maryland State Drug and Alcohol Abuse Council (DAAC) was created within the Office of the Governor, with the enactment of Maryland House Bill 219, Acts of 2010 (Chapter 661). The DAAC is composed of 27 members including representatives from the State Legislature, state agencies, and councils (including DHMH, criminal justice agencies, human resources, budget and management, housing and community development, transportation, State Superintendent of Schools, and the Governor's Office for Children), as well as eight appointed members representing geographic regions of the state, at-risk populations, knowledgeable professionals, consumers, family members and service providers. The DAAC is directed by statute to meet at least four times per year.

The BHA provides staff support to the DAAC and its five work groups, which include:

- Collaboration and Coordination
- Criminal Justice Services
- Prevention of Underage Drinking (MSPF Advisory Committee)
- Technology
- Workforce Development

### **DHMH Prevention and Health Promotion Administration (PHPA)**

The BHA maintains a memorandum of understanding (MOU) with the PHPA Center for HIV Prevention and Health Services Infectious Disease Bureau to provide HIV/AIDS counseling, testing, and referral for individuals in areas of the state with the greatest need, at the locations in which they are receiving substance abuse treatment.

The PHPA has implemented a Sexual Health Integration Initiative that provides HIV Early Intervention Services funding from the SAPT-BG Set Aside to local health departments in Maryland jurisdictions most impacted by HIV. The counties include Anne Arundel, Baltimore, Charles, Harford, Howard, Montgomery, Prince George's, and Washington Counties. This initiative operationalizes a sexual health framework within substance use disorder treatment, with HIV testing and linkages as the capstone interventions. The Letter of Agreement (LOA) between PHPA and the BHA is effective from July 1, 2013 through June 30, 2016. A member of the BHA staff participates in the Community Planning Group, an advisory board to the PHPA.

### **Maryland Department of Public Safety and Correctional Services (DPSCS)**

Health General Articles (HG) 8-505 and 8-507 provide for services to the criminal justice populations. The BHA maintains an MOU with the DPSCS to provide court-ordered HG 8-505 evaluations for inmates within the State correctional institutions and local detention centers. Inmates from each of the twenty-four jurisdictions who are identified as being in need of treatment are referred to community-based treatment programs throughout the state per HG 8-507. In accordance with Maryland legislation DPSCS staff provide clearance status for court-ordered HG 8-505 and HG 8-507 inmates to permit their transfer to and enrollment in community based treatment programs. The BHA Forensics Unit Director attends meetings of Maryland's Problem-Solving Courts Mental Health Oversight Committee and the Substance Abuse Oversight Committee. The Forensics Unit Director convenes meetings, often attended by representatives from local jurisdictions, to perform Case Conference Reviews as a part of the BHA internal quality assurance process.

The DPSCS operates five Residential Substance Abuse Treatment (RSAT) programs within the Maryland correctional system. These programs are managed by a contractor, Gaudenzia, Inc., and are ASAM Level III.5 modified therapeutic communities. One RSAT program within the system is a Recovery Net (Maryland's Access to Recovery – ATR) referral portals. Designated staff are trained to apply for Recovery Net services for eligible individuals, and to arrange for client meetings with Care Coordinators prior to discharge from the correctional system.

### **Maryland Department of Juvenile Services (DJS)**

The BHA maintains a long-standing MOU to address the needs of substance using youth who are under the control and supervision of the DJS. The MOU provides salary support for the DJS Addiction Services Office Administrator, Clinical Supervisor and eight clinicians who deliver screening, drug education, and individual and group counseling.

### **Maryland Department of Human Resources (DHR)**

The BHA maintains an MOU with DHR to provide addictions counseling in local Department of Social Services (DSS) offices throughout the state. There are approximately sixty-one counselor positions (at least one in every jurisdiction). These counselors provide SUD screening for individuals applying for Temporary Cash Assistance (TCA) and refer individuals in need of treatment to local health departments for community-based services.

### **Maryland Medical Assistance (MA) Program**

The Maryland Medical Assistance Program, as part of the Department of Health and Mental Hygiene, contracts with an Administrative Services Organization (ASO) to manage services for the treatment of both mental health disorders and substance use disorders. It is the responsibility of the ASO to provide access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services and stakeholder feedback. The centralized care management and claims processing ensures for better coordination of care for persons with mental health disorders and substance use disorders.

### **Maryland Office of Health Care Quality (OHCQ)**

The OHCQ is the agency within the DHMH charged with monitoring the quality of care in Maryland's 9,900 health, mental health and substance use disorders programs and agencies. The OHCQ licenses and certifies the state's health care facilities, and certifies all addiction treatment programs. The OHCQ uses state and federal regulations, which set forth minimum standards for provision of care and conducts surveys to determine compliance. When problems or deficiencies are noted, the OHCQ initiates administrative action against facilities that violate state rules and regulations. If a facility fails to correct problems and is unable or unwilling to do so, the OHCQ may impose sanctions such as license revocation, fines, bans on admission, or other restrictions on the operating license.

### **Maryland Department of Veterans Affairs**

The Perry Point VA Medical Center offers long and short term inpatient behavioral health care, domiciliary care, and a unique and innovative intensive outpatient addictions treatment program for veterans with drug/alcohol problems. The VA has designated a referral liaison to identify veterans in residential treatment who meet Recovery Net program eligibility criteria, help eligible veterans apply for recovery support services, and arrange for meetings with their Care Coordinators prior to discharge from treatment.

### **University of Maryland – Baltimore School of Medicine**

The BHA maintains two MOU's with the School of Medicine:

- Problem/Pathological Gambling – The MOU with the School of Medicine supports the operation of Maryland's problem and pathological gambling Hotline. Individuals with gambling disorders and their families/friends call the Gambling Hotline for referral to gambling disorders treatment services. The School of Medicine also provides clinical training in problem/pathological gambling for counselors within the state's substance use disorders treatment programs.

- Deaf and Hard of Hearing (DHH) – The MOU provides substance use disorder treatment services for individuals who are DHH. Community based treatment providers throughout the state request the services on an as-needed basis for DHH patients. The School of Medicine program provides necessary services through professional counseling staff that are proficient in American Sign Language and knowledgeable in the unique treatment and cultural needs of this population.

### **University of Maryland – Baltimore School of Pharmacy**

The BHA has two MOU’s with the School of Pharmacy:

- Statewide Epidemiologic Outcomes Workgroup (SEOW) – This MOU supports a portion of the effort of several research faculty who manage and operate the Maryland SEOW. This MOU is funded through the SAPT-BG 20% prevention set aside.
- Maryland Strategic Prevention Framework (MSPF) – This MOU supports a portion of the effort of a number of research faculty who are conducting the MSPF process and outcome evaluations. This MOU is funded through the Center for Substance Abuse Prevention (CSAP) SPF grant.

### **Johns Hopkins University**

The BHA contracts with Johns Hopkins University for Maryland’s participation in the National College Health Improvement Project (NCHIP). The NCHIP is designed to bring a new approach to provide services to college students who engage in high-risk drinking. NCHIP is a joint undertaking between Dartmouth College and the Dartmouth Institute for Health Policy and Clinical Practices (TDI) aimed at bringing population health improvement methods to bear on the many problems affecting student health at post-secondary institutions in the United States. NCHIP’s has initiated a Learning Collaborative on High-Risk Drinking with the objective of working to effect measurable change by reducing the rate of high-risk drinking at participating institutions, as well as the harm that results from this behavior.

### **Regional, County and Local Behavioral Health Entities:**

#### **County Health Departments**

The BHA contracts directly with several accredited providers for the delivery of some residential treatment services. All other services are delivered through the local county health departments located within the twenty-three jurisdictions and Behavioral Health System Baltimore (BHSB) in the City of Baltimore. The County Health Departments are usually arms of DHMH and their employees are State of Maryland employees, except in home-rule counties, where CHD’s are arms of the county government and employees of the county.

Within each jurisdiction, both State and local funds maintain a system for assessment, referral, and treatment of persons with substance use disorders. Individuals may self-refer, or be referred from a primary care provider, other health professional, the courts or other sources. The CHDs are generally the designated location for initial contact for the un or under-insured.

While CHD's provide most services directly, in some cases, CHD's may subcontract for services with accredited and licensed substance use disorder treatment providers. When subcontracting, the CHD assumes responsibility for program monitoring and, in this way, functions as a traditional intermediary to services.

Maryland utilizes a two-tiered system of monitoring compliance with conditions of award. First, the BHA Quality Assurance staff review and audit the jurisdictional health departments and the BHSB regarding the services they directly provide. The local jurisdictions are responsible for monitoring programs they subcontract for additional services, and they submit program monitoring data to the BHA on a quarterly basis. BHA staff perform second tier audit functions as they monitor jurisdictional-level data reports to ensure that services are provided in communities with highest need. Compliance review teams audit those reports during routine compliance or problem investigation review visits, with a focus on adherence to applicable regulations, policies and accepted standards of care.

#### **Local Drug and Alcohol Abuse Councils (LDAAC)**

Maryland utilizes its local advisory councils to conduct state and sub-state level planning. Legislation has established that all twenty-four subdivisions in Maryland develop, and appoint certain agency representatives to the LDAAC. Each LDAAC prepares a biennial plan and consistently reports every six months to the BHA on progress toward implementation of the plan. The composition of each LDAAC must, per the Annotated Code of Maryland, 8-1001, consist of the following agency representatives or their designees:

- Health officer of the local health department
- Director of the local Department of Social Services
- Regional director of Department of Juvenile Services
- Regional Director of the Division of Parole and Probation
- State's Attorney for the county
- District Public Defender
- Chief of the county police department or sheriff
- President of the local Board of Education
- Representative of the County Executive, Mayor of Baltimore city or County Commissioners
- County administrative judge of the circuit court

- The following individuals appointed by the county executive or Mayor of Baltimore City or County Commissioners
  - At least one recipient of addictions treatment services
  - Two SUD providers, at least one with experience with services to individuals with co-occurring DUD and MHD
  - At least one substance use disorder prevention provider
  - At least one individual who is knowledgeable and active on SUD issues that affect the county
  - The superintendent, warden, or director of the local correctional facility
  - At least one other individual who is knowledgeable about treatment of SUDs in the county, including members of civic organizations, the Chamber of Commerce, health care professional organizations, or the clergy

**Needs of Diverse Racial, Ethnic and Sexual Gender Minorities & Proactive efforts to Reduce Health Disparities:**

Racial minorities, including African-Americans suffer disproportionately from homelessness, incarceration, child welfare involvement, trauma and poverty. Nearly one in three African-American males will serve time in prison during their lifetime (Iguchi et al, 2005). Drug addiction and incarceration rates are five to seven times greater than for Whites (Williams and Jackson, 2005). Drug addiction and incarceration increase the risk for mental illness and infectious disease. African-Americans are thirteen percent of the population yet account for forty-nine percent of new AIDS cases (Kaiser, 2005).

African-Americans represent sixty-three percent of the population in Baltimore City, compared to twenty-nine percent for Maryland and twelve percent for the United States. It is well known that opioid and cocaine addiction have reached epidemic proportions in Baltimore City. Therefore, African-Americans living in Baltimore and around the state are disproportionately at higher risk of experiencing poverty, low educational achievement, high infant mortality rates, homicide, incarceration and drug related health risks (HIV, hepatitis, and other infectious disease, certain cancers, and complications/poor outcomes from chronic diseases such as hypertension, diabetes, kidney disease, etc.).

The BHA values the fundamental right of all individuals to high quality healthcare regardless of race/ethnicity, sexual orientation or disability status, and believes that elimination of minority disparities in health and healthcare provides personal, social and economic benefits for individuals, communities and the State (Maryland Office of Minority Health and Health Disparities –MHHS, 2006; Sullivan Commission, 2004). In 2006, the MHHS within the Maryland DHMH released the *Maryland Plan to Eliminate Health Disparities*, developed with the input of

more than 1,200 citizens, health professionals, academia, and public and private health groups. The Plan promoted strategies to eliminate health disparities and healthcare disparities.

In 2010, the MHHS published the second edition of the *Maryland Plan to Eliminate Minority Health Disparities: Plan of Action 2010-2014* and the second edition of the *Maryland Chartbook of Minority Health and Minority Health Disparities Data*. The MHHS serves as a clearinghouse for information on Minority Health Disparities. Additionally, the MHHS reviews and testifies in support of bills; reviews existing laws and regulations to ensure they facilitate adequate health care to minorities; and recommending changes.

According to the United Health Foundation, Maryland ranks 35<sup>th</sup> in infectious diseases, 34<sup>th</sup> in health outcomes, and 33<sup>rd</sup> regarding geographic health disparities, despite numerous positive measures, such as having the second highest rate of primary care providers per capita and one of the ten lowest rates of smoking tobacco. The Health Disparities and Reduction Act of 2012 sought to address the significant health disparities that impact too many Maryland communities, families and individuals. The primary focus of the legislation was the creation of Health Enterprise Zones (HEZ). HEZs are designed to reduce health disparities among Maryland's racial and ethnic groups and between geographic areas; improve health care access, quality and health outcomes; and reduce health care costs by providing a variety of incentives to defined geographic areas with high rates of disparities. It was originally anticipated that between two and four zones would be part of the pilot program, funded with \$4M allocated to the Community Health Resources Commission. In January 2013, five designated areas were selected as the State's first HEZs: Capitol Heights in Prince George's County, Greater Lexington Park in St. Mary's County, Dorchester and Caroline Counties, West Baltimore and Annapolis.

To improve the health of Hispanics in Maryland, the DHMH Secretary has formed an internal workgroup to develop a work plan to address specific areas needed to improve the DHMH engagement with the Hispanic community. The Secretary recruited a behavioral health representative from the BHA. Work plan priorities include: communications, form/data collection, staff training, health care provider education/expectations, and outreach activities.

#### **DHMH BHA Office of Consumer Affairs (OCA)**

The OCA works to gradually increase the sustainability and accountability of the twenty-five peer-run Wellness & Recovery Centers currently established across the State. Many of these centers address issues of co-occurring disorders of mental illness and substance abuse within their programming. The LGBTQ Wellness & Recovery Center has offered several outreach sessions during the fiscal. There is an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community. Many other

consumer-run groups are held in the centers on a regular basis. There are continuing efforts to increase the focus on substance use disorders and the subpopulations of substance users within these centers.

## Planning Steps

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

Narrative Question:

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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](#)<sup>18</sup> 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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<sup>18</sup> <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2. Identify Unmet Services Needs and Critical Gaps within the Current System

### **Data Driven Processes for Identification of Needs and Gaps for Specific Populations:**

Maryland utilizes a data-driven strategic planning process to address identified needs, thus enabling Maryland to develop and implement a strong, viable, prevention, treatment and recovery network. The BHA collects and utilizes data from numerous sources to assess gaps and needs, to measure and report on performance, and to inform stakeholders.

Data sources include the National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Services (N-SSATA), and social indicator data collected and compiled by the Maryland Statewide Epidemiologic Outcomes Workgroup (SEOW). SEOW data include sub-state level data from other state agencies concerning substance-related deaths, arrests, auto crashes, school suspensions, hospital admissions, HIV/AIDS incidence and prevalence, among other indicators.

Analysis of the accumulated data is a vital component of BHA's mission to administer available resources effectively and efficiently to ensure that Maryland citizens in need have access to quality treatment and recovery services. Collectively, this comprehensive array of state and sub-state level data is used to determine areas of highest incidence, prevalence and need; to develop prevention, treatment and recovery service priorities and targeted interventions; and to evaluate the impact of the State's prevention, treatment and recovery service efforts.

The Maryland SEOW provides state substance abuse prevention, treatment and recovery service providers, policy makers, researchers, and citizens with information about the consumption, risk factors, and consequences associated with alcohol, tobacco, and drug use in Maryland. The SEOW oversees the collections, interpretation and dissemination of statewide and local data that quantify substance use and its consequences for the state. The SEOW tracks, monitors and analyzes trends and patterns for legal and illegal substances throughout Maryland, with detailed focus on the twenty-three counties and Baltimore City.

The Maryland SEOW is a partnership between the BHA and the University of Maryland, School of Pharmacy (SOP). Core membership in the SEOW is comprised of state agency representatives, researchers and policymakers, including the State Drug and Alcohol Abuse Council (DAAC), the Department of Education, the Department of Public Safety, the Office of Highway Safety, the Department of Health and Mental Hygiene, the National Guard, the State Police, universities, criminal justice agencies, and service provider agencies. In addition to the core SEOW members; local partners, representatives of various city/county governments or representatives from each Local Drug and Alcohol Abuse Council (LDAAC) participate in the

SEOW. The local partners provide updates on local prevention planning and the use of local level data to create prevention priorities, identify additional data needs, and assist in interpreting patterns identified in the data.

Data systems utilized by the Maryland SEOW include the following:

- Alcohol Epidemiologic Data System (AEDS). The AEDS reports trends in consumption of alcohol in the United States using alcoholic beverage sales.
- Fatality Analysis Reporting System (FARS). FARS is a census of all fatal traffic crashes; it was created by the National Highway Traffic Safety Administration (NHTSA) and is designed to assist the traffic safety community in identifying traffic safety problems, including drinking and driving.
- Maryland Automate Accident Reporting System (MAARS). MAARS presents data extracted from motor vehicle crash reports submitted by more than 200 Maryland law enforcement agencies; Maryland State Police capture the crash data and reports them to NHTSA for inclusion in FARS.
- National Vital Statistics System (NVSS). The National Center for Health Statistics, a division of the Centers for Disease Control (CDC), collects data from vital registration systems responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths; these data help identify and address critical health problems, including those related to the consequences of substance use.
- Treatment Episode Data Set (TEDS). TEDS is an administrative data system providing descriptive information about substance abuse treatment admissions and discharges. While TEDS does not represent the total national demand for substance abuse treatment, it does comprise a significant proportion of all admissions to substance abuse treatment and includes those admissions that constitute a burden on public funds.
- Uniform Crime Report (UCR). The UCR is a nationwide, cooperative statistical effort of over 17,000 law enforcement agencies who voluntarily report data on crimes. Arrest data related to substance use/violent crime is available from these reports.

Data sources utilized by the Maryland SEOW include:

- Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is designed to monitor state level prevalence of the major behavioral risks associated with premature morbidity and mortality among adults. Its purpose is to assess alcohol and tobacco use, health care coverage, testing for HIV/AIDS, physical activity, and fruit and vegetable consumption among adults age 18 and older.

- Youth Risk Behavior Survey (YRBS). The YRBS includes a national school based survey conducted by the CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. Its purpose is to monitor six types of health risk behaviors that contribute to the leading causes of death and disability among youth and adults, including; behaviors that contribute to unintentional injuries and violence; tobacco use, alcohol and other drug use; sexual risk behaviors; unhealthy dietary behaviors; and physical inactivity among students in grades 9-12.
- National Survey on Drug Use and Health (NSDUH). The SAMHSA sponsored NSDUH captures national, state and sub-state level data on the use of tobacco, alcohol, illicit drugs and mental health in the U.S.
- HIV/AIDS Surveillance. The CDC funds and assists state and local health departments to collect information about the distribution and determinants of HIV/AIDS; this surveillance system is the nation's source for timely information used to track the HIV/AIDS epidemic.
- Maryland Youth Tobacco Survey (MYTS). The MYTS is a biennial survey of Maryland public middle and high school students; its purpose is to generate estimates of tobacco use for under age youth as a whole as required by statute for both Maryland and each local jurisdiction.
- The Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS is a surveillance project of the CDC and state health departments; its purpose is to collect state specific, population based data on maternal attitudes and experiences before, during, and shortly after pregnancy.
- State Emergency Department Database (SEDD). The SEDD is a database developed as part of the Healthcare Cost and Utilization Project (HCUP). HCUP data inform decision making at the national, state, and community levels, through a Federal-State-Industry partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ). SEDD data contain information on discharges from emergency department visits to hospital-affiliated emergency departments that do not result in admissions; new HCUP data elements can be used in tandem to track sequential visits for a patient within a state and across facilities and settings (inpatient, emergency department, ambulatory surgery) while adhering to strict privacy guidelines.
- State Inpatient Databases (SID). Also a part of the HCUP, the SID contains information about community hospital outpatient visits and inpatient discharges, including discharges from acute psychiatric hospitals. The SID captures clinical and nonclinical information on all patients, regardless of payer, including persons covered by Medicare, Medicaid, private insurance, and the uninsured.

The BHA and School of Pharmacy have worked extensively with local prevention coordinators to generate input into the implementation of the Maryland Strategic Prevention Framework (MSPF). Assessment and Planning grants have been made to all Maryland jurisdictions to enable them to carry out jurisdiction-wide prevention needs assessment activities, resulting in the selections of their jurisdictional priorities as well as target communities for MSPF resources. Local communities have received MSPF implementation grants to implement prevention services designed specifically towards reducing the State's priority substance use and consequence indicators in highest need communities.

The BHA also partners with SAMHSA regarding admission and discharge data reporting requirements for the Treatment Episode Data Set (TEDS). Programs receiving public funds have been required to report data on all their patients in the State of Maryland Automated Record Tracking (SMART) system. SMART data and data from these other State and Federal resources have been used for utilization and categorical analysis and monitoring population health. Beginning in January 2015 the treatment data collection will be transitioned from SMART to become the responsibility of the Administrative Service Organization (ASO).

The BHA has worked with the Local Addiction Authorities regarding the implementation of a Recovery Oriented System of Care (ROSC). The BHA continues to analyze the available recovery oriented outcomes data to develop recommendations for recovery support services and expansion of data collection to satisfy additional NOMs (i.e. social support). These data inform and incentivize elements of ROSC and the Access to Recovery (ATR) program.

The BHA Epidemiology and Evaluation staff conducts and oversees the following BHA efforts:

- Research and analysis of treatment data for internal decision making and external reports.
- Data analysis and support for the SAPT Block Grant application.
- Fulfillment of requirements of the SAMHSA DASIS contract, including crosswalk development, maintenance and data submission.
- Maintenance of and reporting from the Prevention Minimum Data set.
- Data analysis for the Departmental Managing for Results (MFR) effort.
- Development and analysis of provider, subdivision and statewide performance measurement objectives.
- Estimation of treatment need.
- Collaboration with other agencies on data-matching and data-sharing projects.
- Sampling, research, analysis and IT support for annual Synar survey of tobacco retailers.
- Coordination and writing of controlled correspondence.
- Analysis of data and writing of sections of annual Outlook and Outcomes report.

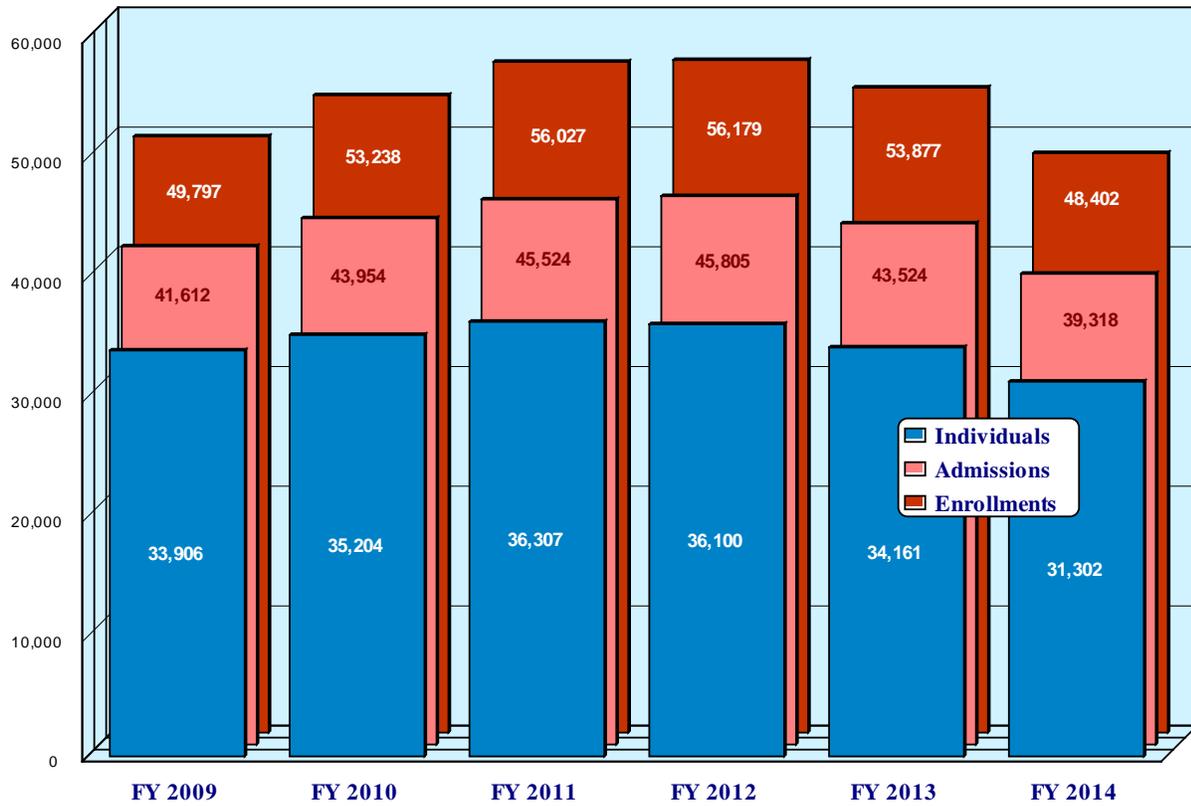
- Technical assistance to local subdivision coordinators and councils on data sources and analysis for local need and performance.

**Utilization (met need).** The following narrative, tables and graphs describe the individuals that are receiving behavioral health services in Maryland, and the services that are being provided.

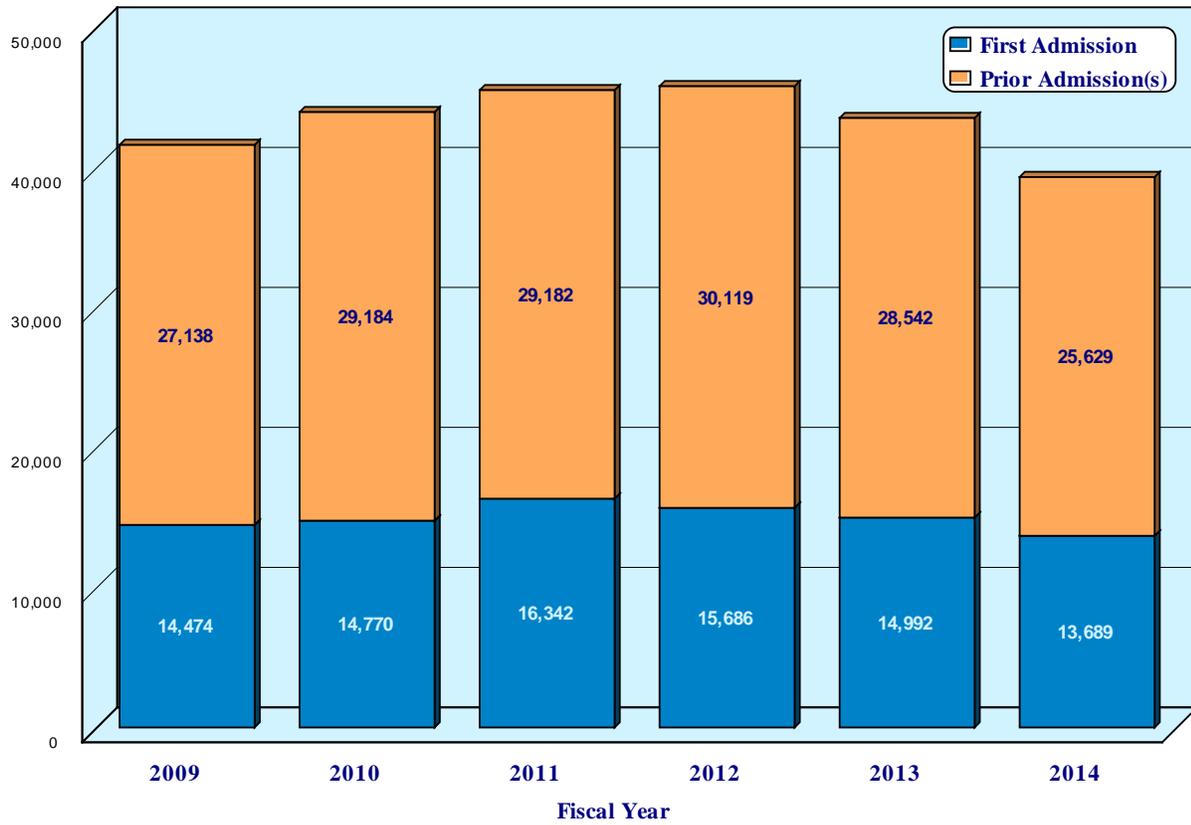
The following data reflect primary- patient admissions to and discharges from programs receiving state funding, reported to the SMART system. Programs receiving any public funds were required to report data on all their patients regardless of source of payment for individual patients. This summary of reporting over six years represents the final such report based on SMART reporting. As the reduction in volume of admissions is largely a reporting artifact, it will be most informative to examine trends in percentages over the past six fiscal years. Beginning January 1, 2015, data reporting by substance related disorder treatment programs has been delegated to the Administrative Service Organization.

With the impending transition to a new reporting system in CY 2015, reporting to SMART declined by 5% in FY 2013 and 10% in FY 2014, as shown in Figures 1 and 2. As will be shown later, a reduction in referrals from criminal justice agencies associated with declining statewide arrests for DUI and drug possession and sales was also a factor.

**Figure 1**  
**Individuals, Admissions and Enrollments in State-Supported Substance-Related Disorder Treatment**  
**Programs Reporting Data**  
**FY 2009 to FY 2014**

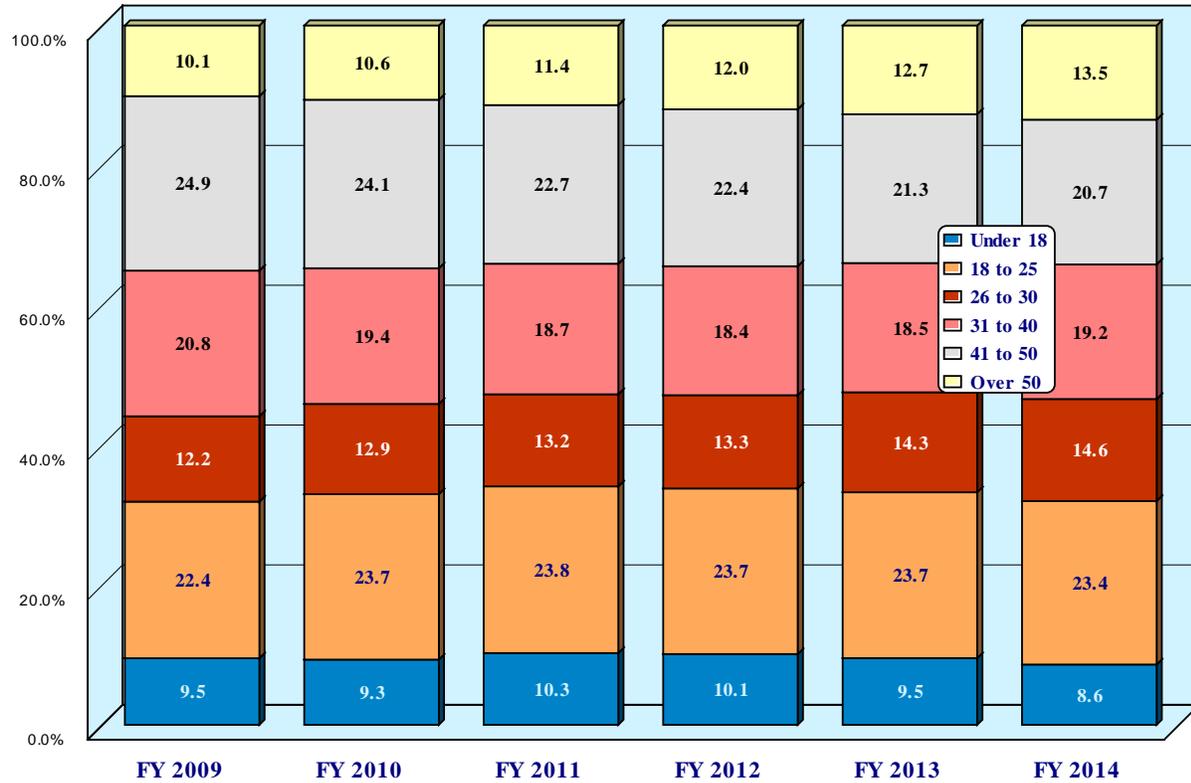


**Figure 2**  
**Prior Admission to State-Supported Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2009 to FY 2014**



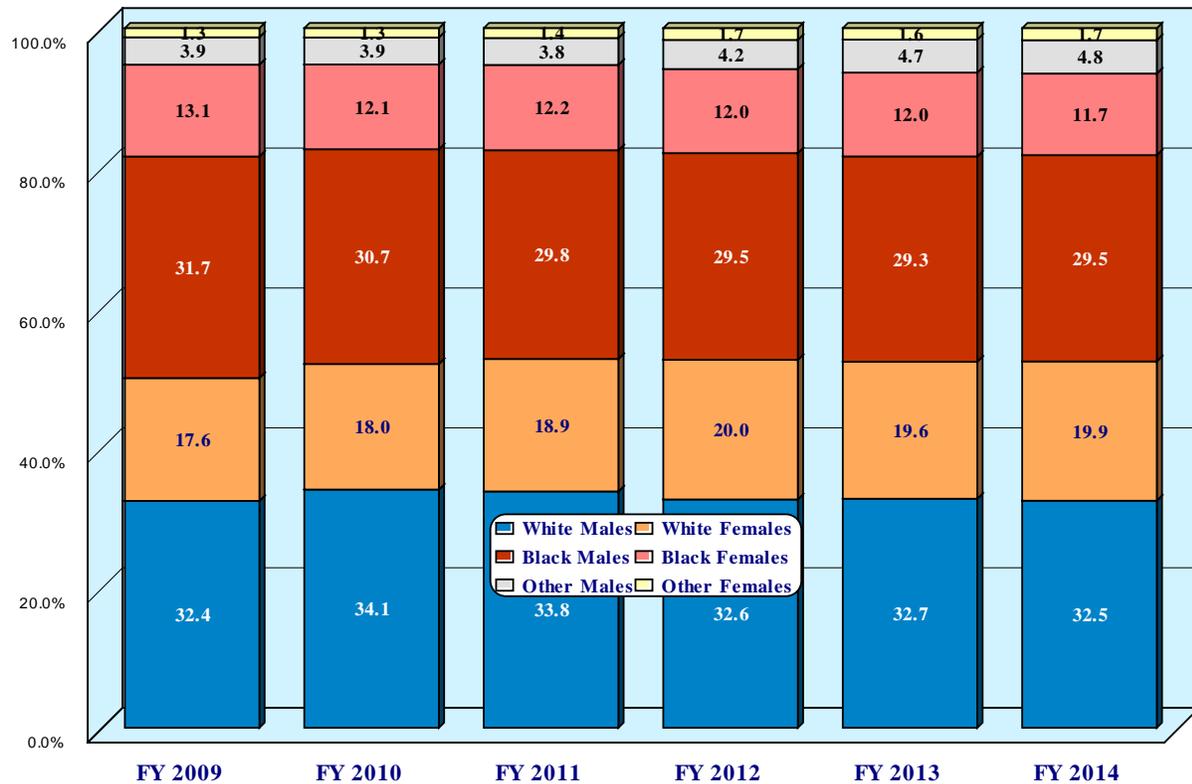
Age at Admission. Figure 3 shows relatively little variation in the distribution of age of admissions over the six years, although there is a steady increase of nearly 20% in admissions in the 26 to 30 age category and an increase of a third in admissions over age 50. The percent of admissions involving adolescents fell by 16% in the last four years.

**Figure 2**  
**Age at Admission to State-Supported Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2009 to FY 2014**



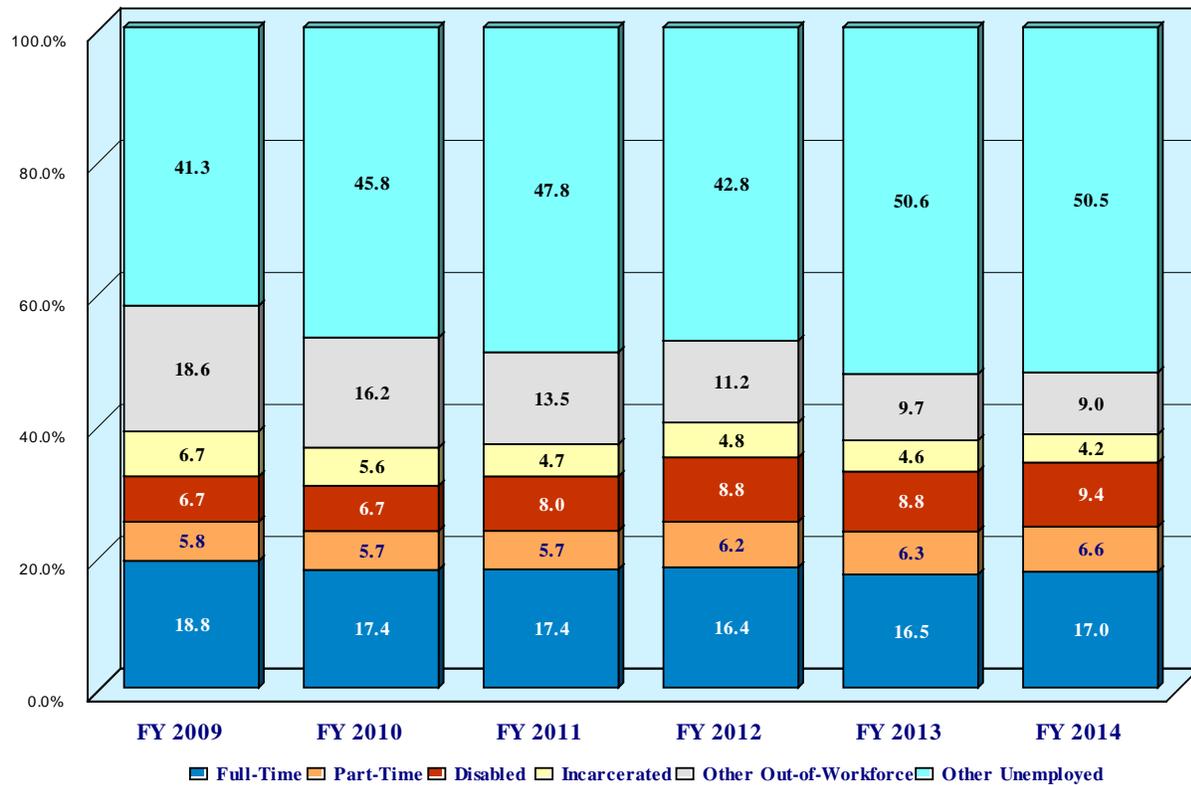
Race and Gender: The race and gender breakdown of admissions is shown in Figure 4. While the percentage of white female admissions increased by 13% in six years, admissions involving black females fell by 11%. The percentage of white male admissions increased slightly and black male admissions declined by 7%. As will be shown later, dramatic increases in heroin problems among white admissions is correlated with this racial transition. Both males and females of other races increased significantly in percentage, largely reflecting greater access to services by Hispanics.

**Figure 4**  
**Race/Gender among Admissions to State-Supported Substance-Related Disorder Treatment Programs**  
**Reporting Data**  
**FY 2009 to FY 2014**



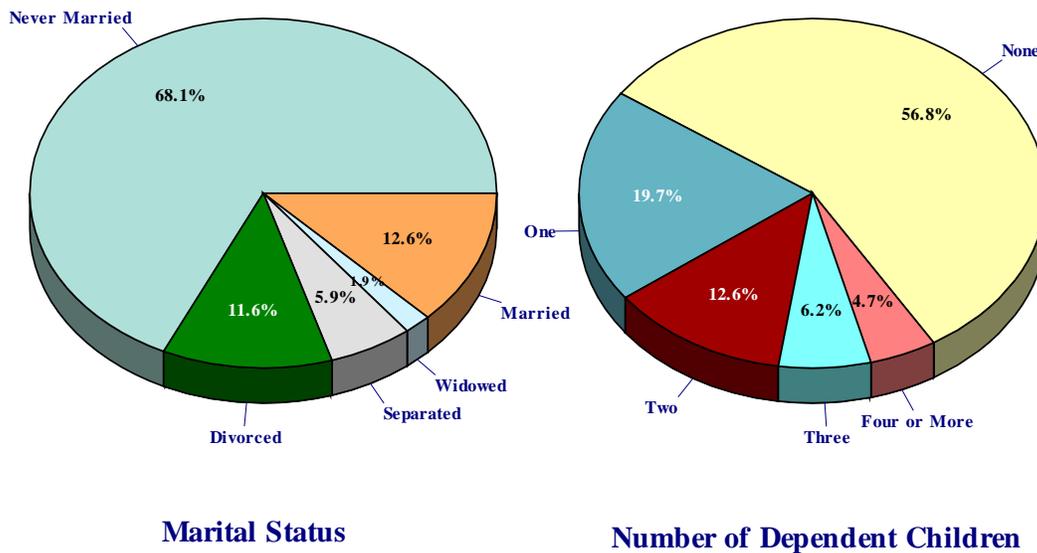
Employment Status: Figure 5 displays the distributions of adult admissions by employment status. While the total percentage unemployed from FY 2009 to 2014 was fairly stable at about 73%, there was a 22% shift away from out-of-the-workforce categories toward the percentage of patients presumably seeking work. The exceptions was the Disabled category, which jumped by 39%. Full-time employment fell by 10% while part-time employment advanced by 14%.

**Figure 5**  
**Employment Status at Admission to State-Supported Substance-Related Disorder Treatment Programs**  
**Reporting Data**  
**FY 2009 to FY 2014**



Marital Status & Dependent Children: Nearly seventy percent of FY 2014 adult admissions had never been married and 13% were married or in a common-law relationship as shown in Figure 6. Forty-three percent of the admissions to treatment in FY 2014 reported having one or more dependent children. The 21,299 unduplicated adult males admitted during FY2014 reported a total fo 15,213 dependent children, while the 9,437 individual females reported 10,239 dependent children. Of the 11,311 females of child-bearing age admitted during FY2014, 523 were reported pregnant at admission.

**Figure 6**  
**Marital Status and Number of Dependent Children among**  
**Adult Admissions to State-Supported Substance-Related Disorder**  
**Treatment Programs Reporting Data**  
**FY 2014**



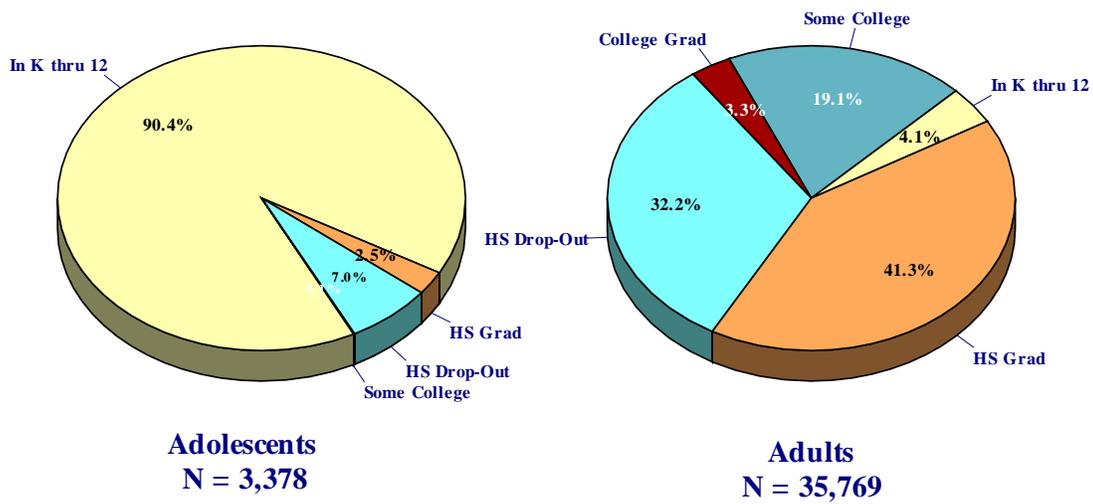
Patient Residence: Admissions are distributed by percentage location of residence from FY 2009 to FY 2014 in Table 1. The largest five-year increases in percentages involved residents of Cecil, Harford, Howard, Dorchester and Calvert Counties. Excluding St. Mary's, which had particularly significant reporting issues, the largest declines were in Garrett, Kent and Montgomery Counties. Our-of-State residents, primarily from Delaware, Washington, D.C., and Virginia decreased by 17%.

**Table 1**  
**Patient Residence Percentages for Admissions to State-Supported**  
**Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2009 to FY 2014**

Residence	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Allegany	2.0	1.9	1.6	1.5	1.5	1.7
Anne Arundel	7.3	7.6	8.3	9.2	8.8	8.5
Baltimore City	30.1	29.2	29.6	30.6	30.3	29.3
Baltimore County	9.3	9.9	10.3	10.6	10.4	10.3
Calvert	2.8	3.3	3.5	3.4	3.5	3.4
Caroline	1.1	1.1	1.0	1.0	0.9	1.2
Carroll	2.2	2.6	2.8	2.0	1.9	2.4
Cecil	1.9	1.8	2.4	3.0	2.9	3.2
Charles	2.9	2.7	2.4	2.4	2.5	2.6
Dorchester	1.4	1.5	1.6	1.5	1.5	1.7
Frederick	3.0	3.3	3.1	2.8	2.8	3.0
Garrett	0.9	0.8	0.8	0.8	0.7	0.6
Harford	2.1	2.5	2.9	3.0	3.1	3.6
Howard	1.7	2.0	2.1	2.0	2.0	2.1
Kent	0.9	0.8	0.8	0.6	0.6	0.7
Montgomery	6.7	5.8	5.4	5.2	5.4	5.2
Prince George's	6.0	5.8	5.0	4.5	5.8	6.1
Queen Anne's	1.6	1.8	1.3	1.6	1.6	1.5
St. Mary's	2.3	2.6	2.7	2.4	2.1	0.9
Somerset	0.9	0.8	0.7	0.8	0.7	0.7
Talbot	1.2	1.2	1.1	0.9	1.0	1.2
Washington	3.0	2.9	2.6	2.5	2.2	2.5
Wicomico	3.0	2.9	3.4	3.2	3.6	3.0
Worcester	1.8	1.8	1.7	1.8	1.6	1.6
Out-of-State	3.6	3.4	2.9	2.6	2.4	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

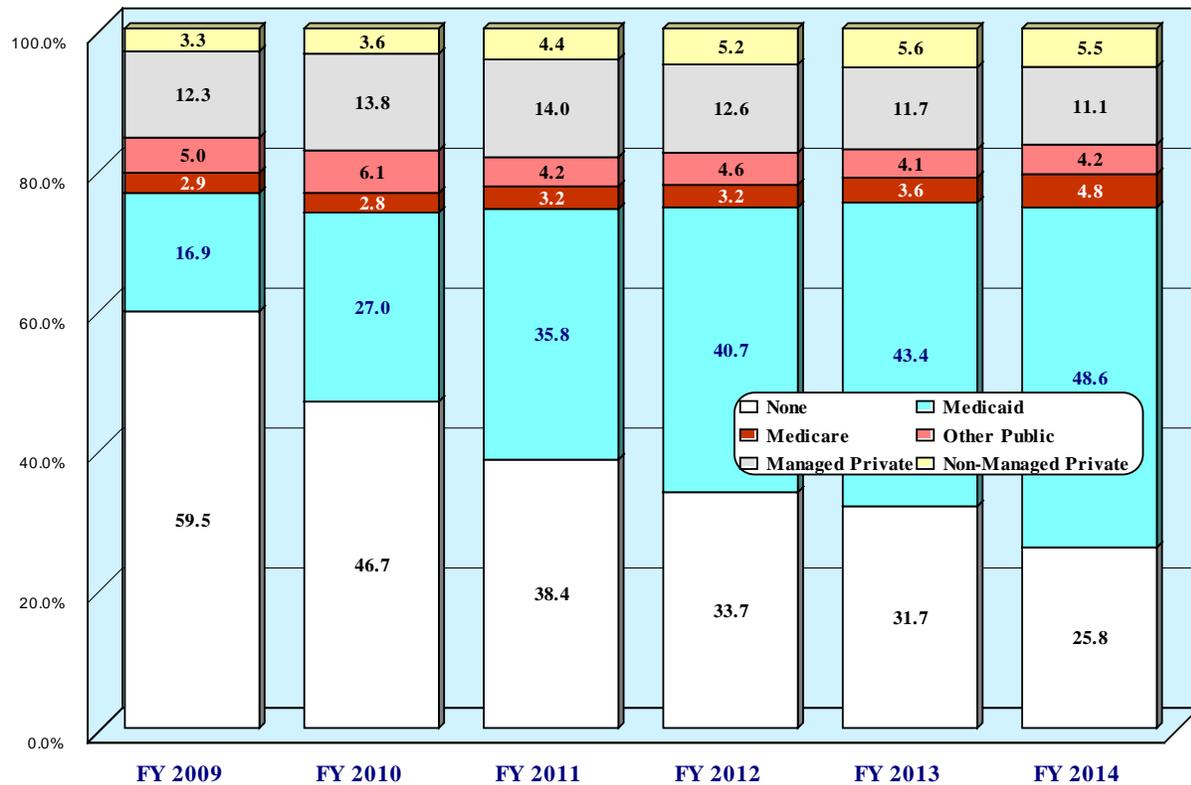
Educational Status: The educational attainment of adolescent and adult admissions is shown in Figure 7. Nine out of ten adolescents were attending school. Only about 64% of adult FY 2014 treatment admissions had high-school diplomas. Seven percent of adolescents and nearly a third of adults admitted could be classified as high-school drop-outs.

**Figure 7**  
**Educational Attainment among Adolescent and Adult Admissions to**  
**State-Supported Substance-Related Disorder Treatment Programs**  
**Reporting Data**  
**FY 2014**



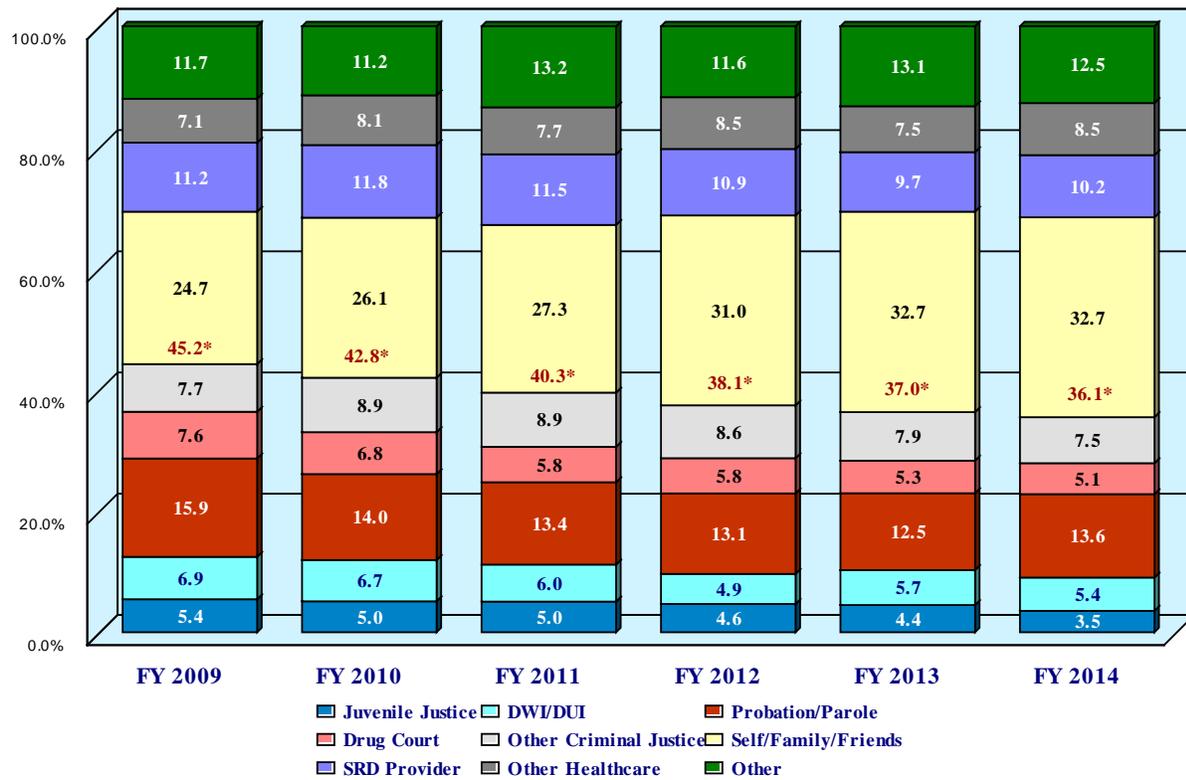
Health Coverage: Health coverage of admissions is shown in Figure 8. The reported coverage does not necessarily reflect payment for the immediate treatment episode. Admissions involving patients with not health coverage decreased steadily from 60% in FY 2009 to just over one-fourth in FY 2014, while the percentage with Medicaid nearly tripled. Admissions with private insurance were relatively stable.

**Figure 8**  
**Health-Care Coverage among Admissions to State-Supported Substance-Related Disorder Treatment Programs Reporting Data FY 2009 to FY 2014**



Source of Referral: Figure 9 shows about a third of FY 2014 admissions were self or family referrals, up from 25% in FY 2009. Criminal-justice sources accounted for 36% of admissions in FY 2014, a 20% reduction from FY 2009. As most criminal-justice referrals originate in arrests, a 6% reduction in arrests for drug sales and possession from 2009 to 2013 (15% since 2008) and a 12% decline in arrests for DUI help explain the declining referrals. Arrest data were drawn from the Maryland State Police Crime in Maryland reports.

**Figure 9**  
**Source of Referral among Admissions to State-Supported Substance-Related Disorder Treatment**  
**Programs Reporting Data**  
**FY 2009 to FY 2014**



\*Total Criminal Justice Percentage

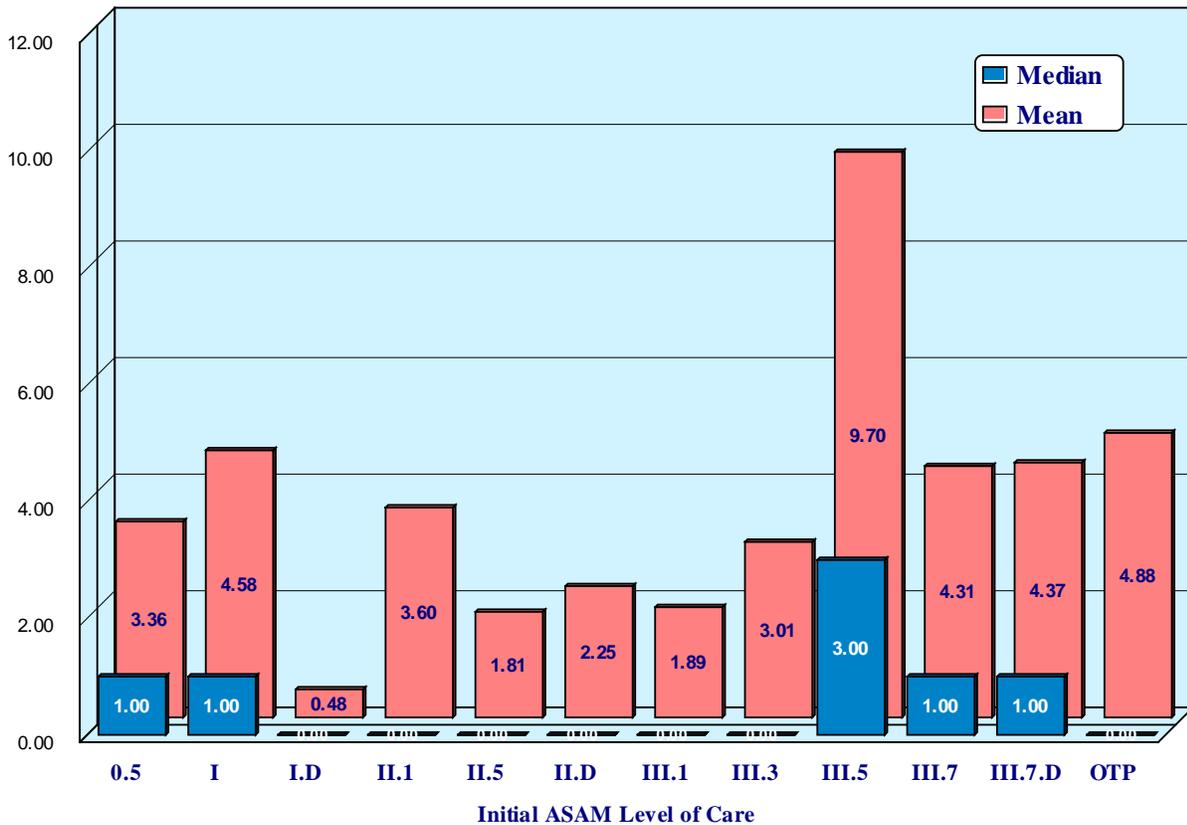
Level of Care: Table 2 presents the distributions of state-supported admissions and enrollments by level of care over the past six years. Admissions reflect the initial enrollments in treatment episodes; subsequent enrollments during the episodes (transfers to other levels of care) are not counted as admissions. The overall ratio of enrollments to admissions was about 1.23 for the last four years. Not surprisingly the highest enrollment/admissions ratios were in levels of care to which patients are typically transferred or referred from more intensive levels. Consistently just over two-thirds of admissions entered ambulatory levels of care

**Table 2**  
**Admissions and Enrollments by ASAM Level of Care in State-Supported Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2009 to FY 2014**

ASAM Level of Care	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Adm	Enr										
Level 0.5	687	703	1027	1069	2131	2207	1859	1945	1764	1882	1834	1934
Level I	17338	20525	17310	20605	17252	21278	16411	20299	15830	19721	14261	17620
Level I.D	323	414	225	278	45	49	65	75	91	115	29	33
Level II.1	7045	8317	7126	8441	7837	9483	8231	9888	7944	9737	6647	8392
Level II.5	444	1071	792	1517	971	1797	837	1692	1063	1868	1536	2265
Level II.D	89	99	102	120	105	126	53	62	33	34	12	16
Level III.1	1687	1765	1539	1678	1364	1519	1217	1368	1005	1203	768	852
Level III.3	748	851	1488	1622	1618	1726	1470	1552	1321	1439	903	1018
Level III.5	1115	1362	1163	1313	1074	1202	1228	1359	933	1104	564	698
Level III.7	4583	6773	5028	8040	5042	8097	5130	8162	4783	7488	4312	6752
Level III.7.D	4676	4768	5280	5381	5089	5176	5268	5367	5074	5169	4972	5034
OTP	2871	3142	2863	3162	2905	3258	3984	4356	3652	4086	3477	3785
OTP.D	6	7	11	12	91	109	52	54	31	31	3	3
Total	41612	49797	43954	53238	45524	56027	45805	56179	43524	53877	39318	48402

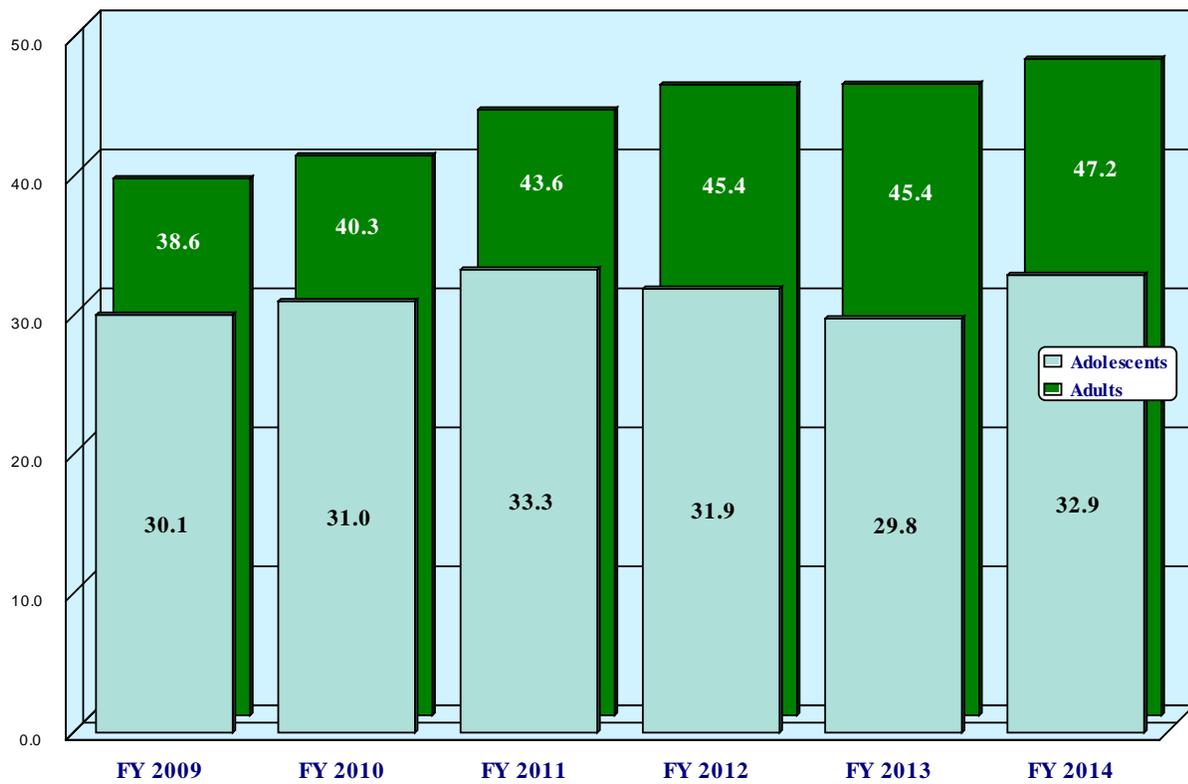
Waiting Time to Enter Treatment: Figure 10 shows those seeking State-supported SUD treatment in Maryland had less than six days on average between their initial request for treatment and the admission date to any level of care except III.5. For level I.D, II.5, II.D, III.1 and OTP the median wait to enter treatment was zero days, indicating more than half the admissions to those levels involved same-day entry. The overall average days patients wait to enter State-supported treatment has gone down 36% from 6.6 in FY 2009 to 4.2 in FY 2014.

**Figure 10**  
**Median and Mean Days Waiting for Admission to State-Supported Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2014**



Mental Health Problems: There was a fairly steady increase in the percentage of admissions identified as reporting mental health problems in addition to substance related disorders. Figure 11 shows a third of adolescents and 47% of adults had mental health issues at admissions to State-supported SUD treatment in FY 2014. In both groups, but especially among adults, females were significantly more likely to be reported as having mental health problems than males – adolescent females were at 47% and adult females were at 63% in FY 2014.

**Figure 11**  
**Mental-Health Problems among Adolescent and Adult Admissions to State-Supported Substance-Related Disorder Treatment Programs Reporting Data**  
**FY 2009 to FY 2014**



## **Estimated Need for Treatment in Maryland**

**Demographic Data:** In this analysis, the BHA utilized the 2011-2013 American Community Survey (ACS) for county-level estimates of total resident population for Maryland jurisdictions, and estimated percentage of population below 400% Federal Poverty Level (Table 1, Maryland's Eligible Population). The ACS is an ongoing survey that provides data every year, giving communities the current information they need to plan investments and services. Whereas, the U.S. Census survey is conducted once every ten years to provide an official count of the entire U.S. population to Congress, the ACS is conducted every year to provide up-to-date information about the social and economic needs of local communities. The ACS samples nearly three million addresses each year, resulting in nearly two million final interviews. It combines population or housing data from multiple years to produce reliable numbers for small counties, neighborhoods, and other local areas. ACS data are very timely because they are released in the year immediately following the year in which they are collected.

The BHA utilized 400% of Federal Poverty Level data to provide a best estimate of the population that will be accessing services that are currently publicly funded in Maryland. The population earning up to this level of income is the population covered by expanded Medicaid benefits and the Health Benefits Exchange.

### **Estimates of Alcohol and Drug Problems:**

Data from small geographic areas provide insight into the nature and scope of substance use problems and help State and local public health authorities to better understand and effectively address the needs in their communities. The National Survey on Drug Use and Health (NSDUH) is designed to obtain representative samples from all fifty States and the District of Columbia; one of its goals is to provide sub-state level estimates showing the geographic distribution of substance use prevalence for regions that states find useful for treatment planning purposes.

The SAMHSA sponsored NSDUH is an annual survey of the civilian, non-institutionalized population aged twelve or older. Data are collected from persons residing in households, non-institutionalized group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases.

The 2012 – 2013 NSDUH presented estimates for 21 measures of substance use among persons twelve and older, as well as estimates for underage (12 to 20) alcohol use and binge alcohol use, providing a detailed perspective on sub-state variations in substance use rates.

Each year the NSDUH survey asks several series of questions to assess the prevalence of substance use disorders in the past twelve months. Substances include alcohol and illicit drugs, such as marijuana, cocaine, heroin, hallucinogens and inhalants, and the nonmedical use of prescription type psychotherapeutic drugs. These series of questions are used to classify persons as being dependent on or abusing specific substances based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV).

Questions on dependence ask about health and emotional problems, attempts to cut down on use, tolerance, withdrawal, and other symptoms associated with substances used. Questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to

substance use. Dependence reflects a more severe substance problem than abuse, and persons are classified with abuse of a particular substance only if they are not dependent on that substance.

In this analysis, the BHA utilized the NSDUH data for estimates of alcohol and drug use problems in sub-state regions within Maryland. The “Dependence on or Abuse of Illicit Drugs or Alcohol in the Past year” NSDUH measure was applied to demographic data from the 2011-2013 American Community Survey (ACS) to calculate estimates for the numbers of Maryland individuals in need of treatment. Percentages for dependence on or abuse of illicit drugs or alcohol in the past year were based on averages of the 2012 and 2013 NSDUH surveys (the latest period in which sub-state estimates were available).

Sub-state regional boundaries used by the NSDUH were developed based on State’s recommendations, assuming the NSDUH sample sizes were large enough to provide estimates with adequate precision. When NSDUH rates were reported regionally (as opposed to individual county level), the BHA applied regional rates to each of the individual counties within that region. In this analysis, the BHA also organized data used for various other calculations according to these NSDUH designated sub-state regions. A number of NSDUH prevalence estimates for Maryland sub-state regions are also displayed in various tables in the Appendices.

Of note, the ACS uses different age group classifications than the NSDUH. Whereas the NSDUH alcohol and drug data were provided for resident population aged twelve and older, ACS resident population and poverty data were provided for individuals aged fifteen and older. Therefore, the estimates of need for treatment in this analysis may under-represent actual need, especially for a resident population aged twelve to fourteen.

This analysis is also limited by the fact that NSDUH only captures data on non-institutionalized individuals. Therefore, the estimates of need for treatment in this analysis likely further under estimate the actual number of individuals in need of treatment, which would include prison and jail populations and non-civilian service members.

This analysis utilized data from the State Maryland Automated Tracking (SMART) System to refine estimates of unmet need within the State’s sub-state regions. Substance use disorder treatment providers are required to use SMART to report data for all BHA funded and Medicaid funded patients. Providers enter data directly into SMART and use a variety of processes to capture and transmit SMART data to the BHA. The BHA uses SMART data to generate routine and ad-hoc reports showing patient characteristics, services needed, services provided, client progress and outcomes, and provider performance. SMART includes mandatory admission and discharge modules, and these modules include all required data for the SAMHSA treatment Episode Data Set (TEDS). SMART also includes a variety of other, sometimes optional modules, including consent/referral, assessment, treatment planning, progress and group notes, and encounters.

In this analysis, the following calculations were created to estimate need, met need, unmet need, and the financial resources that would be required to meet that unmet need:

- Maryland’s “Eligible Population” was defined as individuals over age fifteen up to 400% of federal poverty level.
- “Target Population” was defined as the estimated numbers of individuals with “Need”, (e.g., the individuals in Eligible Population who met NSDUH criteria for dependence on or abuse of illicit drugs or alcohol in the past year).

- “unmet Need” was calculated by subtracting the unduplicated numbers of publicly funded (BHA or Medicaid) patients that received addictions treatment in SFY 2014 (Met Need) from the estimated numbers of individuals with “Need”.
- “Total Treatment Expenditures” refer to the existing fiscal resources that were required to address “met Need”, represented as a combined FY 2014 BHAS funded and Medicaid funded treatment expenditures.
- Two estimates of the “Estimated Costs of Treating Individuals with “Unmet Need” are provided: regionally by jurisdiction and alphabetically.

### **Gaps in Services:**

It is important that individuals with alcohol and/or drug use disorders have access to a comprehensive continuum of care, in which individuals in need of treatment enter the treatment system at a level appropriate to their needs, then step up to more intensive treatment or down to less intensive treatment and recovery support services as appropriate. However, most jurisdictions in Maryland are unable to support a fully comprehensive array of services. In Maryland, a Level of Care is a treatment modality that is defined through standards set by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria 2-Revised (PPC-2R). Regional and jurisdictional level service gaps by Level of Care are evidenced in BHA funded service categories by jurisdiction.

Table 1. Maryland's Eligible Population

A	B	C	D=B X C
<b>Sub-state Region:</b>	<b>Total Resident Population:</b> Maryland jurisdictions, age 15 and older	<b>Percent Living in Poverty:</b> Estimated percentage of population below 400% of Federal Poverty Level 2013	<b>Eligible Population:</b> Estimate numbers of individual in resident population over 15 and older and below 400% of Federal Poverty Level
Anne Arundel	440,039	0.424	186,577
Baltimore City	509,898	0.732	373,245
Baltimore County	666,328	0.536	357,152
Montgomery	794,336	0.394	312,968
Prince George's	704,271	0.539	379,602
<b>North Central</b>			
Carroll	135,182	0.412	55,695
Howard	233,130	0.316	73,669
<i>North Central Total</i>	368,312		129,364
<b>Northeast</b>			
Caroline	26,149	0.696	18,200
Cecil	81,045	0.560	45,385
Harford	198,175	0.456	90,368
Kent	17,262	0.603	10,409
Queen Anne's	38,933	0.424	16,508
Talbot	31,922	0.567	18,100
<i>Northeast Total</i>	393,486		198,970
<b>South</b>			
Calvert	71,176	0.406	28,897
Charles	117,946	0.434	51,189
Dorchester	28,845	0.677	18,174
ST. Mary's	84,144	0.451	37,949
Somerset	22,687	0.737	16,720
Wicomico	81,114	0.676	54,833
Worcester	43,874	0.576	25,271
<i>South Total</i>	449,786		233,033
<b>West</b>			
Allegany	63,544	0.720	45,752
Frederick	188,478	0.433	81,611
Garrett	24,931	0.721	17,975
Washington	129,685	0.640	82,998
<i>West Total</i>	406,638		228,336
State of Maryland	5,742,493	0.504	2,891,886

Table 2. Target Population With Drug and/or Alcohol Problem

A	D = B X C	E	F = D X E
<b>Sub-state Region:</b>	<b>Eligible Population:</b> Estimate numbers of individual in resident population over 15 and older and below 400% of Federal Poverty Level	<b>Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year:</b> Percentage based on 2011-2013 NSDUH	<b>Target Population:</b> Estimated numbers of individual in Eligible Population with Dependence on or abuse of illicit drugs or alcohol in past year
Anne Arundel	186,577	0.0853	15,915
Baltimore City	373,245	0.0895	33,405
Baltimore County	357,152	0.0828	29,572
Montgomery	312,968	0.0697	21,814
Prince George's	379,602	0.0799	30,330
<b>North Central</b>			
Carroll	55,695	0.0736	4,099
Howard	73,669	0.0736	5,422
<i>North Central Total</i>	129,364		9,521
<b>Northeast</b>			
Caroline	18,200	0.0792	1,441
Cecil	45,385	0.0792	3,595
Harford	90,368	0.0792	7,157
Kent	10,409	0.0792	824
Queen Anne's	16,508	0.0792	1,307
Talbot	18,100	0.0792	1,434
<i>Northeast Total</i>	198,970		15,758
<b>South</b>			
Calvert	28,897	0.0851	2,459
Charles	51,189	0.0851	4,356
Dorchester	18,174	0.0851	1,547
ST. Mary's	37,949	0.0851	3,229
Somerset	16,720	0.0851	1,423
Wicomico	54,833	0.0851	4,666
Worcester	25,271	0.0851	2,151
<i>South Total</i>	233,033		19,831
<b>West</b>			
Allegany	45,752	0.0785	3,592
Frederick	81,611	0.0785	6,406
Garrett	17,975	0.0785	1,411
Washington	82,998	0.0785	6,515
<i>West Total</i>	228,366		17,924
State of Maryland	2,399,472	0.08	194,070

**Table 3. Estimated “Met” and “Unmet” need.**

A	F = D X E	G	H = F – G
<b>Sub-state Region:</b>	<b>Target Population:</b> Estimated numbers of individual in Eligible Population with Dependence on or abuse of illicit drugs or alcohol in past year	<b>“Met Need”</b> Unduplicated number of individuals that received publicly-funded (Grant/Medicaid) addictions treatment FY 2014 (SMART and Medicaid Encounters)	<b>Estimated Current “Unmet Need”</b> Estimated number with dependence on or abuse of illicit drugs or alcohol minus numbers treated in the public system FY2014
Anne Arundel	15,915	8,138	7,777
Baltimore City	33,405	40,108	---
Baltimore County	29,572	15,964	13,608
Montgomery	21,814	5,112	16,702
Prince George’s	30,330	6,851	23,479
<b>North Central</b>			
Carroll	4,099	3,026	1,073
Howard	5,422	2,336	3,086
<i>North Central Total</i>	9,521	5,362	4,159
<b>Northeast</b>			
Caroline	1,441	843	598
Cecil	3,595	3,729	---
Harford	7,157	4,740	2,417
Kent	824	1,014	---
Queen Anne’s	1,307	987	320
Talbot	1,434	1,081	353
<i>Northeast Total</i>	15,758	16,717	3,688
<b>South</b>			
Calvert	2,459	2,230	229
Charles	4,356	2,412	1,944
Dorchester	1,547	1,255	292
ST. Mary’s	3,229	2,107	1,122
Somerset	1,423	1,351	72
Wicomico	4,666	3,344	1,322
Worcester	2,151	1,534	617
<i>South Total</i>	19,831	14,233	5,598
<b>West</b>			
Allegany	3,529	2,664	865
Frederick	6,406	3,394	3,012
Garrett	1,411	438	973
Washington	6,515	4,515	2,000
<i>West Total</i>	17,861	11,011	6,850
State of Maryland	194,070	118,972	78,173

**Table 4. Combined Current Cost of Treating Individuals with “Met Need”**

A	G	I	J	K = I + J
<b>Sub-state Region:</b>	<b>“Met Need”</b> Unduplicated number of individuals that received publicly-funded (Grant/Medicaid) addictions treatment FY 2014 (SMART and Medicaid Encounters)	<b>BHA and Jurisdiction-Funded Treatment Expenditures:</b> For portion of need already “Met” FY 2014	<b>Medicaid Treatment Expenditures:</b> For portion of need already “Met” FY2014	<b>Total Treatment Expenditures:</b> BHA, Jurisdiction, and Medicaid funded FY 2014
Anne Arundel	8,138	\$5,139,247	\$13,797,085	\$18,936,332
Baltimore City	40,108	\$38,198,074	\$83,369,756	\$121,567,830
Baltimore County	15,964	\$7,533,010	\$24,964,093	\$32,497,103
Montgomery	5,112	\$7,067,417	\$4,302,274	\$11,369,691
Prince George’s	6,851	\$10,151,201	\$6,929,743	\$17,080,944
<b>North Central</b>				
Carroll	3,026	\$3,587,806*	\$3,957,285	\$7,545,091
Howard	2,336	\$1,706,442	\$2,454,077	\$4,160,519
<i>North Central Total</i>	5,362			
<b>Northeast</b>				
Caroline	843	\$599,620	\$735,799	\$1,335,419
Cecil	3,729	\$1,407,126	\$6,023,933	\$7,431,059
Harford	4,740	\$1,604,712	\$6,126,866	\$7,731,578
Kent	1,014	\$3,263,990*	\$621,511	\$3,885,501
Queen Anne’s	987	\$774,419	\$969,802	\$1,714,221
Talbot	1,081	\$952,157	\$513,688	\$1,465,845
<i>Northeast Total</i>	16,717			
<b>South</b>				
Calvert	2,230	\$824,791	\$2,228,759	\$3,053,550
Charles	2,412	\$2,263,982	\$1,825,335	\$4,089,317
Dorchester	1,255	\$1,887,450	\$1,087,281	\$2,974,731
ST. Mary’s	2,107	\$3,745,327*	\$2,121,437	\$5,866,764
Somerset	1,351	\$1,159,722	\$658,356	\$1,818,078
Wicomico	3,344	\$1,728,232	\$2,898,491	\$4,626,723
Worcester	1,534	\$3,090.124*	\$935,069	\$4,025,193
<i>South Total</i>	14,233			
<b>West</b>				
Allegany	2,664	\$5,280,770*	\$3,693,373	\$8,974,143
Frederick	3,394	\$2,616,820	\$3,703,703	\$6,320,523
Garrett	438	\$778,600	\$747,602	\$1,526,202
Washington	4,515	\$3,357,734*	\$6,394,308	\$9,752,042
<i>West Total</i>	11,011			
State of Maryland	118,972	\$107,094,061	\$181,059,626	\$288,153,687

\*BHA funding includes funding for regional residential treatment.

Table 5. Estimated Costs of Treatment Individuals with “Unmet Need”.

A H = F – G L M

<b>Sub-state Region:</b>	<b>Estimated Current “Unmet Need”</b> Estimated number with dependence on or abuse of illicit drugs or alcohol minus numbers treated in the public system FY2014	<b>Calculation (A) Estimated Treatment Funding Needing to Serve Unmet Need:</b> Based on Jurisdictional Average Cost per Patient.	<b>Calculation (B) Estimated Treatment Funding Needed to Serve Unmet Need:</b> Based on Statewide Average Cost per patient.
Anne Arundel	7,777	\$18,089,302	\$18,835,894
Baltimore City	---	---	---
Baltimore County	13,608	\$27,692,280	\$32,958,576
Montgomery	16,702	\$37,145,248	\$40,452,244
Prince George’s	23,479	\$58,533,147	\$56,866,138
<b>North Central</b>			
Carroll	1,073	\$2,674,989	\$2,598,806
Howard	3,086	\$5,496,166	\$7,474,292
<i>North Central Total</i>	4,159		
<b>Northeast</b>			
Caroline	598	\$947,232	\$1,448,356
Cecil	---	---	---
Harford	2,417	\$3,942,127	\$5,853,974
Kent	---	---	---
Queen Anne’s	320	\$611,520	\$775,040
Talbot	353	\$478,668	\$854,966
<i>Northeast Total</i>	3,688		
<b>South</b>			
Calvert	229	\$313,501	\$554,638
Charles	1,944	\$3,295,080	\$4,708,368
Dorchester	292	\$692,040	\$707,224
ST. Mary’s	1,122	\$3,123,648	\$2,717,484
Somerset	72	\$96,840	\$174,384
Wicomico	1,322	\$1,828,326	\$3,201,884
Worcester	617	\$1,618,391	\$1,494,374
<i>South Total</i>	5,598		
<b>West</b>			
Allegany	865	\$2,913,320	\$2,095,030
Frederick	3,012	\$5,608,344	\$7,295,064
Garrett	973	\$3,389,932	\$2,356,606
Washington	2,000	\$4,318,000	\$4,844,000
<i>West Total</i>	6,850		
State of Maryland	81,861	\$182,808,128	\$198,267,342

Table C1. Illicit Drug Use in Past Month and Illicit Drug Use Other Than Marijuana in Past Month among Persons Aged 12 or Older, by Sub-state Region: Data based on 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Illicit Drug Use in Past Month	Illicit Drug Use Other Than Marijuana in Past Month
Anne Arundel	6.88	2.82
Baltimore City	9.31	3.05
Baltimore County	9.30	3.46
Montgomery	6.22	2.65
Prince George's	7.30	2.70
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	6.92	3.12
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	7.78	3.30
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	7.10	3.35
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	7.10	3.28
State of Maryland	7.57	3.05

Table C2. Marijuana Use in Past Month and Past year among Persons Aged 12 or Older, by Sub-state Region:  
Data from 2008, 2009,2010 NSDUHs.

<b>Sub-state Region:</b>	Marijuana Use in Past Month	Marijuana Use in Past Year
Anne Arundel	5.51	9.39
Baltimore City	7.40	13.21
Baltimore County	6.40	11.36
Montgomery	4.57	9.18
Prince George's	6.13	11.88
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	5.14	8.46
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	5.90	9.61
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	5.12	9.35
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	4.95	
State of Maryland	5.70	10.29

Table C3. Cocaine Use and Nonmedical Use of Pain Relievers in Past Year among Persons Aged 12 or older, by Sub-state Region: Data from 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Cocaine Use in Past Year	Non-medical Use of Pain Relievers in Past Year
Anne Arundel	1.80	4.13
Baltimore City	2.15	3.95
Baltimore County	1.58	4.36
Montgomery	1.30	3.30
Prince George's	1.64	3.51
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	1.50	4.07
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	1.68	4.7
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	1.99	4.45
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	1.69	4.38
State of Maryland	1.68	4.01

Table C4. Alcohol Use in Past Month and Binge Alcohol Use in Past Month among Persons Aged 12 or Older by Sub-state Region: Data from 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Alcohol Use in Past Month Aged 12 or Older	Binge Alcohol Use in Past Month Aged 12 or Older
Anne Arundel	59.19	23.42
Baltimore City	42.46	20.91
Baltimore County	53.19	20.64
Montgomery	55.67	20.42
Prince George's	49.58	19.01
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	60.73	21.42
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	55.30	20.61
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	50.73	21.41
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	53.90	21.68
State of Maryland	53.02	20.87

Table C5. Alcohol Use in Past Month and Binge Alcohol Use in Past Month among Persons Aged 12 to 20, by Sub-state Region: Data from 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Alcohol Use in Past Month Aged 12 to 20	Binge Alcohol Use in Past Month Aged 12 to 20
Anne Arundel	29.33	16.69
Baltimore City	24.60	13.77
Baltimore County	27.93	17.48
Montgomery	27.49	15.17
Prince George's	23.85	14.26
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	27.07	17.90
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	26.45	16.80
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	26.56	16.86
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	28.55	17.88
State of Maryland	25.87	16.28

Table C6. Alcohol and Illicit Drug Dependence in Past Year among Persons Aged 12 or older, by Sub-state Region: Data from 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Alcohol Dependence In Past Year	Illicit Drug Dependence In Past Year
Anne Arundel	3.21	2.11
Baltimore City	4.23	2.77
Baltimore County	3.28	2.19
Montgomery	3.06	1.78
Prince George's	3.63	2.19
<b>North Central</b>		
Carroll		
Howard		
<i>North Central Total</i>	3.09	1.91
<b>Northeast</b>		
Caroline		
Cecil		
Harford		
Kent		
Queen Anne's		
Talbot		
<i>Northeast Total</i>	3.22	1.91
<b>South</b>		
Calvert		
Charles		
Dorchester		
ST. Mary's		
Somerset		
Wicomico		
Worcester		
<i>South Total</i>	3.50	2.15
<b>West</b>		
Allegany		
Frederick		
Garrett		
Washington		
<i>West Total</i>	3.31	2.17
State of Maryland	3.40	2.13

Table C7. Alcohol and Illicit Drug Dependence or Abuse in Past Year among Persons Aged 12 or older, by Sub-state Region: Data from 2008, 2009, 2010 NSDUHs.

<b>Sub-state Region:</b>	Alcohol Dependence or Abuse in Past Year	Illicit Drug Dependence or Abuse in Past Year	Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year
Anne Arundel	6.77	2.92	8.53
Baltimore City	6.87	3.30	8.95
Baltimore County	6.37	2.90	8.28
Montgomery	5.61	2.50	6.97
Prince George's	6.33	2.99	7.99
<b>North Central</b>			
Carroll			
Howard			
<i>North Central Total</i>	6.21	2.53	7.36
<b>Northeast</b>			
Caroline			
Cecil			
Harford			
Kent			
Queen Anne's			
Talbot			
<i>Northeast Total</i>	6.56	2.55	7.92
<b>South</b>			
Calvert			
Charles			
Dorchester			
ST. Mary's			
Somerset			
Wicomico			
Worcester			
<i>South Total</i>	6.68	2.82	8.51
<b>West</b>			
Allegany			
Frederick			
Garrett			
Washington			
<i>West Total</i>	6.45	2.74	7.85
State of Maryland	6.37	2.81	8.00

**Table 6: ADAA-Funded Service Categories by Jurisdiction (FY 2012 FRAN Form Data)**

**KEY:**  
**O:** Jurisdiction operates service  
**P:** Jurisdiction Purchases Service  
**A:** Jurisdiction has Access to Service

A	B	C	D	E	F	G	H	I	J	K	L	M	N
<b>SUBSTATE REGION: ASAM Levels of Care by Jurisdiction</b>	<b>Level 0.5 (Early Inter- vention)</b>	<b>Level I (Out- patient)</b>	<b>Level I.D. (Ambula- tory Detox- ification w/out Extended Onsite Moni- toring)</b>	<b>Level II.1 (Intensive Out- patient)</b>	<b>Level II.5 (Partial Hospital- ization)</b>	<b>Level II.D (Ambula- tory Detox- ification with Extended Onsite Moni- toring)</b>	<b>Level III.1 (Low Intensity Residen- tial)</b>	<b>Level III.3 (Medium Intensity Residen- tial)</b>	<b>Level III.5 (High Intensity Residen- tial)</b>	<b>Level III.7 (Medically- Monitored Intensive Inpatient)</b>	<b>Level III.7.D. (Medically- Monitored Inpatient Detox- ification)</b>	<b>OMT (Opioid Mainten- ance Therapy)</b>	<b>OMT.D (Opioid Mainten- ance Therapy- Detox- ification)</b>
Anne Arundel	A	P		P		X	P	P	P	P	P	O,P	
Baltimore City	P	P		P			P	P	P	P	P	P	
Baltimore County	X	P		P		X		P	P	P	P	P	
Montgomery	A	P		X	O		O	O	P	O	O	O	
<b>NORTH CENTRAL</b>													
Carroll	A	O	O	O		O				O	O	A	
Howard	O	O		O		O	O			P,A	P,A	A	
<b>NORTHEAST</b>													
Caroline	A	O		A						A	A		
Cecil	O	O		O			P			A	A		
Harford	O	O		O						A	A	P	
Kent	O	O		O			P			O	O		
Queen Anne's	A	O								X			
Talbot	O	O								P,A	P,A		
Prince George's	O	O		O			A	P		P,A	P,A	O	
<b>SOUTH</b>													
Calvert	O	O		O			P	P		A	A		
Charles		O		O				P		A	A		
Dorchester		X		X					P	P,A	P,A		
St. Mary's	A	P		P			P			P	P		
Somerset	O	O		O						A	P		
Wicomico	A	O		O			P			A	A	X	X
Worcester	O	O		O			P			P	P		
<b>WEST</b>													
Allegany	A	O		O						O		A	
Frederick	A	O	O	O			P			A	A	O	
Garrett	O	O		O						A		A	
Washington	O	O		O			P	O	O	A		A	

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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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:

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Footnotes:

## **State of Maryland Behavioral Health Administration**

### **PBHS/HMIS DATA SYSTEM**

In order to examine Maryland's current data system capabilities and its ability to collect and report data, it is necessary to review Maryland's Public Behavioral Health System (PBHS) and its funding mechanisms in some detail. 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). Hospital Detox, Outpatient, and 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 its citizens through a network of five psychiatric hospitals, one of which is a forensic facility, and two regional institutes for children and adolescents, or State operated Psychiatric Residential Treatment Facility (PTRF). This is the only area in which Maryland operates services directly. 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, 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.

The primary 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 Public Behavioral Health System (PBHS). The ASO historically gathered all MH CLD data. 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 MH/SRD TEDS data elements are built into VO. Data will be collected and reported according to grant requirements. Currently, Maryland feels that its reporting system is generally 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 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 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.

# Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1  
Priority Area: Regulatory and Finance Enhancements to Support Health Care Reform  
Priority Type: SAT  
Population(s): Other (Individuals with third party insurance coverage; individuals without insurance and individuals who require services that are not covered by Medicaid, Medicare or private insurance.)

Goal of the priority area:

Increase access to SUD and MH services by increasing the base of providers that will be able to bill third party insurers, thus preserving block grant funds for treatment and support services for individuals without insurance, and those who require services that are not covered by Medicaid, Medicare or private insurance.

Objective:

To ensure block grant funds are used to provide substance use disorder treatment services that are not covered by Medicaid, Medicare or private insurance.

Strategies to attain the objective:

Require that treatment programs currently covered through Maryland Mental Health and Substance Use Disorder regulations apply for and become accredited by a State-approved accrediting organization in order to be approved for licensure through the DHMH, facilitate provider move to accreditation via provision of technical assistance

## Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Increased numbers of organizations operating accredited substance use disorder programs  
Baseline Measurement: Programs in FY2014 = 58  
First-year target/outcome measurement: FY2015 > FY2014  
Second-year target/outcome measurement: FY2016 > FY2015

Data Source:

DHMH Office of Health Care Quality

Description of Data:

Number of providers with current accreditation by fiscal year

Data issues/caveats that affect outcome measures::

None

Priority #: 2  
Priority Area: Expand Access (improved access to a broader continuum of addictions treatment for hard to reach populations and communities via: 1. expansion of pharmacological therapies; 2.improved utilization of virtual and tele-behavioral technologies )  
Priority Type: SAT  
Population(s): IVDUs, Other (Rural, disabled and other hard to engage populations)

Goal of the priority area:

Expand access to a broader continuum of addictions treatment for hard to reach populations and communities in Maryland.

Objective:

Educate the public regarding MAT therapies and increase opportunities for MAT treatment.

Strategies to attain the objective:

1. Support the virtual counseling project and other tele-behavioral advances to reach individuals in rural or otherwise challenged environments. 2. Expand access to pharmacotherapy by continuing to fund buprenorphine and other and other pharmacological medications for the treatment of addiction.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Increase the number of patients receiving pharmacological treatment  
Baseline Measurement: Number of patients receiving methadone or buprenorphine in FY14 = Buprenorphine - 4226, Methadone - 3096  
First-year target/outcome measurement: Number of patients receiving methadone or buprenorphine in FY2015 > FY2014  
Second-year target/outcome measurement: Number of patients receiving methadone and buprenorphine in FY2016 > FY2016

Data Source:

ASO Billing

Description of Data:

Number of patients receiving methadone or buprenorphine via submitted data from providers

Data issues/caveats that affect outcome measures::

On January 1, 2015, Maryland changed its data collection from SMART to an ASO (Value Options). Data reliability from late 2014 through 2015 may be affected.

Indicator #: 2  
Indicator: Increase the number of sites using virtual counseling and/or tele-medicine technology  
Baseline Measurement: Number of sites in FY2014 = 1  
First-year target/outcome measurement: Number of sites in FY2015 > FY2014  
Second-year target/outcome measurement: Number of Sites in FY2016 > FY2015

Data Source:

Virtual Counseling Project - University of Maryland School of Pharmacy

Description of Data:

Number of sites participating in the Virtual Counseling Project

Data issues/caveats that affect outcome measures::

None

Priority #: 3  
Priority Area: Recovery Oriented Systems of Care  
Priority Type: SAT  
Population(s): Other (Transform Maryland's behavioral health services system into a recovery-oriented system of care (ROSC))

Goal of the priority area:

Transform Maryland's behavioral health services system in to a recovery oriented system of care (ROSC)

Objective:

Ensure access to recovery support services across Maryland.

Strategies to attain the objective:

Increase participation in recovery support services within the behavioral health services system by providing and enhancing protocols for implementation of continuing care, purchase of recovery housing, care coordination, recovery community centers and supportive employment efforts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of participants in recovery support services.

Baseline Measurement: Number served in FY2014 = 2743

First-year target/outcome measurement: Number served in FY2015 > FY2014

Second-year target/outcome measurement: Number Served in FY2016 > FY2015

Data Source:

ASO billing data

Description of Data:

Number of patients in recovery support programs via submitted billing data from providers

Data issues/caveats that affect outcome measures::

On January 1, 2015, Maryland changed its data collection from SMART to ASO (Value Options). Data reliability from late 2014 through 2015 may be affected.

Priority #: 4

Priority Area: Reduction in the Use of Tobacco Among Individuals Participating in SUD Treatment

Priority Type: SAT

Population(s): IVDUs, Other (Adults with substance use disorders (SUDs))

Goal of the priority area:

Improve the overall health of individuals in substance use treatment who use tobacco products.

Objective:

Reduce the use of tobacco products among individuals in SUD treatment programs through the use of available medications and education during the treatment process.

Strategies to attain the objective:

1. Encourage access to pharmacological interventions to treat tobacco dependence.
2. Provide tobacco cessation education in all funded treatment programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduction in the number of individuals reporting tobacco use at the time of discharge

Baseline Measurement: Number of individuals reporting tobacco use at the time of discharge in FY2014 = 23,253 (58.8%)

First-year target/outcome measurement: Number of individuals reporting tobacco use at discharge for FY2015 < FY2014

Second-year target/outcome measurement: Number of individuals reporting tobacco use at discharge for FY2016 < FY2015

Data Source:

ASO discharge data

Description of Data:

Number of individuals reporting tobacco use

Data issues/caveats that affect outcome measures::

On January 1, 2015, Maryland changed its data collection from SMART to an ASO (Value Options). Data reliability from late 2014 through 2015 may be affected.

Priority #: 5  
Priority Area: Screening, Brief Intervention and Referral to Treatment (SBIRT)  
Priority Type: SAT  
Population(s): Other

Goal of the priority area:

Improve the health status of Maryland citizens through the intergration of behavioral health and somatic health care services.

Objective:

Ensure early identification of potential SUD through the implementation of SBIRT in Health Care Centers.

Strategies to attain the objective:

Implement SBIRT to 60 FOHC's in 15 jurisdictions across Maryland.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of Individuals Screened  
Baseline Measurement: No baseline - this is a new service  
First-year target/outcome measurement: 7,000 Screened  
Second-year target/outcome measurement: Number screened in FY2016 > FY2015

Data Source:

DCI

Description of Data:

Number of individuals screened

Data issues/caveats that affect outcome measures::

None

Priority #: 6  
Priority Area: Pregnant Women and Women with Children  
Priority Type: SAT  
Population(s): PWWDC

Goal of the priority area:

Ensure pregnant women and women with dependent children have access to substance abuse treatment and recovery support services.

Objective:

Minimize risk to pregnant women and women with children related to alcohol/drug use and associated complications; promote family health through the provisions of specialized services addressing gender, development, abuse/neglect, custody and other recovery-related issues.

Strategies to attain the objective:

1. Preferential admissions for pregnant women: Maryland will continue to provide preferential admission for all pregnant women in accordance with 96.131. The BHA will continue the policy which requires that all programs receiving BHA grant funding provide admission to pregnant women within 24 hours of the request for services. Treatment programs will continue to encourage pregnant women to accept admission within 24 hours, maintain them in treatment for the duration of the pregnancy, refer them to different levels of care if necessary and maintain linkages with medical and other services. If pregnant women disengage from treatment, programs are expected to attempt to re-engage them.
2. Gender-specific services: Treatment programs will continue to support gender specific services, including trauma-informed services for substance use disorder treatment: case management; parenting skills classes; educational and vocational services; prenatal; postpartum and gynecological health and child care services; and family therapy. Treatment programs will continue to treat the family as a unit and provide a comprehensive range of services designed to address important health issues related to the addiction treatment needs of pregnant and parenting women and their children. To ensure continued awareness of the availability of gender-specific services, the BHA will continue to post on its website a Directory of Drug and Alcohol Treatment Services for Women, Infants and Children in Maryland.
3. Residential capacity for pregnant women and women with dependent children: the BHA will continue to maintain statewide contracts for gender specific residential programs in the central, southern and western regions of the state.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Pregnant at admission and number of days waiting for admission  
Baseline Measurement: FY2014 = 3.43 days  
First-year target/outcome measurement: FY2015 < or = 3.43  
Second-year target/outcome measurement: FY2016 < or = 3.43

Data Source:

ASO

Description of Data:

time between treatment request and admission

Data issues/caveats that affect outcome measures::

On January 1, 2015, Maryland changed its data collection from SMART to an ASO (Value Options). Data reliability from late 2014 through 2015 may be affected.

Indicator #: 2  
Indicator: Number of opiate dependent pregnant women who enter and stay in OMT programs.  
Number of pregnant women (non-opiate) who enter and complete treatment.  
Baseline Measurement: Number of opiate dependent pregnant women who enter and stay in OMT programs in FY2014 = 2  
Number of pregnant women (non-opiate dependent) who enter and complete treatment in FY2014 = 39  
First-year target/outcome measurement: Number in FY2015 > FY2014  
Second-year target/outcome measurement: Number in FY2016 > FY2015

Data Source:

ASO

Description of Data:

Number of pregnant women admitted to OMT and abstinence programs.

Data issues/caveats that affect outcome measures::

On January 1, 2015, Maryland changed its data collection from SMART to an ASO (Value Options). Data reliability from late 2014 through 2015 may be affected.

Priority #: 7  
Priority Area: Individuals with or at Risk of HIV Infection  
Priority Type: SAT  
Population(s): HIV EIS

Goal of the priority area:

Improve early identification of individuals in substance abuse related treatment that are in areas of highest incidence of HIV.

Objective:

Continue to routinely make available HIV Early Intervention Services to each individual receiving treatment for substance use disorders; including screening and appropriate pre-test counseling for HIV and AIDS; testing with respect to HIV/AIDS to confirm the presence of the diseases and appropriate therapeutic measures; post-test counseling; and providing or referring individuals for appropriate medical evaluation and treatment

Strategies to attain the objective:

Continue the Sexual Health Integration Initiative that provides HIV/EIS funding to local health departments in Maryland jurisdictions most impacted by HIV (Anne Arundel, Baltimore, Charles, Harford, Howard, Montgomery, Prince George's and Washington Counties) To operationalize a sexual health framework within substance use disorder treatment, with HIV testing and linkages as the capstone interventions, under a Letter fo Agreement (LOA) between DHMH Prevention and Health Promotion Administration (PHPA) and the BHA.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: More individuals in SUD treatment tested for HIV, More HIV-infected individuals diagnosed and referred into treatment and care.  
Baseline Measurement: FY2014 data from Table 12  
First-year target/outcome measurement: Number of individuals tested in FY2015 > FY2014  
Second-year target/outcome measurement: Number of individuals tested in FY2016 > Fy2015  
Data Source:  
DHMH Prevention and Health Promotion Administration (PHPA)  
Description of Data:  
BGAS Table 14 required data  
Data issues/caveats that affect outcome measures::  
Non

Priority #: 8  
Priority Area: Individuals with or at Risk of Tuberculosis Infection  
Priority Type: SAT  
Population(s): TB

Goal of the priority area:

Prevent the transmission of tuberculosis among individuals in treatment for substance use disorders.

Objective:

Routinely make available tuberculosis services in cooperation with the Maryland DHMH Center for Tuberculosis Control and Prevention, local health departments and treatment providers.

Strategies to attain the objective:

Continue to routinely make available tuberculosis services to each individual receiving treatment for substance use disorders, including counseling with respect to TB; testing to determine if the individual has been infected with TB and to determine the appropriate form of treatment for the individual; and providing or referring individuals for appropriate medical evaluation and treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Stable number of active TB cases directly associated with residential addictions treatment facilities in Maryland per year.  
Baseline Measurement: FY2014 data - no active cases  
First-year target/outcome measurement: No active cases reported in FY2015  
Second-year target/outcome measurement: No active cases reported in FY2016

Data Source:

DHMH Prevention and Health Promotion Administration (PHPA) Center for Tuberculosis Control

Description of Data:

Active TB cases reported to the State's communicable disease surveillance system.

Data issues/caveats that affect outcome measures::

None

Priority #: 9  
Priority Area: Alcohol use among Maryland youth ages 12-20.  
Priority Type: SAP  
Population(s): Other (Youth ages 12-20)

Goal of the priority area:

Decrease alcohol use among youth ages 12-20

Objective:

Decrease alcohol use among youth by providing comprehensive, evidence based prevention services to youth throughout Maryland.

Strategies to attain the objective:

1. Reduce the retail availability of alcohol to youth
2. Reduce social availability of alcohol to youth
3. Strengthen law enforcement and adjudication of law

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Reduce the percentage of youth who report the use of alcohol in the past 30 days  
Baseline Measurement: 24.50%  
First-year target/outcome measurement: FY2015 < FY2014  
Second-year target/outcome measurement: FY2016 < FY2015

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

Percentage of youth who report past 30 day alcohol use.

Data issues/caveats that affect outcome measures::

None

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	\$0		\$0	\$0	\$0	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$0		\$0	\$0	\$0	\$0	\$0
b. All Other	\$0		\$0	\$0	\$0	\$0	\$0
2. Substance Abuse Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$0		\$0	\$0	\$0	\$0	\$0
13. Total	\$0	\$0	\$0	\$0	\$0	\$0	\$0

\* Prevention other than primary prevention

Footnotes:

# 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	\$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$
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)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
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	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$0

Footnotes:

# Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	
2 . Substance Abuse Primary Prevention	
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	
6. Total	\$0

\* Prevention other than primary prevention

\*\* 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

# Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015    Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	<b>Total</b>		\$0
Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	<b>Total</b>		\$0
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	<b>Total</b>		\$0
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	<b>Total</b>		\$0

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$0
Total SABG Award*		\$0
Planned Primary Prevention Percentage		

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

Footnotes:



# Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total	\$0	
Total SABG Award*	\$0	
Planned Primary Prevention Percentage		

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

Footnotes:

# Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date:  Planning Period End Date:

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

Footnotes:

# Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$0	\$0	\$0
2. Quality Assurance	\$0	\$0	\$0	\$0
3. Training (Post-Employment)	\$0	\$0	\$0	\$0
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$0	\$0	\$0	\$0
7. Information Systems	\$0	\$0	\$0	\$0
8. Total	\$0	\$0	\$0	\$0

Footnotes:



# Environmental Factors and Plan

## 1. The Health Care System and Integration

### Narrative Question:

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>26</sup> 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.<sup>27</sup> 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.<sup>28</sup> 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<sup>29 30</sup> 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.<sup>31</sup> 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.<sup>32</sup> In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.<sup>33</sup> Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.<sup>34</sup> Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.<sup>35</sup> 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.<sup>36</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>37</sup> 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.<sup>38</sup> 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<sup>39</sup> and ACOs<sup>40</sup> 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.<sup>41</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>42</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>43</sup> 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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup> 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.<sup>47</sup> 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.<sup>48</sup>

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.<sup>49</sup> 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.<sup>50</sup>

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.<sup>51</sup> 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.*

<sup>26</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

<sup>27</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>28</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>29</sup> 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

<sup>30</sup> A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

<sup>31</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

<sup>32</sup> Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

<sup>33</sup> J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

<sup>34</sup> C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

<sup>35</sup> TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

<sup>36</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

[http://www.nami.org/Content/NavigationMenu/State\\_Advocacy/About\\_the\\_Issue/Integration\\_MH\\_And\\_Primary\\_Care\\_2011.pdf](http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf); Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>37</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>38</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

<sup>39</sup> Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>40</sup> New financing models, [http://www.samhsa.gov/co-occurring/topics/primary-care/financing\\_final.aspx](http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx)

<sup>41</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

<sup>42</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>43</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>44</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>45</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>46</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>47</sup> <http://www.nrepp.samhsa.gov/>

<sup>48</sup> 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>

<sup>49</sup> 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>

<sup>50</sup> 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>

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

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

Footnotes:

# Environmental Factors and Plan

## 2. Health Disparities

Narrative Question:

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>52</sup>, [Healthy People, 2020](#)<sup>53</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>54</sup>, 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).<sup>55</sup>

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."<sup>56</sup>

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.<sup>57</sup> 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.<sup>58</sup> 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.*

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<sup>52</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>53</sup><http://www.healthypeople.gov/2020/default.aspx>

<sup>54</sup><http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

<sup>55</sup><http://www.ThinkCulturalHealth.hhs.gov>

<sup>56</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>57</sup><http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

<sup>58</sup>[http://www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

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

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Footnotes:

# Environmental Factors and Plan

## 3. Use of Evidence in Purchasing Decisions

### Narrative Question:

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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<sup>59</sup> 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<sup>60</sup>, The New Freedom Commission on Mental Health<sup>61</sup>, the IOM<sup>62</sup>, and the NQF.<sup>63</sup> 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."<sup>64</sup> 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)<sup>65</sup> 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)<sup>66</sup> 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.*

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<sup>59</sup> [Ibid, 47, p. 41](#)

<sup>60</sup> 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

<sup>61</sup> 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.

<sup>62</sup> 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.

<sup>63</sup> National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

<sup>64</sup> <http://psychiatryonline.org/>

<sup>65</sup> <http://store.samhsa.gov>

<sup>66</sup> <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:

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Footnotes:

# Environmental Factors and Plan

## 4. Prevention for Serious Mental Illness

### Narrative Question:

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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.<sup>67</sup> 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.<sup>68</sup> 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.<sup>69</sup> 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.<sup>70 71</sup> 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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<sup>67</sup> 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.

<sup>68</sup> 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.

<sup>69</sup> 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.

<sup>70</sup> 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.

<sup>71</sup> 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.

Footnotes:

# Environmental Factors and Plan

## 5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

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P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.<sup>72</sup> SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)<sup>73</sup>, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

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<sup>72</sup> <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

<sup>73</sup> [http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm\\_source=rss\\_readers&utm\\_medium=rss&utm\\_campaign=rss\\_full](http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full)

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# Environmental Factors and Plan

## 6. Participant Directed Care

Narrative Question:

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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 through 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.*

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# Environmental Factors and Plan

## 7. Program Integrity

### Narrative Question:

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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.*

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# Environmental Factors and Plan

## 8. Tribes

Narrative Question:

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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](#)<sup>74</sup> 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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<sup>74</sup> <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

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# Environmental Factors and Plan

## 9. Primary Prevention for Substance Abuse

### Narrative Question:

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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?

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## Prevention

Maryland uses a variety of evidence-based programs, policies, and practices to develop its prevention system, including primary prevention strategies. These strategies are consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the National Registry of Evidence-based Programs and Practices (NREPP) or other resources that document effectiveness.

**Use of Data to Identify Types of Primary Prevention Services Needed:** Maryland utilizes a data-driven strategic planning process to assess gaps and needs and establish prevention funding priorities. The BHA and the local jurisdictions collect and utilize extensive data from numerous sources regarding substance use and consequences as well as risk and protective factors. This data is used to measure and report on the performance of funded prevention programs and initiatives, monitor outcomes, and enable the development and implementation of a strong, viable prevention and treatment network.

Data sources primarily include the National Survey on Drug Use and Health (NSDUH), the Maryland Youth Risk Behavior Survey (YRBS), and other social indicator data collected and compiled by the Statewide Epidemiologic Outcomes Workgroup (SEOW). The BHA obtains sub-state level data through the SEOW from other state agencies concerning substance-related deaths, arrests, auto crashes, school suspensions and HIV/AIDS incidence and prevalence. The YRBS provides state and sub-state level data on student alcohol, tobacco and other drug use. Other data have been captured at the sub-state level through the State of Maryland Automated Record Tracking (SMART) system. Collectively, this array of sub-state level data is used to determine areas of highest incidence, prevalence and need.

The Maryland SEOW was formed under the oversight of the Alcohol and Drug Abuse Administration (now BHA) in March 2006, with SAMHSA funding through March 2009, formerly under the direction of the Center for Substance Abuse Research (CESAR) at the University of Maryland-College Park. It is now coordinated by the School of Pharmacy at the University of Maryland-Baltimore (UMB-SOP), which also maintains a Memorandum of Agreement with the BHA for the evaluation of the Maryland Strategic Prevention Framework (MSPF) grant project. Since 2009, the SEOW has been funded through Maryland's 20% Prevention Set Aside, in accordance with the BHA sustainability plan for prevention services. Originally focused on the substance abuse preventions needs of Maryland's 23 counties and Baltimore City, the SEOW is now being expanded to include assessment of the need for treatment services.

Over the last four years the ADAA/BHA and the SOP have worked extensively with local prevention coordinators to generate input into the implementation of the MSPF. In FY 2011, Assessment and Planning grants were made to all Maryland jurisdictions to enable them to carry out jurisdiction-wide prevention needs assessment activities, resulting in the selection of their jurisdictional priorities as well as target communities for MSPF resources. Local communities have received MSPF Implementation grants to implement prevention services designed specifically towards reducing the State's priority substance use and consequence indicators in highest need communities.

**How Specific Primary Prevention Programs, Practices and Services are selected:** In July 2008, an Executive Order re-established the Maryland State Drug and Alcohol Abuse Council (DAAC) and mandated that the group “develop a comprehensive, coordinated and strategic approach to the use of State and local resources for prevention, intervention, and treatment of drug and alcohol abuse among the citizens of the state”. Additionally, each of the 24 jurisdictions (23 counties and Baltimore City) have a Local Drug and Alcohol Abuse Council (LDAAC) tasked to develop a strategic plan that includes prevention, intervention, treatment and recovery services. The local strategic plans are updated every two years.

The BHA funds evidence based prevention programs and activities via grant awards to the 24 jurisdictions and four university campuses. Since FY 2012, the BHA has required that at least 50% of SAPT block grant prevention funds awarded to the jurisdictions and the universities must be used to implement Environmental Strategies. The jurisdictions must select universal programs and strategies designed to target the entire population of a community. Depending on assessment outcomes and the recommendations of the LDAAC, remaining funds can be utilized to include both indicated and selected programs. However, due to the increased emphasis on Environmental strategies, the BHA expects that Maryland will experience a significant reduction in selective and indicated strategies.

The BHA strongly recommends that jurisdictions use the Selecting and Implementing Evidence-Based Environmental Prevention Strategies document to help Prevention Coordinators and other prevention staff select appropriate strategies for the communities. To establish a common understanding of Environmental Strategies among prevention planners in Maryland, the BHA also recommends that all Prevention Coordinators and other prevention staff become familiar with the information in The Coalition Impact: Environmental Strategies including their advantages/benefits, their relationship to SPF and community coalitions, methods for matching them to specific community needs, and links to research and resources supporting the implementation of evidence based Environmental Strategies.

The LDAAC’s and local prevention coordinators select EBP’s that are relevant, appropriate and effective for targeted communities. Selected programs, practices and strategies must have “conceptual fit; e.g., the interventions must address the community’s salient risk and protective factors, target opportunities for intervention in multiple domains, and drive positive outcomes in one or more substance abuse problems, consumption patterns, or consequences. Next the selected programs, practices and strategies must have “practical fit”; they must be feasible given the community’s resources, capabilities, and readiness to act, and must add to or reinforce other strategies in the community. Lastly, the specific programs, practices, and strategies must demonstrate “Evidence of Effectiveness”; they must be adequately supported by theory, empirical data, and/or the consensus judgment of informed experts and community prevention leaders.

For the purpose of the BHA grant application submission, Environmental Strategies are defined as prevention efforts aimed at changing or influencing community conditions, norms and standards, institutions, structures, systems, and policies that contribute to substance use and consequences. In an environmental prevention model, the focus on addressing substance use and consequences shifts from

an individual focus to an environmental focus, potentially impacting every member of a target population. Environmental prevention strategies fall into several categories, including:

- Reducing retail access
- Reducing social access
- Changing social norms
- Restricting promotions
- Increasing perceived risk of use
- Increasing pricing
- Strengthening enforcement

The BHA requires that all jurisdictions implement at least one evidence based prevention program, and that they use at least fifty percent (50%) of their prevention funding on environmental strategies. BHA funded evidence-based programs include:

- All Stars
- Creating Lasting Family Connections (CLFC)
- Communities Mobilizing for Change on Alcohol (CMCA)
- Dare to be You (DTBY)
- Guiding Good Choices (GGC)
- Positive Action
- Second Step
- Strengthening Families Program (SFP)

An example of a universal program that the State may fund that targets the entire population of a community is called Communities Mobilizing for Change on Alcohol (CMCA). At least nine of the twenty-four jurisdictions are currently utilizing this evidence-based program designed to reduce teen access to alcohol by changing community policies and practices. CMCA seeks both to limit youth's access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable.

Some jurisdictions may implement selective programs and/or strategies that target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment. An example of a selective program that several of the jurisdictions will be implementing is the Strengthening Families Program (SEP), a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children ages 3-16 years. Parenting skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting.

Based on the jurisdiction's needs assessment and strategic plan, the BHA may fund indicated preventions programs and strategies that are "designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such

as falling grades and consumption of alcohol, tobacco, and/or inhalants". An example of an indicated program that may be funded by the BHA is the Creating Lasting Family Connections (CLFC) program; a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and to reduce the frequency of their AOD use. The CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings. Currently, at least two jurisdictions are using this evidence-based program.

The four university campuses (Towson University, Bowie State University, University of Maryland Eastern Shore, and Frostburg University), regionally located throughout the State, maintain ATOD Prevention Centers. College students are served through strategies that include information dissemination, education, alternatives, problem identification and referral, community-based process, and environmental improvements. The primary focus of these centers is to provide education and training for college students regarding AOD preventions by creating and/or enhancing peer education networks. Each college prevention center is also responsible for the collaboration and development of AOD campus policies and to provide a process for linkages with other colleges within the region to promote AOD prevention strategies.

The BHA is providing funding to the University of Maryland in collaboration with Johns Hopkins School of Public Health, implementing the Maryland Collaborative to Reduce College Drinking and Related Problems. Research studies during the last decade have demonstrated the comparative effectiveness of different approaches to reduce college student drinking. Some approaches, such as simply providing information to students about the risks of alcohol consumptions are not effective in changing behavior. Two major categories of interventions seem to have the most promise. First, providing intensive personalized feedback and monitoring drinking patterns over time can help an individual to recognize the existence of a problem and modify his/her behavior. Second, on a more macro-level, changes in the environment to reduce the availability of alcohol as well as youth access are clearly effective ways to decrease excessive alcohol use and associated problems. Within these two broad categories are several more specific and achievable interventions to reduce high-risk drinking and associated problems among Maryland college students.

Through the Maryland Collaborative, UMD and JHU have provided research, training, technical assistance and support to a collaborative group of ten Maryland colleges and universities that will assist them to take this multi-level approach to addressing alcohol problems at both the individual and the community level. Research findings to date suggest that this kind of multi-level approach can evoke and support change in individual behavior, change normative climates around drinking and reduce the overall level of excessive alcohol use among students attending the Maryland colleges and universities.

An important initial goal of the Maryland Strategic Prevention Framework (MSPF) was the development of the State's strategic prevention plan, based on a systematic, data driven approach to generating and monitoring prevention priorities. Maryland requires, through its MSPF initiative that communities implement evidence-based activities to specifically address the community-level conditions that contribute to misuse of alcohol by youth and young adults. The State's MSPF priority is to reduce the

misuse of alcohol by youth and young adults in Maryland as measured by the following three (3) measurable indicators:

- Reduce the number of youth, ages 12-20, reporting past month alcohol use
- Reduce the number of young persons, ages 18-25, reporting past month binge drinking
- Reduce the number of alcohol related crashes involving youth ages 16-25

In order to carry out this priority and its indicators, MSPF funded all 24 jurisdictions and their community-led coalitions to apply the SPF planning process (assessment, capacity building, planning, implementation, and evaluation) and select environmental strategies designed to reduce alcohol use among youth. Environmental strategies were required because the MSPF goal is to change community conditions, norms, attitudes, and policies in order to create community-level reductions in youth alcohol misuse. As the SPF-SIG funding period comes to its close on June 30, 2015, 21 of the 24 community MSPF coalitions have completed all five steps of the MSPF process and, as a result, have engaged hundreds of community coalition members to plan, implement and begin evaluation of hundreds of evidence-based environmental prevention activities throughout the state.

**Building Prevention System and Prevention Workforce Capacity:** The BHA has contracted with the University of Maryland, Baltimore School of Pharmacy (UMB-SOP) to design and conduct the MSPF evaluation and provide the resources and expertise necessary to collect and report on the required measures. The MSPF Evaluation Team, the SEOW, the Community Implementation Workgroups and the MSPF staff at the BHA are all actively involved in collaborative activities designed to build capacity within Maryland's prevention services system.

These partners view the need for a culturally competent prevention workforce and the delivery of culturally appropriate prevention services as foundational underpinnings critical to the success of all aspects of MSPF capacity building. These include State and local-level planning efforts, the implementation of training and technical assistance provided to sub-recipients in local communities, the selection and implementation of evidence based programs, development of policies and practices; and collection and analysis of data used for decision-making and evaluation.

During the 2014 fiscal year, the State Evaluation Team engaged in activities related to researching environmental strategy protocols, populating the MSPF website and providing training sessions and technical assistance to sub-recipients. The State Evaluation Team also reviewed all reports submitted by the MSPF communities at each state of the MSPF process and provided feedback accordingly.

Community Level Instrument (CLI) Part I data, regarding each community's progress through the five SPF steps, were collected from all participating MSPF communities and reviewed for compliance. The CLI Part I data were submitted to SAMHSA on November 1, 2013. Implementing the MSPF communities also completed the CLI Part II documenting the local strategies being implemented in each community during the fall (n=12) and spring (n=19) reporting periods. The CLI Part II data were reviewed for compliance and submitted to SAMHSA on November 1, 2013 and May 1, 2014.

The State Evaluation Team presented “Utilizing Data in the World of Prevention” at the Annual MAPPA conference on November 4, 2013 and at the Partnership for a safer Maryland Conference on June 3, 2014. These presentations were in collaboration with the University of Maryland, School of Medicine’s National Study Center. Additionally, the MSPF Evaluation Team attended the following trainings:

- SAMHSA and BHA’s Promotion, Wellness and Behavioral Health Training (September 12, 2013)
- Maryland Highway Safety Office Partner Meeting (September 19, 2013)
- MSPF Advisory Council Meeting (September 25, 2013)
- Communities Mobilizing for Change on Alcohol (CMCA) (September 26, 2013)
- Virginia Slims in a Bottle: Girls, Women and Alcohol Marketing (December 11, 2013)
- Ten Steps to Policy Change (Maryland Collaborative to Reduce College Drinking and Related Problems) (February 21, 2014)
- Public Health Research Day at University of Maryland College Park (April 18, 2014)
- Webinar: Understanding Binge Drinking Among Youth, Young Adults and College Population – Session 1 (SAMHSA CAPT) May 13, 2014)
- Webinar: Understanding Binge Drinking Among Youth, Young Adults and College Population – Session 2 (SAMHSA CAPT) May 20, 2014)

### **Training Material Development**

The State Evaluation Team updated the materials for both Needs Assessment and Strategic Planning trainings to incorporate feedback from communities and lessons learned from prior trainings. The team also created an outline for the MSPF communities to use in writing their required bi-annual evaluation reports. The State Evaluation Team also created an evaluation plan template for MSPF communities to use. Local evaluators’ feedback was sought and revisions to these documents were made accordingly.

### **Technical Assistance**

The MSPF Evaluation Team provided nine technical assistance training programs to the sub-recipients:

- 1 Local Evaluator Meeting for all MSPF Communities (September 18, 2013)
- 1 Regional Strategic Planning Training for Anne Arundel County (October 16, 2013)
- 2 Evaluation Report Workgroup Meetings (November 6, 2013 and November 22, 2013)
- 1 MSPF Symposium on November 13-14, 2013 (Annapolis, MD)
- 1 Needs Assessment Training for Prince George’s County (February 4, 2014)
- 3 MSPF FY’15 Training on April 29 (Brooklyn Park)-April 30 (Easton) and May1, 2014 (Hagerstown)

The State Evaluation Team also provided multiple technical assistance sessions (either through site visits or conference calls) to MSPF communities’ leadership teams and attending nine coalition meetings.

## **Outcome and Other Data Maryland Uses to Evaluate the State’s Prevention System:**

The Center for Substance Abuse Prevention (CSAP) State Prevention System Management Information System (SPS-MIS) provides a computer-based process evaluation tool (Minimum Data Set – MDS). The MDS is used to collect specific process and group level information about prevention services delivered (type of service, target population, group and activity information, dates of services performed, applicable CSAP strategies, item counts, participant demographics, or other state-defined data). MDS data collection is uniform across the state, and extensive validations are used to ensure internal consistency.

All prevention programs must establish and evaluate implementation performance indicators, and all funded environmental strategies, programs, practices, and policies must be evaluated for attainment of their stated performance measures. However, when addressing community level change with environmental strategies, generally each specific program or strategy is not evaluated for its outcome. Rather, the entire array of prevention strategies, programs, practices, and policies implemented are evaluated as a whole by measuring reductions in the community’s targeted substance use and consequences.

The State level MSPF evaluation includes both process and outcome evaluation. The process evaluation will address the five steps of the SPF and the MSPF goals and objectives. Data will be collected to answer the six questions required by SAMHSA and five additional questions identified by the State. Maryland’s state-level outcome evaluation collects data to measure changes in the MSPF Priority Indicators across the duration of the MSPF initiative. Data are collected to measure the relationship between these changes and MSPF implementation. Also, data will be collected to measure changes in the National Outcome Measures (NOMS) and the relationship between changes in NOMS and MSPF implementation.

The MSPF evaluation team is working with the SEOW and the National Study Center (NCS) to acquire alcohol consumption and consequence data at the state, jurisdictional and MSPF community level. These outcome measures address MSPF needs for each of the three MSPF priorities (Past month alcohol use, Ages 12-20, Past-Month Binge Drinking Age 12-20, Past-Month Binge Drinking Age 18-25). Preliminary baseline data for these three indicators have been gathered from the National Survey on Drug Use and Health (NSDUH) and the Maryland Accident Analysis Reporting System (MAARS), and analyzed at the jurisdictional/county, State and national levels.

### **Underage Drinking and Binge Drinking**

The Maryland State Epidemiological Outcomes Workgroup released the 2012 National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS) data, which measure alcohol consumption rates in Maryland, as compared to the rest of the United States. The indicators of interest to the MSPF project highlighted in this report were “past month alcohol use among underage drinkers”, “past month binge drinking among young adults aged 18-25”, “past month binge drinking among underage drinkers”, “average number of alcoholic drinks per day in the past 30 days by

age”, and “number of drinks on a single occasion in the past 30 days by age”. We present national and state level trends from 2004 to 2012 (NSDUH) and from 2011 and 2012 (BRFSS).

In 2012, according to NSDUH, 25% of individuals between 12 and 20 years old reported drinking alcohol at least once in the last 30 days in Maryland. This number is lightly lower than the 2011 data. With this small decrease in reported drinking alcohol at least once in the last 30 days, we see underage drinking rates leveling off after a steady decline from 2007 through 2010 (from 28.4% to 25.1%). The Maryland data correspond to the national data where past-month alcohol use among 12-20 year olds declined every year from 2004 through 2012 (from 28.9% to 24.7%).

For binge drinking among young adults ages 18 to 25, 43.2% of NSDUH respondents in Maryland indicated that they had at least one binge drinking episode in the past 30 days in 2012. This number is up from the 2011 figure of 39.6%, and brings the Maryland binge drinking rate for this age group above the national figure for 2012 (39.7%). In Maryland, binge drinking rates for young adults have fluctuated from 39.8% in 2003 to 37.2% in 2005, before rising back up to 40.6% in 2008 then dropping again to 36.1% in 2010. In 2011 and 2012, there has been a sharp increase in binge drinking among 18 to 25 year olds suggesting that binge drinking rates among young adults are on the rise again. Comparatively, the binge drinking rate for this age group in the U.S. has remained constant from 2003 (41.3%) to 2012 (36.7%), with a high of 42% in 2006 and 2007 and a low of 39.7% in 2012, keeping the U.S. rate within a narrow 2.0% range during this time period.

Among 12-20 year olds, past month binge drinking rates in Maryland have been lower than rates in the U.S. since 2004. Furthermore, rates are steadily declining in Maryland since 2008. The 2012 NSDUH results show that 14.4% of 12-20 year olds in Maryland had at least one incident of binge drinking in the past 30 days. This number has steadily declined by about 1% every year since 2008, where it hit a high of 17.9%. This decline corresponds to a steady decline in the U.S. past-month binge drinking rate among 12-20 year olds, which has decreased every year since 2004, from 19.4% to a new low of 15.6% in 2012.

According to the 2012 BRFSS, in Maryland the average number of drinks consumed on days when respondents drank was 7.6 for 18 to 20 year olds and 3.1 drinks for 21 to 25 year olds. Nationally, the average number of drinks consumed was 6.7 for 18-20 year olds and 5.2 for 21-25 year olds. Among 18-20 year olds, both in Maryland and in the U.S., there was an increase in the average number of drinks per day from 2011 to 2012 (6.1 vs. 7.6 drinks in MD and 6.5 vs. 6.7 drinks nationally). On the other hand, among 21-25 year olds, both in Maryland and in the U.S., there was a decrease in the average number of drinks per day from 2011 to 2012 (5.5 vs. 3.1 in MD and 5.6 vs. 5.2 in the U.S.). Overall, there was a large decrease in Maryland among 21-25 year olds of the average number of drinks per day from 5.1 in 2011 to 3.1 in 2012. It is not clear why there was such a decrease in the average number of drinks per day for 21-25 year olds in Maryland while there was an increase in the average number of drinks per day for all other age groups. This is also similar to national trends. Additional longitudinal data are needed to better explain the decline in number of drinks per day among 21-25 year olds.

According to the 2012 BRFSS, 18 to 20 year olds in Maryland also report a higher number of alcoholic drinks consumed on a single occasion during the last 30 days compared to 18 to 20 year olds nationally.

Young adults 18-20 reported an average of 10.4 drinks and adults 21-25 reported an average of 8.3 drinks consumed on their heaviest drinking occasion, compared to a U.S. average of 9.6 and 9.0 drinks respectively. Again, these numbers are much higher than averages among all drinkers of any age in the state of Maryland at 6.8 drinks respectively. Though 18-25 year olds in Maryland consume far more drinks than any other age group in Maryland on a single occasion, these numbers are decreasing since 2011. Among 18-20 year olds the number of drinks consumed on a single occasion decreased from 14.1 drinks to 10.4 drinks. This is a decrease of 3.7 drinks on a single occasion. Among 21-25 year olds the number of drinks consumed on a single occasion dropped from 10.9 drinks to 8.3 drinks or a decrease of 2.6 drinks.

**How the State's Budget Supports Implementation of the Strategic Prevention Framework:**

Sharing SAMHSA's concerns about sustainability, Maryland has made aggressive efforts to incrementally move key MSPF administrative/infrastructure building functions to the SAPT-Block Grant at a rate of at least 25% per year. Thus, during MSPF year 5 and beyond, 100% of the funding for the SEOW functions and 100% of the salaries/fringe for the three MSPF positions will be sustained through the block grant. The BHA allocates the remaining portion of the SABG preventions set-aside to the jurisdictions for the delivery of local-level prevention activities.

# Environmental Factors and Plan

## 10. Quality Improvement Plan

Narrative Question:

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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:

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# Environmental Factors and Plan

## 11. Trauma

Narrative Question:

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[Trauma](#)<sup>75</sup> 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<sup>76</sup>. 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”.<sup>77</sup> 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<sup>78</sup> 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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<sup>75</sup> 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.*

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

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

<sup>78</sup> *Ibid*

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

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Footnotes:

# Environmental Factors and Plan

## 12. Criminal and Juvenile Justice

Narrative Question:

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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.<sup>79</sup>

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.<sup>80 81</sup> 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.<sup>82</sup>

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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<sup>79</sup> <http://csqjusticecenter.org/mental-health/>

<sup>80</sup> The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

<sup>81</sup> 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.

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

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

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Footnotes:

# Environmental Factors and Plan

## 13. State Parity Efforts

Narrative Question:

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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.<sup>83</sup>

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.<sup>84</sup>

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.*

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<sup>83</sup> <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

<sup>84</sup> 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:

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# Environmental Factors and Plan

## 14. Medication Assisted Treatment

Narrative Question:

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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<sup>85</sup>, 43<sup>86</sup>, 45<sup>87</sup>, and 49<sup>88</sup>. 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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<sup>85</sup> <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

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

<sup>87</sup> <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

<sup>88</sup> <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:

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# Environmental Factors and Plan

## 15. Crisis Services

### Narrative Question:

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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](#)<sup>89</sup>,

"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.*

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<sup>89</sup>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>

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

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# Environmental Factors and Plan

## 16. Recovery

### Narrative Question:

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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                          | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators                              | • Peer-run respite services                                      |
| • Peer specialist/Promotoras               | • Peer wellness coaching                              | • Person-centered planning                                       |
| • Clubhouses                               | • Recovery coaching                                   | • Self-care and wellness approaches                              |
| • Self-directed care                       | • Shared decision making                              | • Peer-run crisis diversion services                             |
| • Supportive housing models                | • Telephone recovery checkups                         | • Wellness-based community campaign                              |
| • Recovery community centers               | • Warm lines  |  |
| • WRAP                                     | • Whole Health Action Management (WHAM)               |  |
| • Evidenced-based supported                |   |  |

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:

# Environmental Factors and Plan

## 17. Community Living and the Implementation of Olmstead

Narrative Question:

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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:

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Footnotes:

# Environmental Factors and Plan

## 18. Children and Adolescents Behavioral Health Services

### Narrative Question:

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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.<sup>90</sup> 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.<sup>91</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death.<sup>92</sup>

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.<sup>93</sup> 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.<sup>94</sup>

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

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

<sup>91</sup> 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.

<sup>92</sup> Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

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

<sup>94</sup> Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

<sup>95</sup> 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:

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Footnotes:
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# Environmental Factors and Plan

## 19. Pregnant Women and Women with Dependent Children

Narrative Question:

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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:

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Footnotes:

# Environmental Factors and Plan

## 20. Suicide Prevention

Narrative Question:

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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](#).<sup>96</sup>

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

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<sup>96</sup> [http://www.samhsa.gov/sites/default/files/samhsa\\_state\\_suicide\\_prevention\\_plans\\_guide\\_final\\_508\\_compliant.pdf](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:

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# Environmental Factors and Plan

## 21. Support of State Partners

Narrative Question:

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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:

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Footnotes:

# Environmental Factors and Plan

## 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

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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](#).<sup>97</sup>

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.*<sup>98</sup>

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<sup>97</sup><http://beta.samhsa.gov/grants/block-grants/resources>

<sup>98</sup>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:

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Footnotes:

## **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 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.

## Environmental Factors and Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

\* 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: