Maryland State
Drug and Alcohol Abuse Council

55 Wade Avenue • Catonsville, Maryland • 21228

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

July 27, 2011

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis MD 21401-1991

RE: State Government Article §9-2801-2806 "Subtitle 28. State Drug and Alcohol Abuse Council

Dear Governor O'Malley, President Miller and Speaker Busch:

As per House Bill 219, codified in October, 2010, I am submitting to you a "Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland" on behalf of the Maryland State Drug and Alcohol Abuse Council. This Plan was developed by the Council with opportunity for input from stakeholders, providers, consumers, and Local Drug and Alcohol Abuse Councils. It is the culmination of many hours of work by members of the four main workgroups, detailing progress on goals and objectives from the 2010-2012 plan, as well as deliberations as to where the plan should be changed and updated to reflect the work to be accomplished over the next two years. This plan was not intended to abolish the existing plan, but rather to add to its strengths, and document accomplishments from the past year.

The Plan continues with four main goals which are integral to the continuation of the transformation of the substance abuse system from a standalone system, to a coordinated, comprehensive service delivery system, one that is more fully integrated with behavioral and somatic health, and with a look to shared outcomes that impact upon criminal justice and public health. The Recovery Oriented System of Care Model is the paradigm for this transformation, and is well underway in Maryland; therefore, the continuation of this goal remains the number one goal for this Plan. As a result of improving the coordination and impact of services, we believe that the Plan will continue to advance your overarching goal of expanding access to substance abuse services in Maryland.

I hope that you find this information to be useful. If you have any questions regarding this report, please contact Ms Jill Porter, Assistant Director of the Office of Governmental Affairs at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, M.D., Chair
Maryland State Drug and Alcohol Abuse Council

Laura E. Burns-Heffner, Interim Executive Director
Maryland State Drug and Alcohol Abuse Council

Enclosure
Cc: Renata Henry
Thomas Cargiulo
Jill Porter

# MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL

*Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland*

Progress 2011 and Plans for 2012-2014

**Submitted to Governor Martin O'Malley**
**August 1, 2011**

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# SDAAC MEMBERS
## Maryland State Drug and Alcohol Abuse Council Members

Laura E. Burns-Heffner, Interim Executive Director

Joshua M. Sharfstein, Chair
Secretary, Department of Health and Mental Hygiene

Gary M. Maynard, Secretary
Department of Public Safety and Correctional Services

Samuel Abed, Secretary
Department of Juvenile Services

Theodore Dallas, Secretary
Department of Human Resources

T. Eloise Foster, Secretary
Department of Budget and Management

Raymond A. Skinner, Secretary
Department of Housing and Community Development

Beverley K. Swaim-Staley, Secretary
Department of Transportation

Dr. Bernard J. Sadusky, Interim State Superintendent
Department of Education

Rosemary King Johnston, Executive Director
Governor's Office for Children

Kristen Mahoney, Executive Director Governor's Office
on Crime Control and Prevention

Paul B. DeWolf, Maryland Public Defender
Office of the Public Defender

Kirill Reznik
Maryland House of Delegates

Catherine E. Pugh
Maryland Senate

George M. Lipman, Judge
District Court

Michael Wachs, Judge
Circuit Court

Lori Brewster, Gubernatorial Appointee

Ann Mahling Geddes, Gubernatorial Appointee

Carlos Hardy, Gubernatorial Appointee

Rebecca R. Hogamier, Gubernatorial Appointee

Kim M. Kennedy, Gubernatorial Appointee

Kathleen O. O'Brien, Gubernatorial Appointee

Glen E. Plutschak, Gubernatorial Appointee

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Patricia Vale, Acting Director
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Randall Nero, Acting Deputy Secretary for Programs
and Services
Department of Public Safety and Correctional Services

Gale Saler, President, Maryland Addiction Directors
Council

# WORKGROUP MEMBERSHIP

*****Council member or designee

## Collaboration and Coordination Workgroup

1. Alberta Brier* - DJS
2. Laura Burns-Heffner, SDAAC
3. Tom Cargiulo*, Co-Chair – ADAA
4. Renata Henry,–DHMH
5. Kim Kennedy* Appointee
6. Tom Liberatore*, Co-Chair – DOT
7. Tracey Myers-Preston, MADC
8. Rosemary Malone/Deborah Weathers
9. Kathleen O'Brien*, Treatment Provider
10. Gale Saler*, MADC

## Criminal-Juvenile Justice Workgroup

1. Kevin Amado, Carroll County
2. Gray Barton – Problem-Solving Courts
3. Alberta Brier* – DJS
4. Laura Burns-Heffner, SDAAC
5. Thomas Cargiulo*, ADAA
6. Robert Cassidy – Treatment Provider
7. Bonnie Cosgrove, DPSCS
8. Martha Kumer– Parole and Probation
9. George Lipman* – District Court
10. Mark Luckner, DHMH
11. Patrice Miller (resigned)– DPSCS
12. Kathleen O'Brien* - Appointment Ruth Ogle, Parole Commision
13. Glen Plutschak*, Chair - Appointment
14. Gale Saler* - MADC
15. Cindy Shockey- Smith- Treatment Provider
16. Pam Skelding, DPSCS
17. Susan Steinberg – Forensics Office, DHMH
18. Frank Weathersbee – State's Attorney
19. Karen Yoke, ADAA

## Workforce Development Workgroup

1. Lynn Albizo, MADC
2. Kevin Amado, Provider
3. E. Michael Bartlinski, Provider, Subcommittee Chair
4. Laura Burns-Heffner, SDAAC
5. Kevin Collins, Provider
6. Leroya Cothran, DJS
7. Diedre Davis, BCRC, Inc.
8. Peter D'Souza, Provider
9. Stacy Fruhling,
10. Gary Fry, Provider
11. Tiffany Hall, Provider
12. Rebecca Hogamier*, Co-Chair, Provider
13. Tracey Meyers-Preston, Exec. Dir., MADC
14. Pat Miedusiewski, DHMH
15. Tamara Rigaud, Provider
16. Tracy Schulden, Provider
17. Cindy Shaw-Wilson, Provider
18. Pat Stabile, Provider
19. Oleg Tarkovsky, Provider
20. Dawn Williams, Provider
21. John Winslow, Co-Chair,Provider

### Recruitment Subcommittee

1. Elizabeth Apple, Anne Arundel Comm College
2. Llewellyn Cornelius, Univ. of Md, SSW
3. Donna Cox, Townson University
4. Dallas Dolan, Comm.College of Balt. Co.
5. Carlo DiClemente, Univ. of Md. Balt. Co.
6. Gigi Franyo-Ehlers, Stevenson College
7. Ellarwee Gladsen, Morgan State University
8. Nancy Jenkins-Ryans, Provider
9. Dean Kendall, Md Higher Ed. Commission
10. Marilyn Kuzma, Comm. College of Balt. Co.
11. Rolande Murray, Coppin State College
12. Ozietta Taylor, Coppin State College

**Strategic Prevention Framework Advisory Council/Workgroup**
(Includes SEOW and Community Implementation** Work Groups)

1. Jackie Abendschoen-Milani, Univ. of Md
2. Michelle Atwell, DOT
3. Linda Auerback, Junction, Inc.
4. First Sergeant H. L Barrett
5. Nora Becker, Prevention, Kent Co.
6. Karen Bishop, Caroline Co.
7. Virgil Boysaw, Co-Chair, ADAA
8. Shannon Bowles, DJS
9. Nancy Brady, Prevention, Garrett Co
10. Lori Brewster* Chair, Wicomico Co.
11. Laura Burns-Heffner, SDAAC
12. Tom Cargiulo*, Dir. ADAA
13. Lawrence Carter, Jr., DHMH
14. Caroline Cash, MADD
15. Peter Cohen, M.D., ADAA
16. Kenneth Collins, Sub.Ab.Serv, Cecil Co.
17. Eugenia Conolly, ADAA
18. Marina Chatoo, GOC
19. Larry Dawson, ADAA
20. Katie Durbin, Liquor Control-Montgomery Co
21. Florence Dwek, CSAP
22. Latonya Eaddy, GOCCP
23. Elvira Elek, RTI International
24. Heather Eshelman, Prevention, Anne
25. Sue Jenkins, ADAA
26. Liza Lemaster, MVA-Highway Safety
27. Sam Maser, Maryland PTA
28. Rev. S. Menendez, Light of Truth
29. Dorothy Moore, Prevention, Mont. Co.
30. Lauresa Moten, Univ.of Md, E.Shore
31. Francoise Pradel, PhD, UMD
32. Pat Ramseur, Prince George's Co.
33. Kathy Rebbert-Franklin, ADAA
34. Kirill Reznik*, House of Delegates
35. Cynthia Shifler, Wicomico County
36. Linda Smith, DFC, Charles County
37. Peter Singleton*, MSDE
38. Vernon Spriggs, MAPPA
39. Don Swogger, Frostburg State University
40. Bill Rusinko, ADAA
41. Marlene Trestman, Attorney General's Office
42. John Winslow, Dorchester Co.
43. Kathy Wright, Queen Anne's Co.
44. Lourdes Vazquez, CSAP/CAPT.
45. Wendy Warfel, Caroline Co.
46. Danuta Wilson, Community Rep.

******Community Implementation Work Group (Combines the work of the previous Cultural Competence and Evidence Based Practices Work Groups)

# Section I

# Overview

The health care landscape has changed in the two years since the Maryland State Drug and Alcohol Advisory Council (SDAAC) developed its 2010-2012 Strategic Plan. Most significantly, the US Congress passed, and President Obama signed into law, the federal Affordable Care Act (ACA), which "offered states an unprecedented opportunity to change the face of health care."[1] In response, Governor O'Malley established the Health Care Reform Coordinating Council (HCRCC) which defined Maryland's vision, and created the blueprint, for health care reform in the State. An important HCRCC recommendation was that "DHMH examine different strategies to achieve integration of mental health, substance abuse, and somatic services. Potential avenues to be explored include statewide administrative structure and policy, financing strategies designed to encourage coordination of care, and delivery system changes."[2]

Yet, it must be acknowledged that the field of substance abuse had been moving towards coordinated, comprehensive service delivery even before the 2010 passage of ACA and the recommendations of the HCRCC. In fact, the SDAAC Strategic Plan posits a recovery-oriented system of care as its "intended outcome…consistent with the vision for the Council articulates by its members on December 9, 2008."[3] To help inform this process, Maryland can refer to the concept and definition of recovery refined by leaders in the behavioral health field. In May 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) published the group's working definition of, and set of principles for, recovery to "assure access to recovery-oriented services…as well as reimbursement to providers."[4] The group defined recovery as "a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential." Infused throughout the Principles of Recovery are a focus on individual call for "collaboration and coordination" arises from the U.S. Department of Health And Human Services' Strategic Framework on Multiple Chronic Conditions, which identifies behavioral health problems "such as substance use and addictions disorders, mental illness, dementia and other cognitive impairment disorders, and developmental disabilities" as "multiple chronic conditions." [5]

An important component of Maryland's ROSC is *RecoveryNet*, a four-year Access to Recovery (ATR) grant awarded to ADAA in September 2010 by SAMHSA. ATR *is* a presidential initiative that provides vouchers for individuals to purchase clinical and recovery support services and which links service recipients to their recovery from substance use disorders. ATR emphasizes service recipient choice and increases the array of available

[1] Health Care Reform Coordinating Council (HCRCC), January 1, 2011: *Final Report and Recommendations.* p. i
[2] Ibid. p. vi
[3] Maryland State Drug and Alcohol Abuse Council, August 2009: *Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland 2010 to 2012*, p. 7
[4] SAMHSA, May 2011: *Recovery Defined – A Unified Working Definition and Set of Principles*
[5] http://www.hhs.gov/ash/initiatives/mcc/

community- and faith-based services, supports, and providers. All services are designed to assist recipients in remaining engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.

Services covered by *RecoveryNet* are managed through an electronic Voucher Management System (VMS). After a potential service recipient selects services from a menu of providers and is authorized by a *RecoveryNet* Regional Coordinator to receive services, vouchers (authorizations) are entered into the VMS for selected covered services. All *RecoveryNet* providers will enter encounters into the VMS when they provide a covered service to a *RecoveryNet* service recipient. ValueOptions, under contract with the Maryland Alcohol and Drug Abuse Administration, pays *RecoveryNet* providers by matching claims to authorization.

A coordinated approach to substance abuse prevention has also been emerging over the past few years, and in response to the ACA and its "heavy focus on prevention and promotion activities…" Goal 1 of SAMHSA's Strategic Initiatives reflects attention on development of a more comprehensive focus on the "infrastructure for prevention of substance abuse and mental illness." Goals 1.1 and 1.2 are specifically relevant here:

**Goal 1.1:** With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.
**Goal 1.2:** Prevent or reduce consequences of underage drinking and adult problem drinking.

As well, subsequent to development of the SDAAC Strategic Plan, Maryland's Alcohol and Drug Abuse Administration (ADAA) was awarded a multi-year Strategic Prevention Framework (SPF) grant from the federal Center for Substance Abuse Prevention (CSAP). The Maryland SPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by: reduction of the number of youth, ages 12-20, reporting past month alcohol use; a reduction in the number of young persons, ages 18-25, reporting past month binge drinking; and a reduction in the number of alcohol-related crashes involving youth ages 16-25. SPF funding guidelines required that ADAA develop a statewide comprehensive plan before funded prevention services can begin. (Appendix A: SPF-SIG Prevention Plan) In April 2011, Maryland's local jurisdictions submitted applications for MSPF funding to develop community-level, and community-driven, prevention systems.

Maryland is, increasingly, emphasizing environmental prevention which has a greater potential than does targeted programming to reach a broader population. Beginning in FY 2012, fifty (50) percent of the ADAA's prevention dollars awarded to local jurisdictions must be spent on environmental prevention activities. One such endeavor, supported by a renewable federal Department of Health and Human Services' (DHHS) Food and Drug Administration (FDA) contract will strengthen Maryland's statewide comprehensive youth tobacco program and promote healthy communities in Maryland. Specific objectives of the contract include conduct of inspections in retail outlets that sell and advertise cigarettes and smokeless tobacco products to determine compliance with relevant provisions of the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act); and collection,

documentation, and preservation of evidence of inspections and/or investigations. (Appendix B: Federal Tobacco Contract summary).

These events and trends are significant to the SDAAC Strategic Plan. In some cases, objectives have been achieved; in other cases, objectives and action steps have been put on hold while the State determines the best ways to implement ACA. Some goals and objectives have been restated and amended to incorporate the revised thinking—for example, when the Collaboration and Coordination Workgroup made adjustments in terms of the definitions for prevention, intervention, and treatment, as well as terminology to be used (Specific and Related, instead of Direct and Indirect), and examples for each. These adjustments resulted in inclusion of programs that have substance abuse reduction as at least one of the goals, instead of only including programs that are singularly intended to reduce substance abuse. SDAAC members wonder, as well, what the impact will be of health care reform on substance abuse treatment and integration with mental health and somatic care treatment systems; and, indeed, how the SDAAC fits into the current climate of integration and health care reform.

The accomplishments, changes, issues and concerns are reflected on the following pages, in the fine tuning of the language of the Strategic Plan Goals and Objectives for 2012-2014, and in the action steps identified for the next two years.

# Section II

# Progress to Date

The following highlights the accomplishments made during the 2011 fiscal year in meeting the 2010-2012 Strategic Plan goals and objectives.

## Goal I: Facilitate establishment and maintenance of a statewide structure that shares resources and accountability in the coordination of, and access to, comprehensive recovery-oriented services.

*Objective1.1: Involve all relevant agencies in developing a Recovery Oriented System of Care.*

**Responsible Entities:** Alcohol and Drug Abuse Administration (ADAA), ROSC Steering Committee

**Accomplishments:**

The ADAA has embarked upon a multiple year process of transforming Maryland's addiction service system into a recovery oriented system of care (ROSC). A Recovery Workgroup (described in the August 2010 Strategic Plan Update) developed an implementation plan that included goals emphasizing the development of recovery oriented standards both for existing services and new recovery support services such as recovery housing, recovery coaching, and recovery community centers. Other goals focused on implementing technology transfer processes, development of outcomes measurement and funding strategies, and facilitating interagency collaborations to provide integrated services at the state and local levels. A Recovery Oriented Systems of Care Division created within ADAA is responsible for planning, standards development, technology transfer, and technical assistance.

The Workgroup recommended, and the 2010 update described, establishment of the ROSC Steering Committee which meets monthly and guides multiple ROSC transformation processes. Progress on the stated ROSC implementation goals has been substantive.

Engaged Stakeholder Groups: To date, provider and consumer advisory boards have been created. At the county level, Change Teams comprised of stakeholders, members of the recovery community, family members, treatment providers, and other service providers (including Recovery Support services) are responsible for guiding transformation to ROSC. Each county/jurisdiction must complete program level and jurisdiction level self assessments comparing available services to ROSC elements; and must create ROSC change plans, as a condition of receiving funding from ADAA

Educated the System: A Technology Transfer Subcommittee has established a Learning Collaborative, comprised of the ROSC coordinator from each county. Each coordinator is

responsible for guiding ROSC implementation within their jurisdiction. Coordinators meet regularly at the ADAA to:

- Receive training and technical assistance in the ROSC model and change process,
- Implement the plan. Each county has a ROSC Change Plan based on program and jurisdiction self-assessments and is in the process of implementation

Established Training Network: The ROSC Technology Transfer subcommittee has identified the need to organize and develop a group of trainers to provide training in a wide variety of topics in support of implementing the ROSC model in Maryland over the next several years. To that end, a training network comprised of approximately 15 trainers has been created with plans in place to increase the number of available trainers each year. ADAA/OETAS faculty will train the participants in the basic ROSC model, provide them with support resources, and encourage them to meet regularly as a group to receive additional training in the ROSC model and support for the provision of training. ADAA will offer meeting space and facilitation for these training network meetings; and will look to this group for future curriculum development and ROSC training needs. Scheduled 2011 training of trainers will be September 16, 23, and 30, and October 7 of 2011). Training is free of charge and participants will receive CEUs. Each person trained will be asked to provide one free training for ADAA/OETAS in return.

Established Learning Collaborative: As part of the Technology Transfer effort, a Learning Collaborative was established to further the dissemination of information to support the transformation of Maryland's substance abuse delivery of care system to one that has recovery at its core. The most recent Learning Collaborative was held on May 17th, 2011; the topic was Peer to Peer Recovery Support. The next Learning Collaborative will be held on July 27th, 2011 and will include continuing care trainers as well.

Defined Standards for Services. Through the efforts of a Standards Subcommittee, with three workgroups—Continuing Care, Recovery Housing and Peer Recovery Support—ADAA grant funds may now be used for Continuing Care (offered by outpatient programs, and including telephone support and relapse risk assessment) and Recovery Housing (paid for on a fee-for-service basis).

Changed Funding Priorities: *RecoveryNet*, an Access to Recovery grant, providing $3.2 million statewide each year for four years, assures clinical and recovery support services for individuals leaving residential treatment programs, including halfway house treatment, marital/family counseling, recovery housing, pastoral counseling, care coordination, childcare, transportation, and job readiness counseling. An RFP to fund a Recovery Community Center is in process. Services will be determined by the target population and must be operated by a Recovery Community organization. The target date for implementation of this Center is January 2012.

Collected Data that Measure Recovery Outcomes. There have been several changes to the data system. For example, an episode of treatment is now considered to include the entire time a patient spends in treatment with no break in service longer than 30 days; linkages

between detoxification and subsequent care, and linkages between intensive outpatient and subsequent care are now a part of ADAA performance measures; measurement of self-help group participation is captured at the time of disenrollment; and Continuing Care data tracks recovery activity past Level I treatment.

Collaborated with other Agencies. Dialogue is ongoing between:

- ADAA, Mental Hygiene Administration, and Developmental Disabilities Administration about mutual recovery-oriented goals for the populations the agencies served

- ADAA and Medical Assistance regarding the needs of people in recovery and the potential for reimbursement of recovery support services

The ATR grant will enable providers to offer services to individuals leaving residential facilities within the Department of Public Safety and Correctional Services, and Department of Veterans Affairs. As well, there will be opportunities to collaborate with agencies that license recovery support providers such as childcare, care coordination, and pastoral care. (Please refer to *RecoveryNet*/ATR update on collaboration, Objective 1.2).

***Objective 1.2:*** *Improve coordination and collaboration among departments and agencies that provide services to individuals with substance use conditions to reduce the gap between the need for services and available services and promote the establishment of recovery oriented support services.*

**Responsible Entity:** SDAAC Collaboration and Coordination Workgroup

**Accomplishments:**

During the first year of Strategic Plan implementation, the Collaboration and Coordination Workgroup agreed that the most valuable contribution it could make to achievement of this objective was to identify "gaps in services and barriers to coordination among the agencies represented and seek to set standards of care among these agencies." (Strategic Plan Update Report, August 2010, p. 10) To that end, a letter was sent to the Secretary or Executive Director of eight State departments which potentially have resources for substance abuse prevention, intervention, and/or treatment. As well, several Administrations under the Department of Health and Mental Hygiene (DHMH) and the Office for Problem Solving Courts were surveyed individually.

Along with the letter were instructions for completing a State Survey of Resources and a Survey Grid to be completed by the designated agency. A prior survey of funding specific to Underage Drinking was completed at the request of the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Survey of resources was completed through work of Collaboration and Coordination subcommittee. See Attachment D for the FY11 State Survey of Resources Summary of Funding.

In addition, the following partnerships will enhance the quality of treatment services for substance-using populations in Maryland:

Through its *RecoveryNet* Initiative, ADAA has collaborative relationships with the State Mental Health Administration (MHA), the Maryland Department of Education (MSDE), the Department of Health and Mental Hygiene (DHMH), the University of Maryland Institute of Governmental Services and Research (ISGR), the Division of Correction (DOC) and the Maryland Veterans Administration at Perry Point. In addition, ADAA maintains continued partnership with Maryland's 24 Health Departments which provide oversight for SUD prevention, intervention and treatment in their localities.

The ADAA has also been striving to improve the quality of life of pregnant and parenting women, and to reduce infant mortality in Maryland. To this end, the ADAA will continue to collaborate with the Department of Human Resources (DHR). Certified addictions counselors screen and, when necessary, conduct a comprehensive assessment to determine whether a referral for treatment is required. The ADAA also collaborated with DHMH Family Health Services (FHS) to implement enhanced medical services in three jurisdictions in the state, and plan to collaborate with the DHMH/ FASD office to present FASD training to providers at the individual and population levels.

Further, the ADAA will continue to collaborate with other state and local agencies which have a mandate to provide services for pregnant women and women with dependent children. The ADAA will promote the alignment of state and federal resources to improve the quality of life and reduce infant mortality in Maryland through the Governor's Delivery Unit performance management system. The ADAA women's treatment coordinator will continue to work in collaboration with DHMH Child and Maternal Health to ensure that factors that have lead to high infant mortality rates are eliminated. This partnership will result in enhanced prenatal care for pregnant women in residential addictions treatment programs.

The Infant Mortality Initiative provides a model for development of strategies to "improve coordination and collaboration…" intended by this objective. Focusing on women prior to, during, and after pregnancy, the Initiative is designed to address the impact of substance abuse on infant mortality in Maryland, by improving access to care and outcomes for substance dependent women. See DHMH website http://dhmh.maryland.gov/babiesbornhealthy

The most relevant accomplishments (as shown on the GDU Infant Mortality Dashboard April 2011) to date include:

- Referral mechanisms have been established between behavioral health and substance abuse programs; and are being used by all substance abuse programs. Of the 379 pregnant women admitted to treatment programs, 112 were from the GDU (Governor's Delivery Unit) target jurisdictions, and in April 2011, Somerset County and Baltimore City referred four (4) and one (1) CWH clients to a behavioral health program while Prince George's County's CWH program received one (1) referral *from* a behavioral health program.

- New Medicaid Accelerated Certification for Eligibility (ACE) protocols have been implemented in all jurisdictions; 100 Family Investment Aides (FIA) have been trained to assist in ACE screenings; and 93 FIAs hired statewide.

Other DHMH/ADAA continuing collaborations include those with:

- the Maryland Department of Juvenile Services (DJS) to coordinate referrals to treatment resources for adolescents,

- the Maryland Infectious Disease and Environment Health Administration (IDEHA, formerly the "AIDS Administration") to coordinate HIV Set Aside-funded HIV risk assessment, testing, and referral for individuals undergoing treatment within high incidence areas of the State, and

- with the Maryland Drug Treatment Court Commission and the Maryland Office of Problem-Solving Courts to support local jurisdictions in planning, implementing and operating drug courts, and to encourage a collaborative, comprehensive, multi-disciplinary approach to reducing drug-related crime.

***Objective1. 3:*** *Promote the use of prevention strategies and interventions by informing stakeholders of the seven strategies to affect change considered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to be best practices in prevention: information dissemination, prevention education, alternative activities, community-based processes, problem identification, environmental approaches, and referral.*

**Responsible Entity:** Strategic Prevention Framework Advisory Committee/Workgroup (SPFAC)

**Accomplishments:**

This objective was achieved. Moreover, during the period from 2009-2011, Maryland made significant strides in establishing a Strategic Prevention Framework (subsequent to award of a "Strategic Prevention Framework State Incentive Grant—SPF-SIG—in July 2009). The SPF-SIG is intended to assure that Maryland establishes and maintains a comprehensive prevention infrastructure. Through this process Maryland will implement a comprehensive substance abuse prevention planning process; build and sustain a cross-system prevention data infrastructure; and expand state and local capacity for the provision of effective and culturally competent substance abuse prevention services.

In recognition of the importance of prevention in the continuum of substance abuse programs and services, the Maryland Strategic Prevention Framework Advisory Committee (SPFAC), which includes as well prevention providers, government officials and other stakeholders has served as the SDAAC Prevention Workgroup. (Accordingly, in this, and future reports on the SDAAC Strategic Plan, discussion of prevention will focus on MSPF.)

The SPFAC and its workgroups (one of which, the State Epidemiological Outcomes Workgroup—SEOW—had been established prior to award of the SPF grant) met regularly over the course of the year; their accomplishments are as follows:

The Committee reviewed and made recommendations to the MSPF staff concerning the State's MSPF Program's Strategic Plan, which was accepted by SAMHSA—generating release of the remaining Year 2 funds. These funds will be awarded to the State's 23 jurisdictions and Baltimore City upon approval of both their jurisdictional proposals and the local community's strategic plans. At this time, each jurisdiction has completed Phase 1 of the plan and will in July 2011 (FY 2012) begin embarking on Phase 2 of their SPF initiative during which they will submit their local communities strategic plans, and implement culturally-competent evidence-based programs (EBPs), and engage in continuous quality improvement to assure that all prevention resources and services in a target community are, indeed, EBPs.

Members of SEOW have met to review and discuss a variety of data compilations available for local research and planning. These include: the National Survey on Drug Use/Health (NSDUH); Maryland vehicle crash data; Uniform Crime Report—MD State Police data; Maryland Youth Risk Behavior Survey (YRBS); Behavioral Risk Factor Surveillance System (BRFSS) 2008-2009 data on binge drinking and chronic smoking; alcohol/drug induced deaths; and substance abuse treatment admissions. Due to the loss of the Maryland Adolescent Survey (MAS) on which the State and local jurisdictions relied for specific data regarding substance use among youth, ADAA is currently gathering information concerning the feasibility of expanding (in terms of sample size and questions) the MYRBS.

The Cultural Competency and Evidence-based Program workgroups received training from the Northeast Center for the Advancement of Prevention Technology (CAPT) regarding the role, expectations, and deliveries of the workgroups. The training was designed to increase the membership's understanding of how State-level workgroups in previous SPF cohorts have functioned to strengthen their statewide initiatives.

On May 4-5, 2011 in Linthicum Heights, Maryland, the CAPT provided a two day workshop on Identifying, Selecting and Implementing Environmental Strategies to the Maryland prevention coordinators and representatives. The training was devised to describe the benefits and value of an environmental approach to prevention in the context of Maryland's SPF – SIG priorities. Also, the training was developed so that the coordinators will have a better understanding of the research foundation of the environmental strategies that show strongest evidence of effectiveness.

As local jurisdictions plan to implement their MSPF and other prevention initiatives, they are guided by the ADAA's directive to utilize at least 50 percent of prevention block-grant funds for environmental strategies.

***Objective 1.4:*** *Explore ways that transition from a grant-fund to fee-for-service finance structure can address service capacity deficits, including funding services that support a recovery oriented system of care.*

**Responsible Entities:** ADAA, DHMH

**Accomplishments:**

During its 2009 session, the Maryland General Assembly passed legislation that resulted in transfer of grant funds to Medical Assistance to support the expansion and enhancement of MA. Primary Adult Care began covering substance use disorder treatment services and reimbursement rates for MA and PAC increased. This effort was undertaken to increase access to care for those seeking treatment. Grant funded providers now have a method of reimbursement for many of the previously uninsured. However, most providers were unaware of billing and collections activities, business practice changes needed to support those activities, the methodology for determining if collections support costs, and the regulations, policies and procedures governing the relationship with the MCO's. In response to this new fee for service arrangement, the ADAA sought and received Federal funds to implement a training program that addresses these problems. The ADAA was also able to identify State General Funds to support this needed effort. In November, 2009, a contract was awarded to Health Management Consultants, Inc., (HMC) to provide technical assistance and training on these topics.

The project was divided into phases: Phase I, implemented immediately, involved the selection of four jurisdictions that had the highest MA/PAC population. Treatment providers within these jurisdictions were provided hands-on technical assistance in their facility by HMC. Practice management changes were further supported by a workgroup formed with these jurisdictions. HMC conducted these monthly meetings where system and program problems and successes were discussed. Regulations and long standing practices proved to be barriers for success. For Phase II, HMC conducted 9 trainings throughout the state in March and April, 2010. Over 250 treatment provider staff attended these trainings. HMC and the ADAA continued the monthly technical assistance workgroup meetings.

Informal assistance continues to be provided through several avenues: local jurisdictional leaders trained in billing and collections information and via DHMH agencies (Medical Assistance, ADAA).

***Objective 1.5:*** *Improve and increase data/information sharing capabilities within departments and among partnering agencies and institutions to improve client care while at the same time ensuring that the individual's right to privacy is protected in compliance with laws and regulations*

**Responsible Entities:** Technology Workgroup, DHMH, DPSCS

**Accomplishments:**

As reported in the August 2010 Strategic Plan update, legislation (e.g., the federal Affordable Care Act) and initiatives in Maryland [e.g., DHMH's development of a Maryland Health Information Exchange (MHIE) and an Electronic Health Record (EHR)] supersede SDAAC's plans for data sharing within and among agencies. Thus, specific steps relevant to this objective have been tabled.

In addition to the data sharing activities previously reported, several additional advances are worth noting. The State of Maryland Automated Record Tracking (SMART) system gives providers the ability to implement an electronic record for their patients as well as report required data to the State. The vendor of the SMART system is committed to obtaining EHR certification by January 1, 2012. The SMART system is also the Voucher Management System for consumers of *RecoveryNet* (the State's Access to Recovery program).

ADAA has also been working with DPSCS on the Reentry Task force to develop a Justice Information Exchange Model. The project was supported by a grant awarded by the Bureau of Justice Assistance. Through an extensive discovery process project deliverables and specifications were developed. These deliverables define both the context and the content of the exchanges as well as the technical methodology. DPSCS is identifying funding opportunities to support the implementation.

***Objective 1.6:*** *Ameliorate the workforce shortage*

**Responsible Entity:** Workforce Development Committee of the MADC

**Accomplishments:**

The Workforce Development Committee continues to meet monthly via teleconference.

As reported in the August 2010 Strategic Plan Update, the Maryland Addictions Directors Council (MADC) agreed to adopt the SDAAC Goal 1, Objective 5 as their agenda, and established a workforce development committee to do so.

To improve recruitment and retention, the committee:

Addressed cultural and linguistic competency among the workforce.

- It was brought to the attention of the Workforce Development Committee that cultural and linguistic concerns were not part of the Workforce Development Committee's work plan. This was an oversight on the committee's part. The committee developed a standalone objective to address the cultural and linguistic concerns (objective 7).

Convened and launched Scholarship Committee.

- The Committee has convened a Scholarship Committee who will work to establish the framework for Workforce grants dedicated to educational purposes. The committee will prepare the application and outline the application process, set guidelines for the selection committee and criteria and establish grant structures. MADC continues to promote the effort and accept online donations through its website. A solicitation letter will be circulated to a test group within the corporate community in December 2010.

- Developed a Field Placement Directory.

- Engaged in several marketing activities, including:
  --establishment of a Recruitment Subcommittee with Higher Education Partners;
  --development of a Survey Form to gather information on field placements to connect students with internship opportunities; and
  --launch—on the MADC website—of a Directory of Substance Abuse Programs to inform/and link interested parties with all higher education partners currently offering programs throughout the State (http://madc.homestead.com/Workforce-Development.html).

- Launched exploratory efforts through the Recruitment Subcommittee to gain a greater understanding of the full offerings at each institution; and developed a telephone survey and script to reach out to and make contact with all higher education partners. MADC will soon be offering a career center on their website, where members can offer information about their recruitment efforts.

- Prepared and circulated a salary survey and purchased the National Council on Community and Behavioral Health salary survey.

- The Board of Professional Counselor and Therapists guidelines, established years ago, only allowed for a nominal amount of credit for e-learning. Times, technology and circumstances have changed and the committee worked to establish a relationship with the Board of Professional Counselors and Therapists on HB 311 and SB 476 which successfully passed both the House of Delegates and Maryland Senate. This legislation removes the home study prohibition from the law governing renewal of licenses and certification for professional counselors and therapists. At the start of the session, MADC facilitated the introduction of a these bills sponsored by Delegate Hubbard and Senator Benson. MADC members provided compelling testimony in support of HB 311 and SB and worked with the bill sponsors, committee chairs and subcommittee members to urge passage of the bill 476.

- Collaborated with NCAAD-MD to identify and bring individuals in recovery into the workforce.

- Is in the process of exploring, with ADAA, emerging leader and leadership development offerings under the auspices of a potential Behavioral Health Institute. The group is currently seeking funding for this endeavor.

Actively engaged in Health Care Reform Coordinating Council's Workforce Development Workgroup included:

- Sponsoring and facilitating a provider retreat to prioritize issues and needs surrounding health care reform

- Regularly updating full membership and committee members regarding activities of the Workforce Workgroup and engaged their input.

- Preparing and presenting testimony on behalf of all three disciplines that make up Behavioral Health to Workforce Workgroup

- Collaborating with stakeholders to prepare written comments to Workforce Workgroup

- Preparing response to Workforce Development White Paper Draft

- Committee members have worked very hard to gain an understanding of the workforce issues that are affecting the profession as a result of health care reform

- Convening and supporting Health Care Reform Implementation in Maryland Forum

Launched Benchmarking for Organizational Excellence in Addiction Treatment" initiative. This national benchmarking initiative transforms static performance data into information that providers can utilize to improve their organization's performance

- Facilitated Parity Project with the University of Maryland Law School Drug Policy Clinic. Efforts included: Parity training, Provider Parity resource Guide, On-going subcommittee work exploring Parity authorization issues.

E-learning. The committee has explored several avenues to enhance the offering of virtual learning throughout the state. The committee is also working to establish legislation that will change the current limited opportunity to earn online credits.

- 2011 MADC Conference. The 2011 Behavioral Health conference was held May 11th -13th. The theme of the conference was "Navigating the New Landscape" and was dedicated to how Health Care Reform will affect Behavioral Health professionals. John Morris was the keynote the first day and addressed the changing face of workforce in the era of healthcare reform. Two evening sessions at the conference focused on Workforce topics. We offered 2 scholarships to the conference this year.

The MADC legislative agenda for the 2011 session includes the following:

- Proposing legislation to change the requirements regarding online courses to allow flexibility and access in obtaining licensing requirements

- Modify requirements for college courses to be consistent with what is offered and available to students interested in the profession.

- Changing policies to allow for payment of all levels of certification and licensing.

- Streamline the categories of licensing and credentialing categories and eliminate rarely used categories while allowing current holders to practice.

- Align mental health reimbursable categories with equivalent categories for substance use disorder to ensure payment.

National Efforts. We are also working on important workforce issues that affect our state at the national level. Through our efforts with State Associations of Addiction Services we have supported the following efforts:

- Maryland substance use disorder providers have participated in a Self-Assessment of Readiness and Capabilities survey. We have the compiled data to help inform our training decisions.

- We have actively participated in the Coalition for Whole Heath efforts.

- We have participated in SAMHSA initiatives and responded to several workforce issues that have been raised.

- We are supporting SAAS efforts in developing the Model Scope of Practice for Substance Use Disorder Counseling and Career Ladder for the Field of Substance Use Disorders

Language to enact the “Reciprocity Bill” has been approved. Forms are being developed to allow for qualified substance abuse professionals to be hired and practice in Maryland.

The Board’s Sunset review Interim was due to the General Assembly by 10/1/2010. There are a number of issues/concerns related to workforce development that this report was charged to address. The Workforce Development Committee has not seen the report. The Board is going to make the report available to the committee for feedback.

## Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions

***Objective II.1****: Improve screening, assessment, evaluation, placement, and aftercare for all individuals who interface with the substance abuse treatment, criminal justice and juvenile justice systems at all points of the continuum of care.*

**Responsible Entity:** Criminal-Juvenile Justice Workgroup

**Accomplishments:**

The workgroup's activities flowed from the extensive list of recommendations put forth in the August 2010 Strategic Plan Update in the following areas:

For Juveniles:

- Screening and evaluation: The Department of Juvenile Services has made several efforts to reduce the overly-long period of time from arrest to (treatment) intake in the juvenile justice system. An evidence-based (and less expensive than the instrument currently in use, the SASSI) screening and assessment instrument (the Comprehensive Health Assessment for Teens—CHAT) is being considered. DJS is developing a policy to address the workgroup's recommendation of a complete screening (including urinalysis) on each juvenile at intake to the DJS system, with consideration of a 10-panel test to discern prescription drug abuse.

- Placement: Following up on the workgroup's recommendation that juveniles committed to institutional treatment be placed on formal probation supervision rather than informal or informal placement, DJS and the relevant treatment provider(s) will institute a progress review to assure successful compliance. Lack of positive progress would result in the juvenile attending court and becoming formally involved with DJS.

- Treatment and Reentry: Data were shared with workgroup members on the efficacy of teleconferencing (a 2010 recommendation) in the mid-Shore region. Indications are that this strategy can be both effective and cost effective. Workgroup members are hopeful that the ATR grant can be expanded to cover youth under 18—who are currently not included in the ATR target population.

For Adults:

- Many initiatives are being explored in the area of evidence-based reentry practices, including re-entry courts. DPSCS currently has an electronic "case plan" that can be initially developed by the agency with which the offender first comes in contact; the plan can be updated throughout the time s/he is under DPSCS control. Potentially,

plans can be developed while on pretrial supervision, updated during incarceration, and continually updated while on parole supervision.

- Workgroup members are gathering information about the activities of the Governor's Re-entry Taskforce, with the intention of building on the Taskforce's results. As well, the workgroup is monitoring other reentry activities (e.g., DPSCS' review of a dashboard technique to pull data from multiple agencies and share the data between adult and juvenile systems and the court system; and DPP's development of a Community Corrections model, designed to help the offender set realistic expectations for life after incarceration and foster a smoother transition).

- DHMH and DPSCS developed an MOU for expedited PAC application processing for correctional facilities inmates prior to release so benefits are available upon release. However, du e to staffing concerns, PAC eligibility workers have not begun processing applications for inmates with 8505 and 8507 orders. Further discussion and a solution to this issue needs to occur.

The RSAT and ATR grants are both viewed as facilitating reentry with the financial help they provide for pre-release center and community-based services.

## Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.

***Objective III.1:*** *Engage state and local stakeholders in creating a coordinated and integrated system of care for individuals with co-occurring problems*

**Responsible Entities:** Behavioral Health and Developmental Disabilities Administration

**Accomplishments:**

The Core Service Agency Directors have recently become members of the Maryland Addiction Directors Council and have participated in a statewide Behavioral Health Conference.

***Objective III.2:*** *Integrate and coordinate existing services and resources to service individuals with co-occurring illness evidenced by expansion of service provision*

**Responsible Entity: MHA, ADAA**

**Accomplishments:**

Several jurisdictions have made significant progress in their ability to address the challenges of serving individuals with co-occurring mental health and substance use disorders.

Anne Arundel, Carroll and Washington Counties are in the process of becoming dual diagnosis capable. Garrett Co. is dual diagnosis capable. Worcester Co. has succeeded in becoming DDC and is now in an integrated relationship with primary care using Atlantic General; and Baltimore Co. has made an organization structural change to reflect a more integrated behavioral health system of care. All of the physicians, including a pediatrician, at RICA of Baltimore have passed their boards and are now board certified in addiction medicine.

Wicomico Co. made its first effort to convene a forum with a majority of its mental health and addiction providers to discuss creating partnerships and how to position themselves for Health Care Reform and better serving the co-occurring population. Baltimore City's BSAS and BMHS have partnered to begin developing IDDT evidenced based practice.

***Objective III.3:*** *Recruit, train workforce to provide services to persons with co-occurring illness.*

**Responsible Entities:** Workforce Development Committee, DHMH

**Accomplishments:**

Several efforts are being carried out to accomplish this goal. The most far reaching in terms of disseminating, state-wide, evidence-based practice in providing quality care to individuals with co-occurring substance and mental health conditions is a technology transfer protocol disseminated through the "Co-occurring Supervisors' Academy". Using the curriculum developed by the University of Southern Maine as a foundation, the ADAA, the Mental Hygiene Administration, and the Developmental Disabilities Administration, together with the University of Maryland's Evidence-Based Practice Center developed a training of trainers curriculum for clinicians from the DHMH public mental health, substance abuse, traumatic brain injury and developmental disabilities fields in the screening, assessment, treatment and support of adults with co-occurring mental illness, substance use disorders, traumatic brain injury and/or cognitive disability. Participants were given the skills necessary to impart the information they received to clinical/professional staff at their agency to which they provide clinical supervision or training. The goal of the Academy was to promote co-occurring disorders competency throughout the State of Maryland through professional development of clinical trainers and supervisors. Additional COD Academies will be held in the future.

An invitation letter was sent to clinicians across the state to attend the first "Co-occurring Disorders Supervisors Academy" which began on April 8, 2010 and ended in April 2011. The stated goal of the academy was (and is) "to promote co-occurring disorders competency" throughout the State.

Twenty supervisors from publicly funded substance abuse, mental health and developmental disabilities programs from around the State participated—at no cost to them—in the once/month all-day sessions at ADAA offices. The sessions, held once/month at ADAA offices.

Prerequisites for Participation

In order to become a participant in the Academy, a clinical supervisor/trainer was required to meet the following pre-requisites:

- Ability to learn and apply adult learning techniques.
- Currently involved in providing clinical supervision or clinical training at their agency.
- One year of experience in service provision for individuals with COD.
- Good organizational skills and ability to effectively manage the training event.

Successful applicants also needed to submit written approval to participate in the Academy from the agency director/CEO.

Participants were expected to:

- Attend all sessions. If a session was missed, the participant made up the session during a future offering of the same session or made other arrangements with the instructor(s).
- Provide training of the modules at their respective agencies in between monthly training sessions.
- Demonstrate inclusion of these concepts in clinical supervision and/or training
- Agree to complete training, and to provide COD training at the agency for one year following completion of the course.

Learning Objectives.

At the end of the Academy, participants were able to:

- Define co-occurring disorders (COD); understand the implications of co-occurring mental illness, substance abuse and a cognitive deficit/developmental disability.
- Identify barriers to services for people with complex needs, articulate principles of integrated treatment, and develop solutions toward better collaboration among disciplines.
- Formulate a definition of recovery from the mental health, substance abuse, and developmental disabilities perspectives.
- Demonstrate competent in understanding/appreciating brain injury and its physical, cognitive and behavioral sequelae as a possible co-occurring disorder among individuals with mental illness, developmental disabilities and substance abuse issues.
- Appreciate the importance of consumer involvement/empowerment in all aspects of service delivery and describe the benefits and challenges of working in partnership with families, peers, and natural supports.
- Understand how trauma impacts treatment and recovery.
- Identify developmental milestones, risk factors and patterns of substance abuse as related to adolescents with COD.
- Describe principles and practices of psychopharmacology in the area of COD.
- Identify ethical and risk management issues when working with individuals with COD

Continuing Education Units (CEUs) were provided to social workers, psychologists, and licensed professional counselors. Certificates of Attendance were provided to nurses and all other disciplines. A Certificate of Completion was provided for participants who completed the series. (See attachment E for the Co-Occurring Disorders Academy curriculum.)

Other efforts to promote quality care for individuals with co-occurring disorders include the convening of the Maryland Summit on Youth with Co-occurring Disorders. A Blueprint committee, co-chaired by Dr. Cohen and Dr. Al Zachik, will follow up on the recommendations of the summit. In addition there is a SAMHSA system of care for children and youth with co-occurring need grant for which DHMH is now applying. A Case Review Team, composed of representatives from all administrations, has been established and meets twice monthly to review problem cases. In addition, ADAA reviews a case from each jurisdiction to assess the quality of evaluation and recommendation reports generated for clients with a court order for an 8505 evaluation.

***Objective III.4:*** *Provide adequate resources to support workforce development*

**Responsible Entities:** Workforce Development Committee, DHMH

**Accomplishments:**

Relevant agencies (ADAA, MHA, DDA, and University of Maryland's Evidence Based Practice Center) contributed staff and other resources to development and implementation of the co occurring supervisors' academy.

## Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse

***Objective IV.1:*** *Sustain mission and work of State council across future administrations by codifying SDAAC.*

*Objective IV.2: Improve the understanding of policy makers, opinion leaders, and the general public of the relationship between/among public safety, health, mental health and substance abuse, treatment and recovery.*

*Objective IV.3: Publicize the progress made by the Council in facilitating establishment of a Recovery Oriented System of Care.*

**Responsible Entities:** Behavioral Health and Developmental Disabilities Administrations

**Accomplishments:**

House Bill 219 was passed during the 2010 session of Maryland's General Assembly, codifying the Maryland State Drug and Alcohol Abuse Council.

## Section III

# A STRATEGIC PLAN FOR THE MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL 2012-2013

***OUTCOME: A COORDINATED, STATE-MANDATED RECOVERY-ORIENTED SYSTEM OF CARE (ROSC)***
***(See Appendix C for a list of Acronyms used in the Plan)***

## Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.

*Objective I.1: Involve all relevant agencies in developing a Recovery Oriented System of Care.*

*Objective I. 2: Improve coordination and collaboration among departments and agencies that provide services to individuals with substance use conditions to reduce the gap between the need for services and available services and promote the establishment of recovery oriented support services*

***(New)** Objective I.3: **Promote and expand the use of evidence–based prevention strategies and interventions by implementing the Maryland Strategic Prevention Framework (MSPF) Initiative and other SAMHSA prevention strategies and best practices.***

***(New)** Objective I.4: **Develop youth substance abuse assessment survey process to provide baseline and trend data, at both State and jurisdiction levels, to assist in planning, tracking and evaluating the effectiveness of the MSPF initiative and other evidence-based efforts.***

***(Retained Objective 1.4; New Objective Number)** Objective I.5: Explore ways that transition from a grant-fund to fee-for-service finance structure can address service capacity deficits, including funding services that support a recovery oriented system of care.*

***(Retained Objective 1.5; New Objective Number)** Objective I.6: Improve and increase data/information sharing capabilities within departments and among partnering agencies and institutions to improve client care while at the same time ensuring that the individual's right to privacy is protected in compliance with laws and regulations.*

***(New)** Objective I.7**: Expand, strengthen and sustain a highly competent and specialized workforce to meet growing services and needs in the face of a workforce crisis***

***(New)** Objective I.8: **Recruit and retain a diverse workforce that is culturally and linguistically competent and sensitive***

## Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.

*Objective II.1**:** Improve screening, assessment, evaluation, placement, and aftercare for all individuals who interface with the substance abuse treatment, criminal justice and juvenile justice systems at all points of the continuum of care.*

## Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.

*Objective III.1: Engage state and local stakeholders in creating a coordinated and integrated system of care for individuals with co-occurring problems.*

*Objective III. 2**:** Integrate and coordinate existing services and resources to service individuals with co-occurring illness evidenced by expansion of service provision*

***(Prior Objectives III.3 and III.4 Merged) Objective III. 3:** Recruit, train, and provide adequate resources to co-occurring workforce to assure appropriate services to persons with co-occurring illness.*

## Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse

*Objective IV.1: Sustain mission and work of State council across future administrations by codifying SDAAC. (Achieved in 2010 with passage of HB 219 in 2010)*

*Objective IV. 2**:** Improve the understanding of policy makers, opinion leaders, and the general public of the relationship between/among public safety, health, mental health and substance abuse, treatment and recovery*

*Objective IV.3: Publicize the progress made by the Council in facilitating establishment of a Recovery Oriented System of Care.*

| **Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.** | |
|---|---|
| ***Objective I.1:*** *Involve all relevant agencies in developing a Recovery Oriented System of Care.* | |
| **Action Steps** | **Responsible** |
| 1. Continue the ROSC Implementation Plan<br><br>2. Seek out non-traditional partner agencies in order to educate them on the ROSC such as the Veteran's Administration, other State Agencies such as the Housing Community Planning and Development.<br><br>3. Identify mandates that create barriers/limits to implementation of ROSC such as criminal involvement, zoning issues, etc. | ADAA, ROSC Steering Committee |
| ***Objective I. 2:*** *Improve coordination and collaboration among departments and agencies that provide services to individuals with substance use conditions to reduce the gap between the need for services and available services and promote the establishment of recovery oriented support services.* | |
| **Action Steps** | **Responsible** |
| 1. Continue to perform and review annual survey of resources (in law).<br><br>2. Continue to identify gaps in service by level of care, and population<br><br>3. Identify barriers to collaboration in service delivery among different departments and agencies.<br><br>4. Seek solutions that will overcome those barriers and promote coordination and sharing of resources to ensure availability of recovery support services.<br><br>5. Maintain regular communication with the ROSC Division of the ADAA and relevant ROSC Committees and Advisory Boards.<br><br>6. Encourage collaboration and transfer of information regarding trauma informed treatment.<br><br>7. Improve access to treatment information between/among all agency partners, including specific initiatives for:<br>• Collaboration between the MVA and the ADAA to improve services to substance using individuals and improve highway safety. ADAA and MVA will collaborate on: training or development of a training module for MVA's assessment staff on the SBIRT protocol; provide semi-annual training/updates for the MVA Medical Advisory Board; and review and have input into the prevention section of the Drivers' Education | SDAAC Collaboration and Coordination Workgroup, ROSC Steering Committee |

| **Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.** | |
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| Program<br>• Collaboration between DHR and MVA, with DHR providing an abbreviated training module on the agency's public assistance programs to the MVA's Driver Wellness and Safety unit.<br>• Collaboration between ADAA and the Fetal Alcohol Syndrome Disorder Office to present FASD training to providers at the individual and population levels. | |
| ***(New) Objective I.3: Promote and expand the use of evidence–based prevention strategies and interventions by implementing the Maryland Strategic Prevention Framework (MSPF) Initiative and other SAMHSA prevention strategies and best practices.*** | |
| **Action Steps** | **Responsible** |
| 1. Provide MSPF Implementation grants to the 24 identified MSPF communities, monitor and evaluate the effectiveness of their chosen strategies and interventions.<br><br>2. Provide on-going capacity-building support and training to MSPF grantees and other key stakeholders on the implementation of the Strategic Prevention Framework (SPF) process at the community level.<br><br>3. The MSPF Advisory Committee's Community Implementation Work Group will compile and maintain current resources on best practices related to behavioral health promotion, prevention and community wellness, to include investigation of collaborating with local health entities. | SPFAC |
| ***(New) Objective I.4: Develop youth substance abuse assessment survey process to provide baseline and trend data, at both State and jurisdiction levels, to assist in planning, tracking and evaluating the effectiveness of the MSPF initiative and other evidence-based efforts.*** | |
| **Action Steps:** | **Responsible** |
| 1. Involve the State Epidemiology Outcomes Workgroup (SEOW) and other key agency representatives (i.e., Tobacco Control, MSDE, etc.) in the development, cultural competency and sustainability of the assessment survey.<br><br>2. Implement the assessment survey on a bi-annual basis in all 24 Maryland jurisdictions.<br><br>3. The SEOW will conduct an evaluation of the assessment process as needed to determine if State and jurisdiction level data needs are | SPFAC, DHMH, MSDE |

| **Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.** | |
|---|---|
| being met and will, along with key agency representatives, make adjustments to the process as necessary. | |
| ***(Retained Objective 1.4; New Objective Number) Objective I.5:*** *Explore ways that transition from a grant-fund to fee-for-service finance structure can address service capacity deficits, including funding services that support a recovery oriented system of care.* | |
| **Action Steps** | **Responsible** |
| 1. Explore the impact of healthcare reform on substance abuse treatment to:<br>• Help determine who SA will need to be serving including potential individuals who have not previously been served by the system.<br>• Identify the substance abuse services that should be retained in an essential benefit package, particularly services not paid for in any other system.<br>• Assure that services funded are evidence-based.<br><br>2. Identify/generate steps that relate to information dissemination, regarding the future with Healthcare reform, and potential service integration with mental health and somatic care treatment<br><br>3. ADAA will solicit and provide input on prioritization of existing grant funds<br><br>4. ADAA will inform local jurisdictions and partner agencies regarding changing system to include how grant funds will be prioritized and distributed.<br><br>5. SDAAC will continue to request/report on data on Medicaid and PAC outcomes related to individuals now covered under MA/PAC system. | ADAA, DHMH |
| ***(Retained Objective 1.5; New Objective Number) Objective I.6:*** *Improve and increase data/information sharing capabilities within departments and among partnering agencies and institutions to improve client care while at the same time ensuring that the individual's right to privacy is protected in compliance with laws and regulations.* | |
| **Action Steps** | **Responsible** |
| 1. Support DPSCS efforts to acquire funding for a Justice Information Exchange Model initiative. The discovery and identification project was supported by a grant awarded by the Bureau of Justice Assistance.<br><br>2. Support JIEM implement initiative once funding has been secured | DHMH, DPSCS |

| **Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention-prepared communities and comprehensive recovery-oriented services.** | |
|---|---|
| 3. Assist providers in their efforts to meaningfully use SMART through the use of Guidance Documents in order to further education on Health IT.<br><br>4. Represent behavioral health in the development of the MHIE to ensure confidentiality requirements are met. | |
| ***(New) Objective I.7: Expand, strengthen and sustain a highly competent and specialized workforce to meet growing services and needs in the face of a workforce crisis*** | |
| **Action Steps** | **Responsible** |
| 1. Create and launch a behavioral health institute to provide continuing education for professionals.<br><br>2. Address the scope of practice to include credentialing, levels and standards.<br><br>3. Expand higher education partnerships<br><br>4. Establish a Career Center on the MADC website | Workforce Development Committee |
| ***(New) Objective I.8: Recruit and retain a diverse workforce that is culturally and linguistically competent and sensitive*** | |
| **Action Steps** | **Responsible** |
| 1. Recruit, train, and advance workforce from diverse backgrounds.<br><br>2. Recruit, train, and retain a workforce that is more reflective of the diversity of the community.<br><br>3. Design and implement educational programs to ensure that the workforce is both culturally competent and sensitive | DHMH, Workforce Development Committee |

| **Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.** | |
|---|---|
| ***Objective II.1:*** *Improve screening, assessment, evaluation, placement, and aftercare for all individuals who interface with the substance abuse treatment, criminal justice and juvenile justice systems at all points of the continuum of care.* | |
| **Action Steps** | **Responsible** |
| 1. Assure that DHMH and DPSCS re-visit the MOU developed by which incarcerated individuals can be determined to be PAC eligible so that benefits are effective upon release. This will allow individuals to immediately access both the somatic and behavioral health care they | Criminal-Juvenile Justice Workgroup, ADAA |

| **Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.** | |
|---|---|
| may need.<br><br>2. Continue to promote advances in best practice related to juvenile justice and substance abuse services. Specifically:<br>• Continue discussion regarding DJS developing a policy to address the workgroup's recommendation of a complete screening (including urinalysis) on each juvenile at intake to the DJS system. The policy could include collaboration with local health departments and/or investigation of any existing method of payment for screening services available to the juvenile such as insurance or other forms of payment;<br>• DJS and ADAA to continue committee work on identification of a standardized electronically administered screening and assessment instrument (such as the CHAT) which would be used universally;<br>• Determine what data are available related to informal vs. formal probation status and outcomes related to treatment completion based on probation status (Note: Data on informal probationers is not currently available);<br>• Review data related to referral and placement of DJS adolescents into treatment and drug court;<br>• Encourage expansion of teleconference abilities throughout state.<br><br>3. Inform workgroup on other major efforts related to re-entry and re-entry courts. Specifically:<br>• Obtain and review reports from the Governor's Re-entry Taskforce;<br>• Collaborate with taskforce recommendations where possible<br>• Investigate and obtain information from all other re-entry task groups such as the Public Safety Taskforce on Re-entry; the Judicial Committee on Mental Health and Addictions; and Office of Problem Solving Courts subcommittees;<br>• Review current efforts related to re-entry courts including possible pilot projects in local jurisdictions<br><br>4. Monitor State stat and GDU dashboard mechanisms for opportunities to collaborate with other agencies that share responsibility for individuals with substance use disorders.<br><br>5. Continue to monitor availability of ATR services to offenders leaving jail based treatment programs, and support ADAA in efforts to fully | |

| **Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.** | |
|---|---|
| implement ATR with criminal justice clients.<br><br>6. Continue to encourage sharing of information via the SMART system between DPSCS and ADAA.<br><br>7. Determine how mental health information is currently stored and shared within correctional institutes, as well as possible interfaces to addiction information.<br><br>8. Determine what outcome information is available related to the 8507 process, including initial placement, treatment and supervision outcomes. | |

| **Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.** | |
|---|---|
| ***Objective III.1:*** *Engage state and local stakeholders in creating a coordinated and integrated system of care for individuals with co-occurring problems.* | |
| **Action Steps** | **Responsible** |
| Convene a workgroup of all relevant stakeholders to continue through FY12. | BH and DD |
| ***Objective III. 2:*** *Integrate and coordinate existing services and resources to service individuals with co-occurring illness evidenced by expansion of service provision* | |
| **Action Steps** | **Responsible** |
| 1. Continue to identify resources serving individuals with co occurring illness<br><br>2. Identify evidenced based practices, interventions and staff competencies needed to facilitate integrating systems of care consistent with ROSC (e.g., housing, employment, etc.).<br><br>3. Identify gaps and barriers between existing and necessary resources.<br><br>4. Investigate and recommend cost saving models that encourage integration of somatic, mental and addictions care.<br><br>5. Obtain information on collaborations related to adolescent co-occurring treatment needs in the juvenile justice system | |
| ***(Prior Objectives III.3 and III.4 Merged) Objective III. 3:*** *Recruit, train, and provide adequate resources to co-occurring workforce to assure appropriate services to persons with co-occurring illness.* | |
| **Action Steps** | **Responsible** |

| **Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.** | |
|---|---|
| 1. Continue the Co-Occurring Academy<br><br>2. Establish consistent program and professional standards for integrated service provision<br><br>3. Review regulations and accreditations needed to facilitate integration of services<br><br>4. Recruit and train to expand cadre of professionals qualified in co-occurring care<br><br>5. Train current workforce to service individuals with co-occurring illness | Workforce Dev. Committee & DHMH |

| **Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse** | |
|---|---|
| ***Objective IV.1:*** *Sustain mission and work of State council across future administrations by codifying SDAAC. (Achieved in 2010 with passage of HB 219 in 2010)* | |
| ***Objective IV. 2:*** *Improve the understanding of policy makers, opinion leaders, and the general public of the relationship between/among public safety, health, mental health and substance abuse, treatment and recovery.* | |
| **Action Steps** | |
| Make efforts to create links between all SDAAC partner agency and organizational web pages, and—potentially—link to substance abuse and mental health initiatives delineated on the Governor's web page | SDAAC |
| ***Objective IV.3:*** *Publicize the progress made by the Council in facilitating establishment of a Recovery Oriented System of Care.* | |
| **Action Steps** | **Responsible** |
| Use DHMH website to post plans and progress related to SDAAC activities and receive feedback | **DHMH** |

## *Appendix A: Maryland Strategic Prevention Plan Introduction*[6]

In 2009, the Maryland Alcohol and Drug Abuse Administration (ADAA) was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and implement the Maryland Strategic Prevention Framework (MSPF). The MSPF Advisory Committee, a committee of the Governor's State Drug and Alcohol Abuse Council (SDAAC), was convened and tasked with guiding and overseeing the development, implementation and success of the MSPF Initiative. The MSPF Advisory Committee has three active work groups: the State Epidemiology Outcomes Work Group (SEOW), Cultural Competence Work Group and Evidence Based Practices Work Group. These work groups have met regularly to develop recommendations for MSPF priorities, activities, policies, practices, and guiding principles.

These recommendations were then presented to the MSPF Advisory Council for further discussion and approval. Following this approval, the priorities, activities, policies, practices, and principles were incorporated into the MSPF Strategic Plan that follows.

**Principles Grounding the MSPF**

The effort to profile the impact of substance use in Maryland, described in this plan, was undertaken with the goal of facilitating a systematic, data driven approach to generating and monitoring priorities for prevention in Maryland. This novel approach to prevention for the state, advocated by the Center for Substance Abuse Prevention (CSAP), maintains that prevention should:

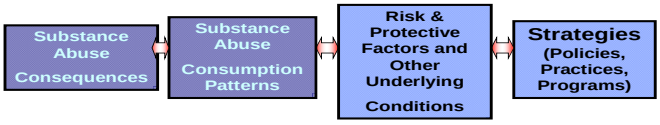
- be outcomes based;
- be public health-oriented; and
- use epidemiological data.

**Outcomes-Based Prevention**

Outcomes-based prevention (Figure 1.) emphasizes as the first step in planning: identifying the outcome or negative consequence of substance use that is to be the target of modification through prevention. Only once the consequence is established can the second step be undertaken: identifying the associated consumption patterns to be targeted. This approach expands the prevailing focus of substance abuse prevention planning, which typically targets only change in consumption, and shifts the focus to reducing the problems experienced as a result of use. In the scope of the SPF process, the first two outcome-based prevention steps pertain to this assessment. The foremost focus on the outcomes/consequences of substance use has guided every aspect of the data collection described in this plan and ultimately the prioritization process.

[6] Maryland Alcohol and Drug Abuse Administration, DHMH, January 2011: Maryland SPF-SIG State Strategic Plan, Introduction, pp. ii-iv.

**Figure 1. Outcomes-Based Prevention**




## Public Health Approach to Prevention

The public health approach encourages a focus on population-based change. Under this approach the ultimate aim of prevention efforts should be to target and measure change at the population level (i.e., among the state population as a whole or among certain sub-populations of the state sharing similar characteristics, such as 18-25 year olds in Baltimore City) rather than solely at an individual/programmatic level (i.e., among prevention program recipients). The assessment described in this Strategic Plan emphasizes a statewide population-level approach.

## Use of Epidemiological Data to Inform Prevention

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas to target based on where and how the state is experiencing the biggest impact of substance use. In addition, data can assist with determining the most effective way to allocate limited resources to elicit change and which sub-populations exhibit the greatest need so that prevention efforts might be maximized. Ultimately the use of data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements.

## MSPF Priority, Indicators, Logic Model, and Theory of Action:

<u>MSPF Priority and Indicators:</u>

The MSPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by the following 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

## MSPF Community Logic Model

| Substance-Related Consequences and Use | Intervening Variables/ Contributing Factors (These are examples; targeted contributing factors will vary by community and be selected by each MSPF community) | Evidence Based Strategies, Programs, Policies & Practices (These are examples; strategies and programs will vary by community and be selected by each MSPF community) |
|---|---|---|
| High incidence of alcohol use by Maryland youth under age 21 | □ Enforcement of alcohol-related laws<br>□ Commercial and social availability of alcohol to youth<br>□ Community attitudes toward alcohol use<br>□ Youth perceptions of the dangers of alcohol use<br>□ Youth perceptions of the social acceptability of use<br>□ Family use and attitudes towards alcohol use | □ Rigorous enforcement of MLDA and other alcohol laws<br>□ Compliance checks<br>□ Community mobilization to address community and institutional underage drinking norms and attitudes<br>□ Normative education emphasizing that most adolescents don't use ATOD<br>□ Parent programs stressing setting clear rules against drinking, enforcing those rules and monitoring child's behavior |
| High incidence of binge drinking by youth ages 18-25 | □ Enforcement of alcohol-elated laws<br>□ Commercial and social availability of alcohol to youth<br>□ Community attitudes toward alcohol use<br>□ Youth perceptions of the dangers of alcohol use<br>□ Youth perceptions of the social acceptability of use<br>□ Family use and attitudes towards alcohol use<br>□ Early onset of alcohol and/or drug use | □ Establishment or more enforcement of underage drinking party, keg registration, adult provider and social host laws<br>□ Alcohol excise taxes to reduce economic availability<br>□ Education programs that follow social influence models and include setting norms, addressing social pressure to use, and resistance skills<br>□ Multi-component programs that involve the individual, family, school and community<br>□ Interventions that identify and provide treatment for adolescents already using |
| High incidence of alcohol crashes involving youth ages 16-25 | □ Enforcement of drinking and driving laws<br>□ Judicial drinking and driving decisions and practices<br>□ Commercial and social availability of alcohol<br>□ Community attitudes toward drinking and driving<br>□ Perceptions of the risk of being caught and punished for drinking and driving<br>□ Availability and access to treatment in the community | □ Rigorous enforcement of drinking and driving laws<br>□ Awareness regarding the increased risk of being caught and punished for drinking and driving<br>□ Enforcement campaigns with sobriety check points<br>□ Court Watch<br>□ Community wide media campaigns and task forces<br>□ Police, judiciary, server, and business training<br>□ Court-ordered and enforced treatment for DUI offenders |

## *Appendix B: Federal Tobacco Control Contract Summary*

**Federal Government Awards the State of Maryland**
**$552,890 for Statewide Tobacco Retailer Inspections and Enforcement**

**Background**

On June 22, 2009, the President signed the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) into law. The Tobacco Control Act amended the FDCA by, among other things, adding a new chapter granting FDA authority to regulate the manufacture, marketing, and distribution of tobacco products to protect the public health generally and to reduce tobacco use by minors.

The provisions of the FDCA, as amended by the Tobacco Control Act, to be enforced under this contract is as follows:

> • Section 907. TOBACCO PRODUCT STANDARDS
> (a)(1)(A) SPECIAL RULE FOR CIGARETTES…a cigarette or any of its component parts (including the tobacco, filter, or paper) shall not contain, as a constituent (including a smoke constituent) or additive, an artificial or natural flavor (other than tobacco or menthol) or an herb spice, including strawberry, grape, orange, clove, cinnamon, pineapple, vanilla, coconut, licorice, cocoa, chocolate, cherry, or coffee, that is a characterizing flavor of the tobacco product or tobacco smoke.
> • Section 911. MODIFIED RISK TOBACCO PRODUCTS
> (a) IN GENERAL. –No person may introduce or deliver for introduction into interstate commerce any modified risk tobacco product unless an order issued pursuant to subsection (g) is effective with respect to such product.

The Tobacco Control Act also requires FDA to reissue the 1996 final rule, "Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents," which FDA has done at 21 CFR Part 1140, et seq. The provisions of the regulations shall be enforced with respect to retail establishments under this contract.

**Award & Objectives**

Maryland responded to the Department of Health and Human Services (DHHS), Food and Drug Administration (FDA) RFP competing with 15 other States in the Central Region and was one of three States to receive a contractual award. The Department of Health and Mental Hygiene (DHMH), Alcohol and Drug Abuse Administration (ADAA) received a one year renewable contract in the amount of $552,890 beginning on July 28, 2010 for the purpose of obtaining state assistance in inspecting retail establishments that sell cigarettes and/or smokeless tobacco products and in surveillance of other entities that fall under the scope of the provisions cited above. The Objectives are as follows:

1. To enforce section 907(a)(1)(A) and section 911 of the FDCA and the regulations reissued under 21 CFR Part 1140with respect to tobacco retail establishments.

2. To conduct inspections in retail establishments that sell and advertise cigarettes and smokeless tobacco products to determine compliance with the provisions cited above and submit observations and inspection results to FDA.

3. To collect, document, and preserve evidence of inspections and/or investigations.

4. To assist FDA in any enforcement or judicial actions, including coordinating the drafting and execution of declarations by the officers and minors who participated in inspections, and arranging for their testimony, if necessary, and furnishing evidence.

5. To coordinate with FDA on responses to press inquiries and press announcements on the FDA program and its results.

6. To assist in responding to any inquiries from FDA, including retailer questions concerning inspections, as necessary.

This award/initiative will strengthen Maryland's statewide comprehensive youth tobacco program and promote healthy communities in Maryland.

## *Appendix C: Acronyms Used*

| | |
|---|---|
| ACE | Accelerated Certification for Eligibility |
| ADAA | Alcohol and Drug Abuse Administration |
| ATR | Access to Recovery |
| BH & DD | Deputy Secretariat for Behavioral Health and Disabilities |
| BOPCT | Maryland Board of Professional Counselors and Therapists |
| CAPT | Center for Advancement of Prevention Technology |
| CEU | Continuing Education Unit |
| CHAT | Comprehensive Health Assessment for Teens |
| COD | Co-occurring Disorder |
| CWH | Comprehensive Women's Health |
| DDA | Developmental Disabilities Administration |
| DHCD | Department of Housing and Community Development |
| DHMH | Department of Health and Mental Hygiene |
| DHR | Department of Human Resources |
| DJS | Department of Juvenile Services |
| DOC | Division of Correction |
| DOJ | Department of Justice |
| DPP | Division of Parole and Probation |
| DPSCS | Department of Public Safety and Correctional Services |
| EBP | Evidence Based Practice |
| EHR | Electronic Health Record |
| FIA | Family Investment Aide |
| FP | Family Planning |
| GDU | Governor's Delivery Unit |
| HMC | Health Management Consultants |
| IDDT | Integrated Dual Diagnosis Treatment |
| ISGR | Institute of Governmental Research |
| MADC | Maryland Addiction Directors Council |
| MA/PAC | Medical Assistance/Primary Adult Care |
| MAS | Maryland Adolescent Survey |
| MCO | Managed Care Organization |
| MHA | Mental Hygiene Administration |
| MHEC | Maryland Higher Education Commission |
| MHIE | Maryland Health Information Exchange |
| MSDE | Maryland State Department of Education |
| MSPF | Maryland Strategic Prevention Framework |
| OETAS | Office of Education and Training in Addictions Services |
| RFP | Request for Proposal |
| ROSC | Recovery-Oriented System of Care |
| RSAT | Residential Substance Abuse Treatment |

| | |
|---|---|
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SASSI | Substance Abuse Subtle Screening Inventory |
| SDAAC | State Drug and Alcohol Abuse Council |
| SEOW | State Epidemiological Outcomes Workgroup |
| SIG | State Incentive Grant |
| SMART | State of Maryland Automated Record Tracking |
| STD | Sexually Transmitted Disease |
| SUD | Substance Use Disorder |
| YRBS | Youth Risk Behavior Survey |

## *Appendix D: State Survey of Resources: Summary of Funding by Type and Funding Detail*

| Specific | Related |
|---|---|
| 151,083, 211.29 | 269,710,505.30 |

| Federal | State | Combined |
|---|---|---|
| 35,409,921.00 | 384,963,182.00 | 420,614.00 |

| Prevention | Intervention | Treatment | Combined |
|---|---|---|---|
| 7,300,404.00 | 6,699,945.29 | 291,131,419.00 | 115,661,948.30 |

| Specific | | | | |
|---|---|---|---|---|
| | Prevention | Intervention | Treatment | Combined |
| State | 150,151.00 | 3,123,730.29 | 21,444,453.00 | 90,860,992.00 |
| Federal | 7,150,253.00 | 3,509,215.00 | 1,100,018.00 | 23,373,785.00 |
| Combined | | | | 370,614.00 |

| Related | | | | |
|---|---|---|---|---|
| | Prevention | Intervention | Treatment | Combined |
| State | | | 268,377,298.00 | 1,006,557.30 |
| Federal | | 67,000.00 | 209,650.00 | |
| Combined | | | | 50,000.00 |

| Department | Agency | Specific vs. Related | Adult, Youth or Both | P, I, or Treatment | Funding Source | Amount |
|---|---|---|---|---|---|---|
| DHMH | ADAA | Specific | all ages | Prevention | Federal | 6,362,417.00 |
| | | Specific | all ages | Intervention | State | 2,322,364.00 |
| | | Specific | all ages | Intervention & tx | State | 86,820,757.00 |
| | | Specific | all ages | Intervention & tx | Federal | 23,171,437.00 |
| | | Specific | all ages | Treatment | State | 15,340,495.00 |
| Total | | | | | | 134,017,470.00 |
| DMHM Total | FHA | Specific | youth | Prevention | State | 150,151.00 |
| DHMH | IDEHA | Specific | all ages | Intervention | State | 162,860.00 |
| | | Specific | all ages | Treatment | State | 128,000 |
| | | Specific | all ages | Treatment | Federal | 248,949.00 |
| Total | | | | | | 539,809.00 |
| DHMH | MHA FY11 | Related | Adults | Treatment | State | 81,188,431.00 |
| | Projected | Related | Youth | Treatment | State | 2,066,867.00 |
| | | Related | All ages | Treatment | State | 185,122,000.00 |
| Total | | | | | | 268,377,298.00 |
| DHR Total | FIA | Specific | all ages | Intervention | Federal | 3,475,000.00 |
| DJS | | Specific | Youth | Intervention & tx | State | 3,985,235.00 |
| | | specific | Youth | *Intervention & tx | Combined | 370,614.00 |
| | | specific | Youth | Intervention | State | 352,286.29 |
| | | specific | youth | P,I, & Tx | State | 55,000.00 |
| | | Related | youth | Prevention & Intervention *contains county $s for journeys | State | 806,557.30 |
| Total | | | | | | 5,569,692.59 |
| DPSCS | | Specific | Adult | Treatment | State | 4,511,348.00 |
| | | Specific | Adult | Screen & Assess | State | 286,220.00 |
| Total | | | | | | 4,797,568.00 |
| GOCCP | | Related | youth | Intervention | Federal | 67,000.00 |
| | | Related | adult | Treatment | Federal | 9,650.00 |
| | | Related | youth & adult | Treatment | Federal | 200,000.00 |
| | | Specific | youth | Prevention | Federal | 787,836.00 |
| | | Specific | adult | Treatment | Federal | 556,775.00 |
| | | Specific | adult | Treatment | State | 1,464,610.00 |
| | | Specific | youth | Intervention | Federal | 34,215.00 |
| | | Specific | youth | Treatment | Federal | 294,294.00 |
| Total | | | | | | 3,414,380.00 |
| MDOT | | Specific | | I&T | Federal | 202,348.00 |
| | | Related | | I&T | State | 200,000.00 |
| | | Related | | P&I | State and Federal | 50,000.00 |
| Total | | | | | | 452,348.00 |
| **Grand Total** | | | | | | **420,793,716.59** |

## *Appendix E: Co-Occurring Disorders Curriculum Syllabus*

| Time Period | Modules | Format | Presenter(s) |
|---|---|---|---|
| Month 1<br>April 8, 2010 | ii. Trainer Orientation (including how to apply Adult Learning Theory) | Whole Day (9:00-4:00) | Christina Grodnitzky DHMH |
| Month 2<br>May 27, 2010 | CC1. People with Co-Occurring Disorders | Whole Day | Dr. Peter Cohen, Tom Godwin, Stasia Edmonston and Joyce Sims |
| Month 3<br>June 10, 2010 | Troubleshooting session and CC3. Substance Use Disorders including TBI | Whole Day | Dr. Peter Cohen and Stasia Edmonston |
| Month 4<br>July 8, 2010 | CC4. Overview of Mental Health Conditions & Terminology | Whole Day | Dr. Lisa Hovermale<br>Dr. Gayle Jordan-Randolph |
| Month 5<br>August 12, 2010 | CC4a. DD/TBI | Whole Day | Stasia Edmonston<br>Dr. Dosia Paclawskyj<br>Joyce Sims |
| Month 6<br>September 23, 2010 | CC2. Treatment and Recovery Philosophies | Whole Day | Cheryl Sharp, Joyce Sims |
| Month 7<br>October 14, 2010 | CC5. Principles for Integrated Treatment | Whole Day | Dr. Peter Cohen<br>Dr. Lisa Hovermale |
| Month 8<br>November 18, 2010 | CC6. Screening and Assessment Skills and Process | Whole Day | Tom Godwin, Dr. Jeff Gary<br>Stasia Edmonston<br>Dr. Dosia Paclawskyj |
| Month 9<br>December 9, 2010 | CC7. Motivational Interviewing and Treatment Strategies including DD/TBI | Whole Day | Dr. Peter Cohen<br>Dr. Lisa Hovermale |
| Month 10<br>February 10, 2011 | CC9. Family, Peer, and Natural Supports<br><br>CC10. Crisis Intervention for People with Co-Occurring Disorders | Morning<br><br>Afternoon | Denise Camp<br><br>Wendy Turner |
| Month 11<br>March 10, 2011 | CC11. Children and Adolescents at Risk for Co-Occurring Disorders | Whole Day | Dr. Peter Cohen<br>Dr. Al Zachik |
| Month 12<br>March 31, 2011 | CC8. Assessing Our Own Attitudes, Motivation, and Health and section on Trauma | Whole Day | Darren McGregor<br>David Washington<br>Brianna Luna |

| | | | |
|---|---|---|---|
| Month 13<br>April 14, 2011 | CC12. Psychopharmacology<br><br>CC13. Ethical and Risk Management<br><br>Wrap-up session and Graduation | Whole Day | Dr. Tom Cargiulo<br><br>Dr. Peter Cohen<br>Dr. Lisa Hovermale |

**Faculty List**

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Christina Grodnitsky, DHMH Training Services
Lisa Hovermale, M.D., MHA and Developmental Disabilities Administration (DDA)
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Theodosia Paclawskyj, Ph.D., Johns Hopkins University – Kennedy Krieger Institute
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David Washington, LCADC, LGSW, AD-PC Sup, Program Coordinator, Jail Substance Abuse Program, TAMAR Program
Washington County Health Department
Al Zachik, M.D., Director of the Office of Child and Adolescent Services, MHA

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