Maryland State
Drug and Alcohol Abuse Council

55 Wade Avenue • Catonsville, Maryland • 21228

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

DEC 14 2012

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 § 9-2805 and Executive Order 01.01.2008.08 - State Drug and Alcohol Abuse Council Annual Update

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

As per House Bill 219, Chapter 661 of the Acts of 2010, I am submitting to you an annual update to the "Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland 2012-2014, on behalf of the Maryland State Drug and Alcohol Abuse Council. This document provides progress on the deliberations and accomplishments of the Council, stakeholders, providers, consumers, public officials and representatives from Local Drug and Alcohol Abuse Councils to address the goals and objectives of the approved Strategic Plan.

This Document continues with the four main goals which are integral to the continuation of the transformation of the substance abuse system to a coordinated and comprehensive Behavioral and Public Health service delivery system. I hope that you find this information useful. If you have any questions regarding this report, please contact Marie Grant, Director of the Office of Governmental Affairs at 410-767-6480.

Sincerely,

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

Enclosure

cc: Kathleen Rebbert-Franklin
Sarah Albert, MSAR # 7442 and 8442

MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL

Annual Update to the 2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland

State Government Article § 9-2805

Executive Order 01.01.2008.08

August 2012

Maryland State Drug and Alcohol Abuse Council Members

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

Beverly 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

Nelson W. Rupp, Jr., 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

Kathleen Rebbert-Franklin, Acting Director
Alcohol and Drug Abuse Administration

Brian M. Hepburn, Director
Mental Hygiene Administration

Patricia Vale, Acting Director
Division of Parole and Probation

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

Alberta Brier/Arleen Rogan* - DJS
Laura Burns-Heffner, SDAAC through 4/12
Tom Cargiulo*, Co-Chair, ADAA through 4/12
Renata Henry, DHMH, through 6/12
Kim Kennedy*, Appointee
Tom Liberatore*, Co-Chair – DOT
Tracey Myers-Preston, MADC
Rosemary Malone/Deborah Weathers-DHR
Kathleen O'Brien*, Treatment Provider
Gale Saler*, MADC
Carlos Hardy*, Appointee

Criminal-Juvenile Justice Workgroup

Kevin Amado, Carroll County
Gray Barton – Problem-Solving Courts
Alberta Brier* – DJS
Laura Burns-Heffner, SDAAC through 4/12
Thomas Cargiulo*, ADAA through 4/12
Robert Cassidy – Treatment Provider
Bonnie Cosgrove, DPSCS
Martha Kumer– Parole and Probation
George Lipman* – District Court
Mark Luckner, DHMH
Patrice Miller (resigned)– DPSCS
Kathleen O'Brien*, Appointment
Ruth Ogle, Parole Commission
Glen Plutschak*, Chair - Appointment
Gale Saler* - MADC
Cindy Shockey-Smith - Treatment Provider
Pam Skelding, DPSCS
Susan Steinberg , DHMH through 10/11
Frank Weathersbee – State's Attorney
Karen Yoke, ADAA

WORKGROUP MEMBERSHIP, continued

***Council member or designee*

Workforce Development Workgroup

Lynn Albizo, MADC
Kevin Amado, Provider
E. Michael Bartlinski, Provider, Subcommittee Chair
Laura Burns-Heffner, SDAAC
Kevin Collins, Provider
Leroya Cothran, DJS
Diedre Davis, BCRC, Inc.
Peter D'Souza, Provider
Stacy Fruhling, Provider
Gary Fry, Provider
Tiffany Hall, Provider
Rebecca Hogamier*, Co-Chair, Provider
Tracey Meyers-Preston, Exec. Dir., MADC
Pat Miedusiewski, DHMH
Tamara Rigaud, Provider
Tracy Schulden, Provider
Cindy Shaw-Wilson, Provider
Pat Stabile, Provider
Oleg Tarkovsky, Provider
Dawn Williams, Provider
John Winslow, Co-Chair, Provider

WORKGROUP MEMBERSHIP, continued

Maryland Strategic Prevention Framework (MSPF) Advisory Council/Workgroup
(Includes State Epidemiological Outcomes Workgroups and Community Implementation Work Groups)

Jackie Abendschoen-Milani, Univ. of Md
Michelle Atwell, DOT
Linda Auerback, Junction, Inc.
First Sergeant H. L Barrett, Maryland State Police
Nora Becker, Prevention, Kent Co.
Karen Bishop, Caroline Co.
Virgil Boysaw, Co-Chair, ADAA
Nancy Brady, Prevention, Garrett Co.
Lori Brewster*, Chair, Wicomico Co.
Laura Burns-Heffner, SDAAC (through 4/12)
Lawrence Carter, Jr., DHMH
Caroline Cash, MADD
Peter Cohen, M.D., ADAA
Kenneth Collins, Substance Abuse Svcs. Cecil Co.
Eugenia Conolly, ADAA
Marina Chatoo, GOC
Larry Dawson, ADAA
Katie Durbin, Liquor Control-Montgomery Co.
Florence Dwek, CSAP
Latonya Eaddy, GOCCP
Elvira Elek, RTI International
Heather Eshelman, Prevention, Anne Arundel Co.
Sue Jenkins, ADAA
Liza Lemaster, MVA-Highway Safety
Sam Maser, Maryland PTA
Rev. S. Menendez, Light of Truth
Dorothy Moore, Prevention, Montgomery Co.
Lauresa Moten, Univ. of Md, Eastern Shore
Francoise Pradel, PhD, UMB
Pat Ramseur, Prince George's Co.
Kathleen Rebbert-Franklin, ADAA
Kirill Reznik*, House of Delegates
Cynthia Shifler, Wicomico Co.
Linda Smith, DFC, Charles Co.
Peter Singleton*, MSDE
Vernon Spriggs, MAPPA
Don Swogger, Frostburg State University
Bill Rusinko, ADAA
Marlene Trestman, Office of the Attorney General
John Winslow, Dorchester Co.
Kathy Wright, Queen Anne's Co.
Lourdes Vazquez, CSAP/CAPT.
Wendy Warfel, Caroline Co.
Danuta Wilson, Community Rep.

Annual Update to the 2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland
July, 2012

INTRODUCTION:

The Maryland State Drug and Alcohol Abuse Council (SDAAC) is pleased to deliver to Governor Martin O'Malley this *Annual Update to the 2012-2014 Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland*. Council members and various collaborating stakeholders have diligently worked over the past 12 months to address important issues in need of improvement and/or enhancement.

During the past year, there has been significant emphasis on the integration of care for behavioral health disorders. The Council has been kept fully informed of the Department of Health and Mental Hygiene's (DHMH's) planning activities for behavioral health integration. Representatives from the Behavioral Health Administration Process Workgroup, the Regulations Workgroup, and the Finance and Integration Options Stakeholder Process Workgroup have attended Council meetings in order to keep membership abreast of the evolving process. Council members have also attended various Workgroup meetings scheduled around the state to have a better understanding of consumer and provider concerns.

The Maryland SDAAC is collaborating with the State of Maryland Advisory Council on Mental Hygiene/Planning Council (Joint Council) to form a joint workgroup to provide further recommendations for an integrated Behavioral Health State Advisory Council.

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 (ROSC).*		
Action Steps	**Responsible**	**Actions and Progress Towards Goals**
1. Continue the ROSC Implementation Plan.	SDAAC,ADAA, Collaboration and Coordination Workgroup	1. The ROSC steering committee has disbanded as there has been a ROSC Division created within ADAA. A member of the ADAA ROSC staff attends the collaboration and coordination workgroup. Technical assistance was provided to Jurisdictional Treatment Coordinators and Prevention Directors at Local Health Departments on continuing care and system transformation starting in October, 2011. Extensive training has been developed by the ROSC Division and is routinely provided to Care Coordinators and Peer Recovery Support Specialists within state and local jurisdictions.
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 Department of Housing and Community Development.		2. SDAAC reviewed SAMHSA's Military Families Strategic Initiative, Service Systems Development Program (SSDP). ADAA established relationships with the Maryland Department of Veterans Affairs-Maryland's Commitment to Veterans Project. Collaborated with the National Guard and the VA Medical Health System to facilitate access for service men and women and veterans to ATR/Recovery Net services.
3. Identify mandates that create barriers/limits to implementation of ROSC such as criminal involvement, zoning issues, etc.		3. Continues to be under review by the workgroup.

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.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**	**Actions and Progress Towards Goals**
1. Continue to perform and review annual survey of resources (in law). 2. Continue to identify gaps in service by level of care, and population 3. Identify barriers to collaboration in service delivery among different departments and agencies. 4. Seek solutions that will overcome those barriers and promote coordination and sharing of resources to ensure availability of recovery support services. 5. Maintain regular communication with the ROSC Division of the ADAA and relevant ROSC Committees and Advisory Boards.	SDAAC Collaboration and Coordination Workgroup, ADAA -ROSC Division	1. - 4. The committee discussed the fact that the Survey summary information was not enough to do an analysis of gaps in service delivery, duplications, or opportunities for improved collaboration or coordination between agencies. The committee agreed that the original purpose of the survey was to improve efficiency in the delivery of services, and this analysis should be one of the main tasks for this workgroup. Members of the workgroup spent several meetings reviewing each State Agency Survey, for gaps, duplications and opportunities for increased collaborations. If further information is needed, agency representatives can be asked to present information relative to programs included in the surveys. Questions about barriers and potential solutions could be raised at that time, or in a separate process as needed. It was agreed that this is a complex project that will require additional support and analysis. 5. Communication with ROSC Division was resolved with the addition of the ADAA ROSC Manager to the workgroup. There are presently 3 peer recovery support specialist (PRSS) workgroups in various stages of activity: 2 of these are managed by the ADAA 1) for providers and the other aimed at 2) clarifying goals and objectives for workforce training and certification for ADAA and MHA support peer support specialist. The 3rd workgroup is facilitated by MHA and its latest goal is to seek Medicaid reimbursement for peer support specialist working in the home health model. As an outcome of Behavioral Health Integration there is consideration to merge the workgroups. ADAA funds awarded to support four (4) additional RCCs in FY 2013. ADAA provided support to a total of two hundred peer recovery support specialist (PRSS) in 20 of 24 jurisdictions.

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.		
6. Encourage collaboration and transfer of information regarding trauma informed treatment. 7. Improve access to treatment information between/among all agency partners, including specific initiatives for: • 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 Program. • 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. • Collaboration between ADAA and the Fetal Alcohol Syndrome Disorder Office to present FASD training to providers at the individual and population levels.		6. Trauma informed treatment information transfer and collaboration will be deferred until there is the Behavioral Health merger between the MHA and ADAA training units. 7. Progress continues in this area related to review and approval of training modules for MVA assessment staff and the provision of updates for the MVA Medical Advisory Board, as well as providing input into the prevention section of the Driver's Education Program. ADAA Women's Services Section collaborating with FHA, DHR and other agencies. A statewide Conference on Women's Somatic and Behavioral Health Issues is scheduled for September 21, 2012.

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.		
(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**	**Actions and Progress Towards Goals**
1. Provide MSPF Implementation grants to the 24 identified MSPF communities, monitor and evaluate the effectiveness of their chosen strategies and interventions.	Strategic Prevention Framework Advisory Committee	1. Fifteen (15) MSPF Community Coalitions are in the final stages of needs assessment & strategy planning and should be approved for MSPF Implementation funding by July 1, 2012.
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.		2. Nine (9) MSPF Coalitions are in the early stage of coalition capacity building and/or needs assessment and will receive the remainder of their FY 13 MSPF funds as they process through the MSPF process. On February 15, 2012 the Community Anti [Drug Coalitions of America (CADCA) conducted training to the community coalitions entitled "Building Coalition Capacity to do the Work". The training focused on the following: Community level change and the role of the coalition; Form follows function; Build capacity to do the work; Building coalition membership; Organizing for success; Enhancing leadership; Fostering cultural competence, and creating a capacity building plan. In addition, the MSPF team conducted over 33 technical assistance meetings to help jurisdictional planning teams to complete their needs assessment, select and orient their MSPF community and lead organization; 19 technical assistance sessions with community level MSPF Leadership Teams, and attendance at 14 MSPF Coalition meetings.
3. The MSPF Advisory Committee's Community Implementation Workgroup 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.		3. The Community Implementation Workgroup (CIW) assisted the MSPF communities in infusing cultural competence and evidence based practices in all of their local SPF assessment and planning activities. To date, there have been five (5) MSPF trainings, four (4) regional community needs assessment workshops conducted, three (3) strategic planning training workshops along with two (2) Community Level Instrument (CLI) trainings conducted. In addition, the CIW has developed, reviewed, and approved guidance documents, checklists and tool kits that assisted community coalitions to assess and plan using evidence based, culturally competent prevention strategies.

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.		
(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**	**Actions and Progress Towards Goals**
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. 2. Implement the assessment survey on a bi-annual basis in all 24 Maryland jurisdictions. 3. The SEOW will conduct an evaluation of the assessment process as needed to determine if State and jurisdiction level data needs are being met and will, along with key agency representatives, make adjustments to the process as necessary.	SPFAC, DHMH, MSDE	1. & 2. The SEOW produced a document titled Maryland's State Epidemiological Workgroup Data Inventory. The Data Inventory provides a summary of the data sources and indicators available nationally and state level related to substance abuse consumption and consequences as well as behavioral health indicators related to substance abuse. Robert Fiedler, Coordinator for the Surveillance & Policy Analysis Center for Health Promotion, DHMH, submitted an update on the progress of the YRBS/YTS survey. A YRBS/YTS RFP was advertised and a team was put together to review the proposals. The YRBS document was circulated to the middle schools for groups to start process of question review. 3. No progress to date- Activities to be implemented as needed.

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.		
(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**	**Actions and Progress Towards Goals**
1. Explore the impact of healthcare reform on substance abuse treatment to: • Help determine who SA will need to be serving including potential individuals not previously served by the system. • Identify the SA services that should be retained in an essential benefit package, particularly services not paid for in any other system. • Assure that services funded are evidence-based. 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	ADAA, DHMH SDAAC	1. A presentation was made for the full Council on September 21, 2012 by Rita Vandivort-Warren, Public Health Analyst for CSAT/SAMHSA regarding Healthcare Reform and the Impact on the Substance Use System. See power point presentation on SDAAC website at http://adaa.dhmh.maryland.gov/SDAAC/ under September 21, 2011 meeting minutes. 2. Potential service integration encompasses three specific areas: Regulations- committee to review both sets of regulations is underway: Administration – looking at possibilities for coordination and true integration of service system: and, Financing group to meet with stakeholders and obtain suggestions about alternative financing structures. There is an open communication process to distribute information, solicit input and build consensus; there are no preconceived notions on how to best make improvements to the system; intention is to proceed with an opportunity for input at each step. See Dr. Sharfstein's memorandum to interested parties and updates at http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx Regulations will reflect system and service integration, promote administrative simplicity, support evidenced based interventions and a person-centered approach. Consultants will perform database review of current benefit management structure, look at other states, identify innovations and developments to improve patient care and propose models to improve outcomes and reduce costs. See the DHMH Final Report on Recommendations for Integrated Healthcare Consultants report presented and discussed on December 21, 2011 at full Council meeting. See Consultants report and related JCR on

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.		
		SDAAC website at http://adaa.dhmh.maryland.gov/SDAAC/ (December 21, 2011 meeting minutes). Updates to the Behavioral Health Integration process were provided at the April 4, 2012 meeting. Criteria for an integrated financial model were presented, workgroups to facilitate recommendations for a financing model were discussed and a timeline for workgroup activity and a final report of recommendations was provided. Discussion was held June, 2012, as to the restructuring of the SDAAC and the Mental Health Advisory Council in light of the merger of the ADAA and the MHA by July 2013. Decision made to form a joint MHA and ADAA workgroup to make recommendations for a Behavioral Health State Advisory Council.
3. ADAA will solicit and provide input on prioritization of existing grant funds 4. ADAA will inform local jurisdictions and partner agencies regarding changing system to include how grant funds will be prioritized and distributed.		3. & 4. ADAA continually communicates with jurisdictional coordinators regarding changes to the system of care that include both treatment and recovery services. Recently approved services for grant funding include: Continuing Care and Recovery Housing. Pending Recovery support Services to be included for funding are: Care Coordination; services within Recovery Community Centers; and Recovery Coaching. One of the public workgroups identified under the Behavioral Health Integration process has been assigned the responsibility of recommending what services should be left outside of a "Medicaid" model to accommodate non-Medicaid populations and services, as well as the role of the locals should perform related to the funding models being reviewed. This work will greatly impact how grant funds will be prioritized and distributed in the future.
5. SDAAC will continue to request/report on data on Medicaid and PAC outcomes related to individuals now covered under MA/PAC system.		5. The Joint Chairmen's Report on Substance Abuse Treatment Services contains information on the increase in access to substance abuse services related to the MA/PAC expansion. See report on SDAAC website www.maryland-sdaac.org under December 21, 2011 meeting minutes. An updated analysis of the November, 2011 Joint Chairmen's report was submitted by Secretary Sharfstein in June, 2012. The report demonstrates that access to substance abuse services have increased (See http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx .

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.		
(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**	**Actions and Progress Towards Goals**
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. 2. Support JIEM implement initiative once funding has been secured 3. Assist providers in their efforts to meaningfully use SMART through the use of Guidance Documents in order to further education on Health IT. 4. Represent behavioral health in the development of the MHIE to ensure confidentiality requirements are met.	DHMH, ADAA, DPSCS, SDAAC	Following passage of legislation in May, 2011 to create a **Prescription Drug Monitoring Program** (PDMP) in Maryland, the ADAA applied for and was awarded, in July, 2011 a $500,000 Byrne Justice Assistance Grant (BJAG) from the Governor's Office of Crime Control and Prevention, and in September, 2011 a $400,000 Harold Rogers PDMP Grant (for 2 years) from the federal Department of Justice, Bureau of Justice Assistance (BJA). These grants fund 3 positions and the information technology necessary to support a state-of-the-art PDMP. With the assistance of the newly-appointed Advisory Board on Prescription Drug Monitoring, the PDMP will electronically monitor the prescribing and dispensing of controlled dangerous substances and provide this information to healthcare practitioners, law enforcement, regulatory agencies and public health professionals on the front lines of the battle against prescription drug abuse and diversion. A presentation on the PDMP was provided on September 9, 2011to inform the State council. See power point presentation on SDAAC website at http://adaa.dhmh.maryland.gov/SDAAC under September 21, 2011 meeting minutes. The PDMP Advisory Board has met quarterly and reviewed information on regulations, funding, information technology, program evaluation and other issues. The proposed regulations will be published on DHMH's website for the 30-day public comment period beginning on June 29th. Discussions continue on program design and a Scope of Work has been developed for PDMP IT. The tentative date for an operational program is March, 2013. The ADAA has also developed and provided a guidance resource for Physicians and other medical personnel on how to prevent the diversion of Buprenorphine. See ADAA website at http://adaa.dhmh.maryland.gov/SitePages/Home.aspx.

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.		
(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**	**Actions and Progress Towards Goals**
1. Create and launch a behavioral health institute to provide continuing education for professionals.	Workforce Development Committee	1. The WDC members are no longer pursuing an institute format, but rather educational opportunities that will support providers in the transformation of the system with regards to both the ACA and BH integration. Members have worked with the Deputy Secretary DHMH, the ATTC and the National Council for Community Behavioral Healthcare to establish a series of workshops that began in February and culminated at the MADC conference in May 2012. The workgroup in collaboration with MADC will hold an education forum on Synthetic Drugs on September 25, 2012.
2. Address the scope of practice to include credentialing, levels and standards.		2. Workforce Development Committee members have been actively engaged in a variety of activities to address scope of practice including Listening Sessions between providers and the Board of Professional Counselors and Therapists.
3. Expand higher education partnerships.		3. WDC has convened a Higher Education Committee to explore a number of issues that have been identified. The Committee's goal is to enhance the pool of qualified professionals by working with higher education partners in the development of system priorities and enhance education delivery, grow the workforce and enhance a crosswalk between courses, licensing and certification requirements. Currently they are completing an official position on the full range of issues that exist regarding higher education and all Board issues.
4. Establish a Career Center on the MADC website.		4. The Career Center has been developed and launched. Providers are using it to share job openings. The web stats demonstrate that it is an increasingly well visited area of the website at www.madc.homestead.com . They continue to outreach to the community and promote opportunities to share openings. They are also exploring how professionals can share their interest in potential employment.

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.		
(New) Objective I.8: Recruit and retain a diverse workforce that is culturally and linguistically competent and sensitive		
Action Steps	**Responsible**	**Actions and Progress Towards Goals**
1. Recruit, train, and advance workforce from diverse backgrounds. 2. Recruit, train, and retain a workforce that is more reflective of the diversity of the community. 3. Design and implement educational programs to ensure that the workforce is both culturally competent and sensitive.	DHMH, Workforce Development Committee	1.-3. As noted above: WDC members have worked with the Deputy Secretary, the ATTC and The National Council for Community Behavioral Healthcare to establish a series of workshops that will begin in February and culminated at the MADC conference in May 2012. The Workgroup in collaboration with MADC will hold an education Forum on Synthetic drugs on September 25, 2012 and another one-day conference in October of 2012 to provide further education for providers.

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**	**Action and Progress Towards Goals**
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 may need.	Criminal-Juvenile Justice Workgroup, ADAA	1. The committee discussed not only looking at inmates who are PAC eligible but also those who are eligible to regain PAC benefits upon their release. It was determined that this is a priority issue to be taken on by this workgroup. The process may be able to be streamlined based on the new offender case management system. The PAC application activity is not being done universally on all inmates. This process is only done within the correctional institution by a transitional coordinator when the inmate requests assistance. It was noted that the Federal Department of Justice continues to advise that benefits can be suspended instead of terminated while incarcerated, making it easier to re-instate or re-activate on re-entry. This issue will be presented to the new Deputy Secretary for Behavioral Health.
2. Continue to promote advances in best practice related to juvenile justice and substance abuse services. Specifically: • 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;		2. DJS is aware that it would be ideal to test all juveniles at intake for substance use. Policy and procedures have been reviewed related to SA screening. The committee thinks it would be beneficial for youth to be able to be screened, and if indicated, assessed for substance use issues at intake. **C**urrently every youth is given a risk assessment, and there are questions about substance abuse on that instrument. Once a youth is adjudicated, he/she is given a needs assessment that also includes substance abuse questions, but not a comprehensive assessment. If a youth is positive on the needs assessment for substance abuse, he/she will be referred for further assessment (SASSIE and/or POSIT). DJS is in the process of updating Substance Abuse policies including the drug testing policy. When a youth is referred to

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.		
• 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 use universally; • 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); • Review data related to referral and placement of DJS adolescents into treatment and drug court; • Encourage expansion of teleconference abilities throughout state.		intake, DJS cannot conduct a urine analysis unless the youth and guardians provide consent. Once they are in the system, DJS either needs consent or a court order to conduct a urinalysis. The SASSI is used to screen youth when they enter a facility. The workgroup discussed the alcohol screening and brief intervention instrument published by NIAAA for practitioners. It was suggested that committee members review Court and Judicial Proceeding §3-8A-10 which is a Statutory Plan regarding screening for substance abuse in juvenile offenders. There was conversation that screening or urinalysis testing of all juvenile offenders is contrary to this statute and recommended that there should be more discussion. DJS requested some TA from ADAA to help choose a standardized, valid screening and assessment tools that can be used statewide. The ADAA provided information on drug and alcohol screening and risk assessment instruments to the workgroup. Data was provided by ADAA to DJS regarding adolescent admissions to treatment facilities by County and the DJS Assessment of Need for FY10. DJS does not keep stats on treatment completion or on youth on informal status. Local inpatient treatment programs prefer that youth be court ordered or placed on formal supervision when sent to their facility. Treatment providers recommended that youth be "monitored" for up to 90 days after any residential service. This will be investigated further by DJS with data from Jackson unit an adolescent residential facility. DJS facilities all have teleconference capabilities.

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.		
3. Inform workgroup on other major efforts related to re-entry and re-entry courts. Specifically: • Obtain and review reports from the Governor's Re-entry Taskforce; • Collaborate with taskforce recommendations where possible; • 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; and • Review current efforts related to re-entry courts including possible pilot projects in local jurisdictions.		3. The Workgroup decided to defer any re-entry issues to the Governor's Task Force on Re-Entry. DPSCS provided the final report and the comprehensive plan for re-entry. Recommendations were made with regard to juvenile transition issues in the areas of case planning, education continuity and the CORP program. Legislative action was proposed regarding reducing barriers to employment, housing and financial stability and GED incentives. Other recommendations included standardization of assessment, data collection and outcome measurement, as well as improving effectiveness and efficiency of offenders moving through the criminal justice system. The workgroup noted the following re-entry initiative recommendations to be in line with this workgroups goals and objectives: a standardized risk and needs assessment at sentencing, continuing at incarceration and community supervision; individual re-entry plan to include treatment and medical needs; availability of sufficient high quality treatment programming; and potentially, transferring through county correctional facilities.
4. Monitor StateStat and GDU dashboard mechanisms for opportunities to collaborate with other agencies that share responsibility for individuals with substance use disorders.		4. StateStat and GDU Dashboard have been reviewed and do not reveal opportunities for specific collaborations at this time. The Council will continue to review periodically with the ADAA Director for new opportunities or developments.
5. Continue to monitor availability of ATR services to offenders leaving jail based treatment programs, and support ADAA in efforts to fully implement ATR with criminal justice clients.		5. Two of the DPSCS institutions are now portal sites for services to offenders through access to recovery. There has been a significant break through in the referral process in that offenders who have 60 or less days left on their sentence are now being identified and referred to the treatment provider within the institution, who is able to determine eligibility and make the referral for services.

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.		
6. Continue to encourage sharing of information via the SMART system between DPSCS and ADAA.		6. A meeting was held with representatives from DPP, DJS, ADAA, and the University of Maryland's IGSR to encourage the usage of SMART among the partnering agencies. The workgroup members continue to think that this is an important issue. DPSCS reported that all of the behind the walls programs were in the final steps of Additions Certification, and should be completed in 2012.Therefore, as a condition of certification; they would be reporting data in SMART. There was discussion regarding potential interface between the Offender Case Management System and SMART, as well as the DPSCS policy change to discontinue reporting of urinalysis through SMART as there will be a new vendor for urinalysis services after May, 2012. The Workgroup recommended there be a mechanism for sharing data between all agencies, and suggested the re-establishment of the Technology Workgroup.
7. Determine how mental health information is currently stored and shared within correctional institutions, as well as possible interfaces to addiction information.		7. Deferred.
8. Determine what outcome information is available related to the 8507 process, including initial placement, treatment and supervision outcomes.		8. SMART data are available for 8505 and 8507 clients upon request from ADAA.

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**	**Actions and Progress Towards Goals**
1. Convene a workgroup of all relevant stakeholders to continue through FY12.	BH and D	
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**	**Actions and Progress Towards Goals**
1. Continue to identify resources serving individuals with co occurring illness. 2. Identify evidenced based practices, interventions and staff competencies needed to facilitate integrating systems of care consistent with ROSC (e.g., housing, employment, etc.). 3. Identify gaps and barriers between existing and necessary resources. 4. Investigate and recommend cost saving models that encourage integration of somatic, mental and addictions care. 5. Obtain information on collaborations related to adolescent co-occurring treatment needs in the juvenile justice system.	DHMH-Behavioral Health Integration Workgroup	1.-5. This goal is being accomplished through the Department of Health and Mental Hygiene Behavioral Health Integration Initiative and will result in an integrated service delivery system encompassing financing, administration, service delivery, and regulations. Extensive public process has been conducted in the development of recommendations for selection of a funding model. Recommendations will be available by September 30, 2012. http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx

Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.		
(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**	**Actions and Progress Towards Goals**
1. Continue the Co-Occurring Academy.	Workforce Dev. Committee & DHMH	1. The Co-Occurring Disorders Supervisor's Academy is in its second phase, with concurrent sessions taking place on the Eastern Shore and in Western Maryland, October 2011-October 2012
2. Establish consistent program and professional standards for integrated service provision.		2. The Workforce Development Committee has been actively involved in all integration activities. Conference calls and provider forums have been held to explore the proposals being set out by the State for consideration. Several responses and position papers have been prepared in response to proposals. They can all be located on the MADC website at www.madc.homestead.com click on Advocacy and the click on Position Statements.
3. Review regulations and accreditations needed to facilitate integration of services.		3. As part of the overall Behavioral Health Integration Initiative, a Regulations Workgroup was convened for the purpose of reviewing methods to integrate the current system of mental health and addictions regulations. See http://dhmh.maryland.gov/bhd/SitePages/Regulations Workgroup_Status_Updates.aspx
4. Recruit and train to expand cadre of professionals qualified in co-occurring care.		4. The workgroup is currently working on opportunities to expand educational activities to include the Core Service Agencies and other mental health providers. A Behavioral Health Cross Agency Workgroup was established in 2011, to develop a plan to integrate the MHA and ADAA training units into a Behavioral Health Training Division. The plan is currently being reviewed by Behavioral Health Integration staff.
5. Train current workforce to service individuals with co-occurring illness.		5. The Co-Occurring Disorders Supervisor's Academy is a collaboration between ADAA, MHA and DDA and provides in-depth training for clinicians from multiple disciplines in the screening, assessment, treatment and support of adults and adolescents with co-occurring mental illnesses, substance use disorders, traumatic brain injury and/or cognitive disability.

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 the State council across future administrations by codifying SDAAC. (Achieved in 2010 with passage of HB 219,Chapter 661 of the Acts of 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 agencies 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**	**Actions and Progress Towards Goals**
Use DHMH website to post plans and progress related to SDAAC activities and receive feedback.	**DHMH**	The Strategic Plan for the Organization and Delivery of Services in Maryland (SDAAC Two Year Plan) has been posted on the DHMH, ADAA and SDAAC websites.

Acronyms Used

ACE	Accelerated Certification for Eligibility
ADAA	Alcohol and Drug Abuse Administration
ATR	Access to Recovery
BH & D	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

Acronyms Used (cont.)

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