# MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL

*Strategic Plan for the Organization and Delivery of Substance Abuse Services in Maryland 2010 to 2012*

**Submitted to Governor Martin O'Malley**
**August 1, 2009**

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## Mandate of the Maryland State Drug and Alcohol Abuse Council

In July 2008, Governor Martin O'Malley issued Executive Order 01.01.2008.08 re-establishing the Maryland State Drug and Alcohol Abuse Council (the Council) and mandated that the group:

- *Develop a comprehensive, coordinated and strategic approach to the use of State and local resources for prevention, intervention, and treatment of drug and alcohol abuse among the citizens of the State.*

The Executive Order further directed the Council to:

- *Promote a coordinated, collaborative, and comprehensive effort by State executive agencies, as well as local councils and State service agencies, to insure the efficient and effective use of State resources for delivery of a full continuum of drug and alcohol abuse prevention, intervention and treatment services for all citizens of Maryland and all citizens within the respective jurisdictions.*

Moreover, the Council was charged with ensuring that:

- *Persons with substance abuse problems who are involved in the criminal justice system and persons with co-occurring substance abuse and mental health problems receive all the specialized services they may need at every stage of system involvement and every level of care; and that*

- *Special attention be given to sustaining the State focus on the impact of drug and alcohol abuse on the health and well-being of Maryland's citizens, the economic and social costs of substance abuse and on demonstrated promising practices in the organization and delivery of effective and efficient prevention, treatment, and evaluation services.*

Specific duties were also articulated, one of which was development of a two year Strategic Plan to be presented to the Governor on August 1, 2009, with an annual report on progress presented each year thereafter. The Governor's public health and safety priorities include increasing the number of individuals receiving drug treatment services.

To accomplish this task, the Council established three workgroups: the Safer Neighborhoods Workgroup, the Healthier Maryland Workgroup, and the Planning and Coordination Workgroup. These workgroups were composed of Council members, stakeholders, providers, consumers and recognized experts in the field of substance abuse services. Each workgroup met an average of six times between January and June 2009. Members reviewed relevant data, information on the strengths, weakness, opportunities and threats concerning the organization and delivery of substance abuse services in Maryland, and the most current strategic plan each of the jurisdictions have submitted to the Alcohol and Drug Abuse Administration.

Subsequently, the workgroup members generated a list of service delivery issues, and prioritized concerns that should be addressed first in the strategic plan (i.e., an integrated human services database and a response to the current workforce crisis) as they establish a foundation for attending to the longer term challenges.
The Safer Neighborhoods Workgroup and the Healthier Maryland Workgroup submitted their lists of concerns for the current service delivery system to the Planning and Coordination Workgroup. The Planning and Coordination Workgroup reviewed the work of both workgroups, combined and prioritized the recommendations, and issued a report to the full Council to inform members of their deliberations and decisions at the June 24, 2009 Strategic Planning Retreat.

## System Strengths and Challenges

A key aspect of preparing for the Strategic Plan was identification of system strengths and challenges. An extensive list of strengths was solicited from individuals and major stakeholder groups throughout Maryland. A cursory glance at this list might lead a reader to conclude that the "system" is sufficient and that nothing additional is needed in order to meet the needs of individuals with substance abuse problems. However, as stakeholders agreed, such is not the case as every strength is mitigated by significant challenges.

For example, stakeholders said that the current funding system provides jurisdictions the latitude to network, provide case management services, interact collaboratively with other agencies, organizations, institutions, etc. as needed to accomplish the overall mission of providing prevention, intervention, and treatment services. They agreed as well that the structure of an administration (ADAA) that listens to and is responsive to the needs of the substance abuse field (to the degree that funding allows) is a strength.

On the other hand, they found that multiple public departments and agencies use their resources to provide services to the same individual with the mutual goal of returning the individual to health and productivity. While the resources available through one agency may be insufficient to meet all the needs of the individual, often public agencies fail to coordinate with other service agencies to leverage the use of all resources available to that individual for maximum benefit for his/her recovery/re-entry.

Public agencies often operate in silos, with their own eligibility criteria and their own individual policies and procedures for the distribution of their resources. There is little collaboration or coordination in the use of these resources to ensure maximum benefit to the client. Sometimes this is a result of categorical funding and restrictions placed on the use of dollars by the awarding entity. Other times, it is the result of agency policies and procedures that fail to take a holistic approach to assisting the individual.

A significant strength is a service-delivery system that, for the most part, is effective in responding to those in need. Though far from perfect, the interaction and cooperation shown by and among providers from all sectors (public, non-profit, and for-profit) is evidence of a strong, viable system of care. Those in the greatest need with the fewest resources can be and are seen and served with care and compassion. Treatment agencies collaborate well in regard

to sharing best treatment practices and business practices; patient matching is driven by clinically sound criteria (ASAM PPC II-2R); some programs are adopting "trauma informed" counseling to address the high prevalence of post-traumatic stress disorders among the population served; and residential care for adults, including inpatient detoxification, is available either jurisdictionally or regionally.

Like many other states, though, Maryland has not integrated current research-based evidence that demonstrates substance use conditions as chronic illnesses into a system of care that provides access to appropriate levels of care across the lifespan of the illness. Substance abuse services continue to be organized and delivered predicated on the view of substance use conditions as acute illnesses. State agencies/departments that provide services to individuals with substance use conditions do not always coordinate/collaborate to maximize the use of their available resources to ensure optimum benefit to these individuals in support of attaining and sustaining recovery.

It is critical to successful rehabilitation of offenders, for example, that appropriate services and levels of care are available to them in a timely manner at the point of entry the criminal justice system, throughout their engagement with and as part of their reentry to the community. Too often there is a waiting list to access substance abuse treatment services or a lack of the appropriate level of care within the jurisdiction when the offender is transitioning to the community. This results in lost opportunity for rapid engagement before the offender relapses into old behaviors. Likewise, the use of drug court and/or other intensive supervision strategies is limited. These problems can be attributed to the lack of funding for services, the lack of recognition of the need for these services and coordination among agencies serving the offender, and failure to fully explore the use of drug courts as a means of supporting successful re-entry and reducing recidivism. Offenders re-entering the community are often faced with a lack of services, lack of service coordination, and insufficient support and monitoring during the critical days immediately following his/her release from incarceration. This lack of adequate and coordinated services and sufficient supervision promotes relapse into criminal and substance using behavior and, thus, return to an institution.

In addition, substance use prevention methods and technology are not widely known by the general public or even substance use professionals. Because of this, prevention services are neither adequately funded nor adequately used in Maryland's strategy to address substance use. This lack of awareness and knowledge is not only a deficit in Maryland. Nationally, prevention services receive considerably less funding than treatment services, and best-practices in prevention services are generally less known then those in treatment. In the main, this is due to an outdated and erroneous notion that prevention strategies and interventions are not well-researched and therefore not "evidence-based."

Another strength is the workforce, a cadre of clinicians who are generally well trained and highly committed to their jobs. They are dedicated and passionate about helping people remain alcohol and drug free and continue in recovery. Moreover, the workforce has grown in its collective perception of the value of performance-related data and a recognition that simultaneous and integrated treatment can be provided for those with, for example, co-occurring disorders.

Even so, there is a critical shortage of behavioral healthcare workers both entering and staying in the field of substance abuse prevention, intervention and treatment, and a critical shortage of professionals currently practicing in the field who are sufficiently trained and skilled in working with the variety of disorders presented by individuals seeking substance abuse services in Maryland. Any attempt to improve the organization and delivery of services within Maryland must address the barriers to eliminating this shortage, including the stigma associated with substance use; the lack of an active campaign by Maryland's public education system at the secondary and postsecondary levels; licensing and credentialing regulations that are difficult to implement while at the same time promoting quality care and protecting consumers; inadequate salary and benefits; and so on.

Data and information technology offers, at least the potential of, an important system strength. Maryland's ability to harness available and newly-developed/developing technologies and availability of multiple data sets provides a view to stakeholders of how well the system provides services and the needs and challenges that remain. The State of Maryland Automated Record Tracking System (SMART) is useful in the transitioning and coordination of services for the population served. The system is managed by data enabling more accurate decision-making.

Nonetheless, the lack of an integrated health and human services database—the result of a lack of a uniform state plan requiring state departments and agencies to use the same database system or one that interfaces with an identified primary system—promotes inadequate coordination and poor management of services offered by multiple agencies (those in DHMH, DHR, DJS, DPSCS, DHCD, the Judiciary, and others), often to the same client. This lack of coordination and management of services results in failure to leverage dollars for effective and efficient use of resources and failure to provide quality, "wrap-around" services for those individuals in need. Additionally, it promotes a waste of State resources when employees in one agency have to collect and enter the same data another employee from a different agency just collected and entered into a different data base. An integrated data base that can capture an individual's current status and progress in recovery as he/she interfaces with multiple social agencies is critical to the development of a quality recovery-oriented system of care, can enhance the system's capacity to collaborate among departments and agencies in providing services, and can maximize the use of resources available to assist those in need.

At various points during an individual's interface with the health care and justice systems, psychosocial and behavioral screenings and assessments are conducted. The results of these evaluations and interchanges with the individual do not routinely follow the individual as they move through these systems. This failure results in duplicative work for the different agencies/institutions with which the individual comes in contact and in poor case management/treatment planning, as all the information known about the individual is not available when decisions about appropriate levels of care and placement are made. All information known by the various agencies/institutions about an individual should become part of a case record that travels with the individual as he/she moves through the multiple social systems.

## A Recovery Oriented System of Care: The Intended Outcome of the Council's Strategic Plan

During their deliberations the Planning and Coordination workgroup also recommended including in the Strategic Plan the goal of moving Maryland's service delivery system towards a recovery-oriented system of care (Appendix A), an approach promoted by the federal Department of Health and Human Services/Substance Abuse and Mental Health Services Administration. This recommendation becomes the intended outcome for the Strategic Plan and is consistent with the vision for the Council articulated by its members on December 9, 2008:

***To promote and support prevention and recovery for the citizens of Maryland.***

Recovery is conceived as an on-going process in which an individual accesses a variety of formal and informal resources, across his/her life-span, in the service of attaining and maintaining a healthy and productive lifestyle. Maryland's current system of care for substance use conditions is focused on formal treatment resources, with insufficient attention to ensuring the presence of, and access to, wrap-around recovery support services critical to sustaining recovery.

Adopting a recovery-oriented model requires many changes in how substance use conditions are approached, including how individuals access services and programs, what services are funded, what and how data are collected and—perhaps most important—who is involved in such a system. For it is not only the treatment provider or the detox counselor or the drug court supervisor who plays a role. It is, instead, every agency and organization that touches the lives of individuals with substance use problems, including the housing counselor, the employment coach, the nutritionist, the parenting trainer, the educator, the pastor. The list goes on.

A recovery oriented system recognizes that many individuals with substance use problems also have a co-occurring mental illness. Thus, a truly comprehensive system will focus on behavioral health (substance abuse and mental health) and not on one or the other. This, then, requires even more "out of the box" thought and action. In fact, one Council member suggested that the name of the Council be changed to The Recovery Oriented System of Care Council—and that its focus be broadened to include mental health

However, the "co-occurring" mental health condition is really only one of the "co-occurring" conditions that must be addressed to achieve recovery. Many addicts and abusers have co-occurring somatic health conditions, such as HIV/ADS and Hepatitis C. Many do not have Axis I mental illness, but have personality disorders that endanger the individual her/himself as well as others. Some may need to address "cognitive processes" that lead to criminal thinking, although not to the level of formal diagnosis; and still others may simply need assistance in obtaining shelter, food, education, and job skills as well as general help in navigating a system of assistance that too often is unable to assist the individual coming in through the "wrong door."

## Guiding Principles

All three workgroups affirmed several principles to guide and inform the organization and delivery of all substance abuse services in Maryland and all outcomes related to the strategic plan. Two paramount principles are pursuit of quality health care, and cultural and linguistic competency.

Quality Health Care:

In *Crossing the Quality Chasm*, the Institute of Medicine identified six aims of quality health care, i.e., that it be safe, effective, patient/client centered, timely, efficient, and equitable. Moreover, the report iterated a set of rules governing the provision of such care that:

- It is based on continuous healing relationships
- It is customized based on patient/client needs and values
- The patient who is the source of control
- Shared knowledge and the free flow of information is key
- There is evidence-based decision-making
- Safety is a system property
- There is a need for transparency
- Patient/client needs are anticipated
- There is a continuous decrease in waste
- There be cooperation among clinicians

The aims and the rules iterated in the report comport precisely with a Recovery-Oriented System of Care.

Cultural and Linguistic Competency:

Cultural competence requires that the organizations, agencies and programs that comprise Maryland's substance use system of care have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally; and the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve. Moreover, system participants must incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities; sanction, and in some cases mandate the incorporation of cultural knowledge into policy making, infrastructure and practice; and embrace the principles of equal access and non-discriminatory practices in service delivery.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic

competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity:

- services and supports are delivered in the preferred language and/or mode of delivery of the population served.
- written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served.
- interpretation and translation services comply with all relevant Federal, state, and local mandates governing language access.
- consumers are engaged in evaluation of language access and other communication services to ensure for quality and satisfaction.

No Wrong Door:

In addition, Council members agreed that there should be "no wrong door" for entry to the system or its services. There should be multiple points of access to services, programs, and supports facilitated by a cross agency integrated data base—one of the strategies described in the Strategic Plan below.

Seamless Services:

Once a person enters the system, s/he should expect to easily access a wide range of services and move between these services in a seamless, uncomplicated way. This will require case management capabilities that ensure the needs of individuals can be met without requiring reentry into the service delivery system. As well, there should be neither service gaps nor overlap.

Strategic Plan Oversight and Management:

A final consideration of the Council was that given the extensive time, knowledge, and experience they, and other workgroup members who are not on the Council devoted to the process of producing this Strategic Plan, every attempt should be made to assure it is implemented and acted on, and not end up, as so many others, as a great plan never executed. Accordingly, members recommend the establishment of a strategic plan governance workgroup. This workgroup would be responsible for monitoring progress at regular intervals and reporting their findings to the Governor through the Council. This principle has been incorporated into Goal IV of the Strategic Plan.

## A Strategic Plan to Capitalize on System Strengths and Address the Challenges

The Council's purposes and major duties are defined by Governor O'Malley's executive order, and the pathway to achieving these goals is informed by research, best practice, and common sense. Council members fully understand that the anticipated outcome, *A coordinated, State-mandated Recovery Oriented System of Care,* will not be achieved in six months, or a year, or

even the two years of the Strategic Plan. Accordingly the goals set forth on the following pages look further into the future; objectives may/may not be accomplished in the two-year time frame while most action steps should be completed. Members know, as well, that human and financial resources to implement the Plan are limited and somewhat uncertain, and will require involvement and buy-in from others beyond the Council's membership.

Nonetheless, Council members are eager to move forward.

# STRATEGIC PLAN FOR THE MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL
## Overview

***OUTCOME: A COORDINATED, STATE-MANDATED RECOVERY-ORIENTED SYSTEM OF CARE (ROSC)***

**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. (Purposes 1, 2, 3 per Executive Order)**

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

Objective 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.

Objective 3**:** Promote the use of prevention strategies and interventions by informing stakeholders of the seven strategies to effect change considered by the Substance Abuse and Mental Health Service Administration to be best practices in prevention: information dissemination, prevention education, alternative activities, community-based processes, and problem identification, environmental.

Objective 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.

Objective 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.

Objective 6: Ameliorate the workforce shortage crisis.

**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. (Purpose 4 per Executive Order)**

Objective: 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**: **Improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems. (Purpose 5 per Executive Order)**

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

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

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

Objective 4: Provide adequate resources to support workforce development.

**Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse (Purpose 6 per Executive Order)**

Objective 1: Sustain mission and work of State council across future administrations.

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

# A STRATEGIC PLAN FOR THE MARYLAND STATE DRUG AND ALCOHOL ABUSE COUNCIL
## August 1, 2009

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

| **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.** | | |
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| Objective 1: Involve all relevant agencies in developing a Recovery Oriented System of Care. | | |
| Action Steps | Measures | Responsible |
| Identify the key state departments that play a role in the ROSC.<br>Create a Council by Executive Order.<br>Identify current business practices that contribute to/support the ROSC.<br>Identify and eliminate redundancies.<br>Identify mandates that create barriers/limits to as well as opportunities for efficiencies. | The number of patients overlapping in each system (discrete process measures)<br><br>The unified consistent outputs in ROSC<br><br>Outcome measures for ROSC | DHMH, DPSCS, DJS, DHR, DHCD, MSDE, GOC, GOCCP, SDAAC |
| Objective 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 | Measures | Responsible |
| Convene a workgroup of the Council to:<br>a) review survey of resources.<br>b) identify gaps in service by level of care, region and population.<br>c) identify barriers to collaboration in service delivery among different departments and agencies.<br>d) develop policies and procedures that will overcome those barriers and promote coordination and sharing of resources to ensure availability of recovery support services.<br>e) develop shared MFRs to promote coordination and collaborations among these departments. | Workgroup convened by 10/30/09<br><br>Policies and procedures and shared MFRs developed by 9/30/2010<br><br>Reduced waiting times for care<br><br>Increased services and supports | DHMH, DPSCS, DJS, DHR, DHCD, MSDE, GOC, GOCCP, SDAAC |

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|---|---|---|
| **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.** | | |
| Convene a workgroup to:<br>a) develop policies and procedures that facilitate the funds available in each department following client through the multiple systems of care with which s/he interfaces in order to improve patient outcomes.<br>b) develop MFRs for the multiple agencies that provide services to individuals with substance use conditions and monitor accountability and outcomes through Subject Stat. | Policies and procedures developed by 9/30/10 | DHMH, DPSCS, DJS, DHR, DHCD, MSDE, GOC, GOCCP, SDAAC |
| Objective 3**:** Promote the use of prevention strategies and inventions by informing stakeholders of the seven strategies to effect change considered by the Substance Abuse and Mental Health Service Administration to be best practices in prevention: information dissemination, prevention education, alternative activities, community-based processes, problem identification, environmental approaches, and referral. | | |
| Action Steps | Measures | Responsible |
| Present information on the seven strategies to major stakeholder groups and coalitions, and to the Local Drug and Alcohol Abuse Councils. | Presentations to groups completed by 7/1/10 | MAPPA, ADAA, MADC, SDAAC |
| Objective 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. | | |
| Action Steps | Measures | Responsible |
| Ensure all stakeholder groups, provider groups, and consumer groups have input into all the workgroups that are meeting or will be meeting concerning services funded under the new structure.<br><br>Ensure the decisions made about the funding structure for substance abuse services and services to be funded are informed by the principles of a recovery oriented system of care.<br><br>Develop mechanisms to ensure seamless transition of coverage for individuals reentering the community from incarceration. | List of relevant stakeholder groups completed by 01/15/10<br><br>ROSC assessment procedure in place by 01/15/10<br><br>TBD | DHMH<br><br>DHMH, DPSCS |
| Objective 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. | | |
| Action Steps | Measures | Responsible |
| Identify service utilization trends and track outcomes based on the principles of a recovery oriented system of care | Technology Group established by 10/1/09 | Governor's office, SDAAC, designated |

| **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.** | | |
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| Establish a technology workgroup, with members from health and human services and the criminal justice system, to develop a plan, by August 1, 2010 to implement, and monitor a plan to have an integrated database. (See Appendix C, *Workgroups' Report to the Council, pp. 8-9 for detailed steps).*<br><br>Establish an Access to Care Workgroup charged with developing a plan, by 08/10/10 to create a database with the capability of serving as a reservation system for available treatment slots/beds. (See Appendix C, *Workgroups' Report to the Council, pp.8-9 for detailed steps).*<br><br>Establish protocols for the timely sharing of information gathered by one agency with other agencies providing services to offenders to improve treatment/case planning. (See Appendix C, *Workgroups' Report to the Council, pp. 8-9 for detailed steps).*<br><br>Secure a requirement from the Governor's Office that all designated department database systems are interactive and the requirement of an interactive database is incorporated into all State RFPs, contracts, work orders, etc. | Plan developed by 08/01/10<br><br>Quarterly reports submitted beginning 1/15/10<br><br>Integrated database completed by 02/11.<br><br>Access to Care workgroup established by 10/1/09<br><br>Plan developed by 08/01/10.<br><br>Reservation system established by 08/01/11.<br><br>Protocols established by 08/01/10. | departments |
| Establish an electronic Consumer Record workgroup to develop a comprehensive, portable case management/treatment record:<br>a) Determine content of the record.<br>b) Determine which agencies/departments should participate.<br>c) Identify relevant privacy laws and regulations and ensure compliance.<br>d) Interact with Technology Workgroup to ensure integration and feasibility with identified primary database. | Electronic Consumer Record developed and in place by 09/30/10 | DHMH, DPSCS, DJS, DHR, DHCD, MSDE, GOC, GOCCP, SCAAC |
| Objective 6: Ameliorate the workforce shortage | | |
| Action Steps | Measures | Responsible |
| Improve recruitment: | | MSDE, MHEC, |

| **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.** | | |
|---|---|---|
| a) Develop a marketing Objective to actively raise the awareness of students in high schools and colleges/universities of opportunities in the field of substance use services. | Marketing Objective completed 6/1/10 | BOPCT, MADC, MAPPA, MD. Office of Personnel, ADAA, SDAAC, LDAACs, HRSA |
| b) Place substance use curricula track in all behavioral healthcare departments in Maryland's higher education institutions, including increasing the number of institutions that offer a fifteen credit minor in substance use service. | Substance use curricula track in place by 01/1/11 | |
| c) Review benefit and salary packages offered by public and private providers within the State and in contiguous states with the goal of publishing standards of compensation and establishing a financing structure for the purchase of substance abuse services that takes into account adequate compensation for providers. (This should include provider administrative and clinical positions and employees of the Alcohol and Drug Abuse Administration) | Review completed by 07/1/10 | |
| d) Identify those personnel policies at local and state levels that pose barriers to timely hiring of staff with the goal of eliminating those barriers through changing policies or temporarily granting exceptions to those policies during the workforce shortage crisis**.** | Barriers identified 01/15/11 | |
| e) Review current loan forgiveness programs and explore ways to maximize its use. Explore the use of "sign-up" bonuses to attract candidates to the field. | Review completed 01/15/11 | |
| f) Identify methods to actively use existing "pipelines" and programs that provide career counseling to young adults. Identify opportunities in current stimulus package for workforce development. (HRSA training money) | Identification completed/reported 01/15/10 | |
| g) Identify methods of bringing individuals in recovery into the workforce and seek ways to reduce the barriers that prevent them from joining the workforce (certification and licensure, education and training, etc.). | Identification completed 01/01/11 | |

| **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.** | | |
|---|---|---|
| h) Work with licensing/certifying authority and state legislature to identify methods of increasing the number of approved individuals in the workforce during this work force crisis. | Identification completed 01/15/11 | |
| Improve retention:<br><br>a) Explore salary structure and other compensation packages, including retention bonuses.<br><br>b) Develop a state-wide, structured mentoring program to develop clinical, administrative and leadership skills in current workforce.<br><br>c) Develop structured progressive training curricula on leadership for the entire workforce from the beginning counselor/preventionist to the "seasoned" program manager.<br><br>d) Develop a state-wide system of quality supervision, including an on-going training and preceptorship program. | <br><br>Review completed 01/15/10<br><br>Program developed 01/15/11<br><br>Curricula developed 01/15/11<br><br>Supervision system completed 01/15/11 | |

| **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 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 | Measures | Responsible |
| Identify and address impediments to transfer of information about clients among designated agencies and among staff at all stages of the criminal justice process. (All records should travel with the client/offender as they move through the criminal justice and health/human services systems.)<br>Identify information needed to produce a quality, comprehensive evaluation.<br><br>a. Ensure well-trained practitioners are providing these clinical services. | Barriers to information exchange identified and addressed by 09/30/10 | DOC, DPP, Judiciary, DPSCS, ADAA, DJS |

| **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.** | | |
|---|---|---|
| b. Identify and implement use of evidence-based instruments and assessment methods/tools that are in the public domain or low in cost, and that have high reliability across interviewers/raters.<br>c. Develop protocol to screen and assess individuals immediately at point of first contact with the criminal justice system (e.g., courthouse).<br>d. Establish continuum of care plan to be shared with all involved agencies prior to release. | | |
| Expand services for offenders with co-occurring disorders by jurisdiction where appropriate.<br><br>Expand the use of evidence-based substance abuse treatment interventions for offenders (promising practices).<br><br>Expand jail-based programming.<br><br>Expand access to buprenorphine.<br><br>Expand number of drug courts and bring caseloads up to a manageable capacity.<br>a. Establish dialogue with Office of Public Defender to address their concerns about drug courts.<br>b. Reduce restrictions on drug court eligibility to increase caseload.<br><br>Increase number of parole and probation agents to meet the "special population need" of drug court clients. | Task force convened by 11/1/09<br><br>Using 2009 data as baseline:<br><br>Increased number of personnel<br><br>Increased number of treatment slots<br><br>Increased number of jail-based programs<br><br>Expanded access to medication-assisted treatment | DOC, DPP, DPSCS, ADAA, DJS |
| Explore promising practices in offender re-entry<br>a. Explore use of re-entry courts as a best practice for prisoner re-entry.<br>b. Promote state-wide use of promising practices in offender re-entry being used in some jurisdictions such as Montgomery, Wicomico and Dorchester Counties, and other identified programs.<br>c. Assess detention center reentry linkages by jurisdiction—identify barriers, | Task force on reentry convened by 11/1/09<br><br>Two demonstration projects in place by 1/1/11 | DOC, DPP, DPSCS, ADAA, Judiciary, DJS |

| **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.** | | |
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| challenges, strengths, best practices, etc to successful treatment engagement.<br>d. Explore establishment of half-way in/half-way out programs.<br><br>Examine barriers to timely and appropriate, evidence-based incentives for positive behavior and sanctions to avoid relapse into recidivism.<br><br>Expand demonstration sites for evidence based practices.<br>a. Increase the number of sites.<br>b. Secure funding for expansion in urban, rural, and suburban settings.<br>c. Utilize funds re-allocated from less effective programs to support statewide demonstration of evidence based practices (e.g., multi-jurisdictional aftercare planning before release). | | |

| **Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.** | | |
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| Objective 1. Engage state and local stakeholders in creating a coordinated and integrated system of care for individuals with co-occurring problems. | | |
| Action Steps | Measures | Responsible |
| Convene a workgroup of all relevant stakeholders.<br><br>Develop a state plan for coordination and integration of DHMH administrations.<br><br>Develop a local plan for coordination and integration of local DHMH services.<br><br>Execute a MOU for the coordinated/integrated system involving all stakeholders. | State and local workgroup formed 01/10<br><br>State Plan written and approved by stakeholders 06/10<br><br>Local Plan written and approved by stakeholders 06/11<br><br>MOU finalized 07/11 | Deputy Secretariat for BH & DDA |
| Objective 2: Integrate and coordinate existing services and resources to service individuals with co-occurring illness evidenced by expansion of service provision. | | |

| **Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.** | | |
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| Action Steps | Measures | Responsible |
| Identify existing resources serving individuals with co occurring illness<br><br>Identify a method and models to integrating systems of care consistent with ROSC (e.g., housing, employment, etc.).<br><br>Identify gaps between existing and necessary resources.<br><br>Provide integrated and coordinated resources and services to achieve long term recovery.<br><br>Establish consistent program and professional standards for service provision and reimbursement across administrations (MHA,ADAA, DDA). | Inventory of current providers capable of providing services to individuals with co-occurring illness by 12/09<br><br>Multiple models identified by 1/10<br><br>Selection of model(s) for implementation by 6/10<br><br>Gap analysis by jurisdiction and by population and updating of current needs from CESAR by 3/10<br><br>Using 2009 data as a baseline, increase by 50% number of individuals with co-occurring illness who are receiving supportive housing, employment, substance abuse and mental health treatment, education health care, etc. by 6/12.<br><br>6- and 12-month standards for delivery of services to persons with co-occurring illness | MHA, ADAA, DDA CESAR, DHMH, DHCD, SDAAC |
| Objective 3: Recruit, train workforce to provide services to persons with co-occurring illness. | | |
| Action Steps | Measures | Responsible |

| **Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.** | | |
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| Establish workforce standards.<br><br>Identify training needs.<br><br>Train current workforce to service individuals with co-occurring illness.<br><br>Recruit and train for co-occurring professionals. | Current COD workforce standards<br><br>Baseline established for COD workforce standards | Maryland Commission of Higher Education, Professional Counselors and Therapists, OETAS |
| Objective 4: Provide adequate resources to support workforce development | | |
| Action Steps | Measures | Responsible |
| Identify existing intellectual and financial resources.<br><br>Identify gaps between existing and required resources for training and service provision. | Resources identified by 3/10 | DHMH, MHA, ADAA, DDA |

| **Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse** | | |
|---|---|---|
| Objective 1: Sustain mission and work of State council across future administrations by codifying SDAAC. | | |
| Action Steps | Measures | Responsible |
| Educate legislators and policy makers regarding need for continuity of State Council to help guide and lead Recovery Oriented System of Care. | Council legislation enacted during 2011 legislative session | MADC, NCADD |
| Objective 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 | Measures | Responsible |
| Convene annual joint meeting of state and local councils.<br><br>Use data to emphasize the links between public safety and behavioral health problems.<br><br>Engage local councils in targeted communications efforts in all 24 jurisdictions. | Meeting held annually in October | Governor's Office, SDAAC |
| Objective 3: Publicize the progress made by the Council in facilitating establishment of a Recovery Oriented System of Care. | | |
| Action Steps | Measures | Responsible |

| **Goal IV: Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse** | | |
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| Create a strategic plan governance workgroup or oversight committee of the Council.<br>a) Identify Strategic Plan priorities.<br>b) Appoint Council members to the various workgroups called for in the Plan.<br>c) Charge workgroups with refining the action steps for which they are responsible, with specific tasks, time lines, and persons responsible.<br><br>Monitor progress of the Strategic Plan at quarterly intervals.<br><br>Make recommendations to the Council if modifications in the Plan are warranted.<br><br>Annually report findings to the Governor.<br><br>Issue, statewide, a Report Card on the progress of the Council and the Strategic Plan. | Workgroups established<br><br>Workgroup tasks delineated<br><br>Quarterly reports to the Council<br><br>Annual Report to the Governor<br><br>Report Card to the citizens of Maryland | SDAAC |

# Appendix A

## RECOVERY – ORIENTED SYSTEM OF CARE

**One Definition of Recovery**:
Recovery from alcohol and drug addiction is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.
Abstinence includes use of medication as prescribed by an authorized health care provider.

**Guiding Principles**:

- There are many pathways to and through recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change
- Recovery is holistic
- Recovery has cultural dimensions
- Recovery exists on a continuum of improved health and wellness
- Recovery emerges from hope and gratitude
- Recovery involves a process of healing and self-redefinition
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery is supported by peers and allies
- Recovery involves (re)joining and (re)building a life in the community
- Recovery is a reality

**Elements of a Recovery Oriented System of Care:**

- Person centered
- Family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally responsive
- Responsive to personal belief systems
- Commitment to peer recovery support services
- Inclusion of voices and experiences of recovering individuals and families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes driven
- Research based
- Adequately and flexibly financed

# Appendix B
# Acronyms Used

| | |
|---|---|
| ADAA | Alcohol and Drug Abuse Administration |
| ASAM PPC-2R | American Society for Addiction Medicine Patient Placement Criteria, 2nd Edition-Rev. |
| BH & DD | Deputy Secretariat for Behavioral Health and Disabilities |
| BOPCT | Maryland Board of Professional Counselors and Therapists |
| CESAR | Center for Substance Abuse Research |
| 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 | Department of Corrections |
| DPSCS | Department of Public Safety and Correctional Services |
| GOC | Governor's Office on Children |
| GOCCP | Governor's Office on Crime Control and Prevention |
| HRSA | Health Resources and Services Administration |
| LDAACs | Local Drug and Alcohol Abuse Councils |
| MADC | Maryland Addiction Directors Council |
| MFR | Managing for Results (Performance measures) |
| MHA | Mental Hygiene Administration |
| MHEC | Maryland Higher Education Commission |
| MSDE | Maryland State Department of Education |
| NCADD | National Council on Alcoholism and Drug Dependence |
| OETAS | Office of Education and Training in Addictions Services |
| ROSC | Recovery-Oriented System of Care |
| SDAAC | State Drug and Alcohol Abuse Council |

# Appendix C
# Workgroup Report to the Council
# PP. 8-9

### 3. Integrated Database

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| 1. PROBLEM STATEMENT | **What?:** The lack of an integrated health and human services database promotes inadequate coordination and poor management of services offered by multiple agencies (those in DHMH, DHR, DJS, DPSCS, DHCD, the Judiciary, and others), often to the same client. This lack of coordination and management of services results in failure to leverage dollars for effective and efficient use of resources and failure to provide quality, "wrap-around" services for those individuals in need. Additionally, it promotes a waste of State resources when employees in one agency have to collect and enter the same data another employee from a different agency just collected and entered into a different data base. An integrated data base that can capture an individual's current status and progress in recovery as he/she interfaces with multiple social agencies is critical to the development of a quality recovery-oriented system of care, can enhance the system's capacity to collaborate among departments and agencies in providing services, and can maximize the use of resources available to assist those in need.<br><br>**Why?:** This lack of an integrated database is the result of a lack of a uniform state plan requiring state departments and agencies to use the same database system or use one that interfaces with one identified primary system. |
| STRATEGY 3. | 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. |
| ACTIVITIES | 1. Establish a technology workgroup, with members from health and human services and the criminal justice system, to develop, implement, and monitor a plan to have an integrated database by **February 2011**. The workgroup shall establish a plan with benchmarks and timelines that: a) determines the data that needs to be collected and shared, with special attention to the data collection needs of a recovery-oriented system of care; b) determines the state departments and divisions that must participate in an interactive database; c) determines the primary database platform with which all identified department databases will be mandated to interface; and, d) develops guidelines to be incorporated in all State requests for proposals, contracts, work orders, etc. requiring, when appropriate, that databases used be able to interact with the identified primary database. This work group shall submit quarterly progress reports to the Governor through the Maryland State Drug and Alcohol Abuse Council. **Complete by: August 1, 2010.**<br>**2.** Establish an Access to Care Workgroup charged with developing a plan |

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| | to create a database with the capability of serving as a reservation system for available treatment slots/beds. The workgroup shall: a) explore existing and new databases for the feasibility of providing this service, and the cost associated with developing the system; b) select the program/database to be used; c) set and monitor timelines for progress toward establishing the reservation system by **August 1, 2011**; and, d) submit quarterly reports to the Governor through the Maryland State Drug and Alcohol Abuse Council. **Complete by**: **August 1, 2010.**<br>3. Establish protocols for the timely sharing of information gathered by one agency with other agencies providing services to offenders to improve treatment/case planning. Initially, this can be done through the transferring of hard copies of documents among agencies. Eventually, it should be accomplished through an integrated database. It is expected that all data/information sharing will be done in such a manner as to comply with all relevant federal, state and local laws and regulations protecting the confidentiality of the client/offender. **Complete by: August 1, 2010.** |
| OUTCOMES | The Governor's Office requires all designated department database systems to be interactive and the requirement of an interactive database is incorporated into all State RFPs (Requests for Proposals), contracts, work orders, etc. |
| ACCOUNTABLE | Governor's office, SDAAC, designated departments. |