Report Number 2015-13 July 28, 2015

Behavioral Health in Montgomery County

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OLO Office of Legislative Oversight

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EXECUTIVE SUMMARY

Behavioral health refers to a person's mental or emotional condition as well as choices and behaviors that affect wellness. Behavioral health problems include mental health and substance use disorders. This OLO report examines the prevalence of behavioral health disorders in Montgomery County, access to behavioral health services via public and private insurance, services provided through the criminal justice system, behavioral health prevention, referral and recovery support services, data on the behavioral health workforce and facilities in Montgomery County, and feedback from stakeholders on major gaps in services.

Prevalence of Behavioral Health Disorders

Data from the 2013 National Survey on Drug Use and Health (NSDUH) indicate that approximately 18.5% of adults in the United States experienced mental illness in the past year and 4.2% experienced seriously disabling mental illness. Limited data are available on overall mental illness prevalence rates among children, but NSDUH data show that 10.7% of youth aged 12-17 experienced a major depressive episode in the past year. Additionally, according to NSDUH data, 8.2% of youth and adults aged 12 and over experienced past-year substance use disorders.

OLO applied national prevalence rates to the county population to estimate how many county residents experienced behavioral health disorders in the past year, shown on the table below.

County Past Year Behavioral Health Disorder Estimates Assuming National Prevalence Rates, 2013

Characteristic for Mental Health Concern	Prevalence Rate	County Estimate
Adults With Any Mental Illness	18.5%	143,774
Seriously Disabling	4.2%	32,641
Youth Aged 12-17 With Major Depressive Episode	10.7%	8,659
Adults and Youth Aged 12+ With Substance Use Disorder	8.2%	70,363
Substance Use Disorders Among Adults With Any Mental Illness	17.5%	25,160

Access to Behavioral Health Services Via Public and Private Insurance

Individuals in the United States access behavioral health services through public or private health insurance, other public programs, and by paying for services out of pocket. The types of insurance are summarized below:

- **Medicare** is a nationwide federally administered health insurance program for individuals aged 65 and older, individuals with disabilities, and individuals with end-stage renal disease or Lou Gehrig's Disease.
- **Medicaid** provides medical assistance for low-income populations.
- **Private health insurance coverage** includes employer-based plans and individual plans purchased directly from an insurer or through Maryland's health exchange.

The table on the following page displays 2013 American Community Survey (ACS) data on the numbers and percentages of non-institutionalized Montgomery County residents holding different types of health

insurance coverage, as well as the corresponding percentages for the non-institutionalized population of the United States. It is important to note that these data precede a major expansion of the Medicaid program in 2014 and the implementation of other important elements of the Affordable Care Act. National data suggest that the number of uninsured dropped by 25% in 2014.

Health Insurance Coverage Status of Non-Institutionalized Montgomery County Residents, 2013

Health Coverage Type	Montgomery County		United States
	#	%*	%*
Private health insurance	**774,807**	**77%**	**65%**
Employment-based health insurance	668,071	66%	54%
Direct-purchase health insurance	114,306	11%	12%
TRICARE/military health coverage	32,564	3%	3%
Public coverage	**231,644**	**23%**	**32%**
Medicare coverage	130,798	13%	16%
Medicaid/means-tested public coverage	113,823	11%	18%
Department of Veterans Affairs (VA) Health Care	9,487	1%	2%
Uninsured	**111,515**	**11%**	**15%**

*Percentages add up to more than 100% because an individual can hold more one type of health insurance coverage.

Medicare and Medicaid, the two major public health insurance programs available to County residents, cover a broad range of behavioral health services. However, Medicare premiums and coinsurance requirements create financial barriers to accessing services. Additionally, gaps in behavioral health service coverage exist in both programs, specifically coverage of inpatient and residential care through Medicaid and certain specialized types of outpatient care through Medicare.

Private health insurance plans are subject to Federal and State laws that establish rules regarding the type of coverage that they must provide. However, different rules apply to the different types of private plans, and only some plans are required to cover behavioral health services. Of the approximately 775,000 County residents who held private health insurance plans in 2013, OLO estimates that about half held plans subject to laws and regulations that require coverage of specific behavioral health services.

Services for the Criminal Justice-Involved Population

Montgomery County residents can receive behavioral health services as a result of being involved in the criminal or juvenile justice systems. Inmates in prisons and jails have a constitutional right to adequate health care, including behavioral health care, and evidence indicates that a significant proportion of justice-involved individuals suffer from behavioral health disorders. State and County agencies provide services to address the needs of justice-involved individuals, including efforts to divert individuals from the criminal justice system as well as treatment services, at all stages of the criminal justice process from law enforcement to parole and probation.

Despite these interventions, stakeholders report concerns that too many individuals with behavioral health disorders are incarcerated due to a lack of appropriate alternatives, that State psychiatric hospitals do not have sufficient bed space to serve individuals certified to be a danger to themselves or others, and that the lack of a mental health court in Montgomery County represents a missed opportunity to provide an alternative to incarceration and motivate adherence to treatment among offenders suffering from mental illness. Efforts are underway to establish a mental health court in the Montgomery County Circuit Court in 2016.

Promotion, Prevention, Referral and Recovery Support Services

The Substance Abuse and Mental Health Services Administration identifies behavioral health promotion, prevention and recovery as three key elements of the continuum of care for behavioral health in addition to treatment services. Promotion and prevention can be distinguished in that promotion activities are aimed at strengthening determinants of mental wellness such as social-emotional competence and strengthening an individual's ability to cope with adversity, while prevention focuses on averting behavioral health problems, particularly substance use disorders. Recovery is the process of ameliorating the negative impacts of behavioral health disorders, and recovery supports include peer-led recovery centers and mutual support groups.

MCPS, the County Government and various community organizations provide behavioral health promotion, prevention, and referral services, most of which are targeted at school-age children and youth. Additionally, various community organizations and groups in the County offer recovery support services for adults as well as children and youth. Services in these categories are typically provided free of charge and are supported with state, local and private foundation funding. Further study would be required to determine the quality and adequacy of services.

Montgomery County Behavioral Health Workforce

The behavioral health workforce includes psychiatrists, psychologists, psychiatric nurses, clinical social workers, marriage and family therapists, professional counselors, and substance abuse counselors. The table below lists estimates of the need for and supply of mental health professionals in Montgomery County. The data show that the County has a shortage of psychiatrists but a sufficient workforce of other mental health professionals.

Comparison Between Estimated Need for Mental Health Professionals and Number of Existing Licensed Professionals in Montgomery County

	Psychiatrists	Any Mental Health Professional
Estimated Need for Professionals Per 100,000 Population*	27	62
Licensed Professionals Per 100,000 Population	33	313
Estimated FTEs per 100,000 population	21	NA*

*Data on full-time equivalents for professionals other than psychiatrists were not available

These data do not include information on whether providers accept public or private health insurance or on the language skills of providers. Stakeholders report that many behavioral health providers, particularly psychiatrists and child psychiatrists, do not accept reimbursement through private or public insurance, thereby requiring patients to pay for the full cost of care out of pocket. Additionally, psychiatrist costs are often prohibitively high for many community-based programs to provide these services to their clients. Finally, numerous stakeholders reported difficulties in recruiting bilingual behavioral health professionals, who are needed to serve individuals with limited English proficiency.

Montgomery County Behavioral Health Facilities

Individuals can receive a variety of different types of outpatient, residential and inpatient care in behavioral health treatment facilities. OLO compiled data from various sources to provide an inventory of behavioral health facilities in Montgomery County, as summarized in the table on the following page. The table lists bed space or treatment slot capacity where it was available, but in many cases only data on the numbers of facilities were available.

Montgomery County Behavioral Health Treatment Facilities Data Summary

Setting	Available Data Points
Outpatient	• 19 mental health facilities • 24 substance abuse facilities • 138 slots in hospital-based intensive outpatient or partial hospitalization programs
Residential	• 11 mental health facilities • 4 substance abuse facilities • 168 beds in two residential treatment centers for children and adolescents • 382 residential rehabilitation beds for serious mental illness
Inpatient	• 89 inpatient psychiatric beds in three general hospitals • 106 staffed beds in one private psychiatric hospital • Four general hospitals providing inpatient substance abuse detoxification or treatment
Crisis	• DHHS 24-hour crisis services include two crisis hotlines, a walk-in crisis center, two mobile crisis teams and residential crisis services • The MCPD's Crisis Intervention Team responds to crises in the community
Other health institutions	• Five general hospitals have a combined total of 256 treatment spaces in emergency departments, which treat individuals experiencing behavioral health crises. • The Montgomery Cares Behavioral Health Program provides behavioral health services delivered by primary care physicians to uninsured adults in six clinics at 12 sites.

Survey data and stakeholder feedback indicate several areas where current facilities do not meet the need, summarized below:

- **Access to services for individuals not eligible for Medicaid**: Survey data show that mental health and substance abuse outpatient treatment facilities in the County are much more likely to accept Medicaid for payment compared with Medicare or private insurance and that few offer payment assistance or a sliding fee scale for those paying out of pocket. Similarly, stakeholders reported that low-income individuals who are not eligible for Medicaid, including undocumented immigrants and certain elderly and disabled individuals, are often unable to access services due to high out-of-pocket costs and a lack of providers accepting insurance.

- **Services designed to support individuals with serious mental illness living in the community**: Multiple stakeholders reported that limited bed capacity in State psychiatric hospitals and limited availability of special housing contribute to a gap in services for individuals with serious behavioral health disorders. Stakeholders state that a need exists for more services designed to support this population living in community and their access to community-based behavioral health and other necessary services. The specific service needs stakeholders mention in this category include case management, Assertive Community Treatment, Health Homes, Wraparound, and care management systems.

- **Crisis facility capacity and coordination**: Stakeholders report that existing facilities are inadequate or inappropriate for addressing the needs of individuals in crisis, and police must often detain individuals in crisis due to a lack of appropriate alternatives to incarceration. Additionally, the County's Crisis Center has experienced steady increases each year in the numbers of MCPS students requiring services, creating an additional strain on existing resources. Finally, stakeholders identify a need for better coordination between hospitals and community providers to ensure that individuals in crisis receive correct medications in the hospital and connect to appropriate follow-up care to prevent readmission to the hospital.

- **Facilities for individuals with multiple needs**: Many individuals experience multiple types of behavioral health disorders or other health or developmental disabilities in addition to behavioral health disorders. In many cases, facilities are not equipped to meet their needs. For example, residential rehabilitation programs and substance abuse programs lack home health aides or other service supports to address seniors' age-related issues, and individuals with serious behavioral health disorders face barriers in obtaining care for their physical health needs.

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A. Authority

Council Resolution 17-1183, *Fiscal Year 2015 Work Program of the Office of Legislative Oversight*

B. Scope of Report

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as, "a state of mental/emotional being and/or choices and actions that affect wellness."[1] Behavioral health problems include mental health disorders and substance use disorders. A mental health disorder is a condition in which alterations in thinking, mood or behavior occur that may cause distress and impair functioning. A substance use disorder is the dependence on or abuse of alcohol or illicit drugs. The purpose of this report is to examine the interplay of public and private resources as they are directed towards behavioral health services in the County and identify areas where service gaps exist. Specifically, this report:

- Provides information on definitions of behavioral health disorders and their prevalence;
- Describes the private and public funding sources that finance behavioral health services in the United States;
- Describes the behavioral health services available to Montgomery County residents eligible for public insurance programs or enrolled in private plans;
- Summarizes the behavioral health services provided in Montgomery County by County and State agencies at different points in the criminal and juvenile justice processes;
- Describes behavioral health promotion, prevention, referral and recovery services provided in Montgomery County;
- Defines the behavioral health workforce and describes workforce data for Montgomery County;
- Defines and describes data on the many types of facilities and diverse settings where behavioral treatments are provided in Montgomery County;
- Summarizes stakeholder feedback and information from reports on gaps in the provision of and access to behavioral health services;

C. Methodology

Office of Legislative Oversight staff members Natalia Carrizosa and Sue Richards conducted this study with editorial assistance from Stephanie Bryant and Kelli Robinson. OLO gathered information through document reviews, interviews with staff from the County Government and stakeholders from community organizations, and analysis of data from State licensing boards and surveys of behavioral health facilities.

[1] "What Is Behavioral Health," Substance Abuse and Mental Health Services Administration (SAMHSA) website, < http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/1 > accessed 3/9/2015

D. Acknowledgements

OLO received a high level of cooperation from those who contributed to this report. OLO appreciates the time commitment, the expertise, and the insights provided by all who participated. In particular, OLO acknowledges the time and insights of the following individuals:

Department of Health and Human Services
Uma Ahluwalia
JoAnn Barnes
Raymond Crowel
Alicia Flores
Scott Greene
Sybil Greenhut
Monir Khanjani
Eugene Morris
Athena Morrow
Jennifer Vidas

Department of Correction and Rehabilitation
Robert Green
Arthur Wallenstein
Lauren Campbell
Anthony Sturgess

Montgomery County Fire and Rescue Service
Assistant Chief Barry Reid
Battalion Chief Alan Butsch
Lieutenant Robert Tobin

Montgomery County Police Department
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Officer Scott Davis
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State's Attorney's Office
Phil Andrews
Laura Chase
Debbie Feinstein
Christina Miles

Sheriff's Office
Daryl Leach
Tom Manion

Other
Debra Berner, Montgomery County Public Schools
Susan DeFrancesco, Institute for Public Health Innovation
Tracey DeShields, Maryland Board of Professional Counselors and Therapists
Larry Epp, Mental Health Advisory Committee
Barrie Friedman, Cornerstone Montgomery
Steve Galen, Primary Care Coalition
Mary Kay Goetter, Maryland Board of Nursing
Thom Harr, Family Services and Healthy Montgomery Behavioral Health Task Force
Brian Hepburn, Maryland Department of Health and Mental Hygiene
Brenda Jones, Maryland Board of Physicians
April Kaplan, Montgomery County Collaboration Council
Kiki Li, Mental Health Advisory Committee
Diane Lininger, Mental Health Advisory Committee
Michele Molesworth, Maryland Board of Nursing
Joseph Murphy, On Our Own of Montgomery County
On Our Own Consumers
Fred Osher, Council of State Governments Justice Center
Jennifer Pauk, Montgomery Cares
Paula Puglisi, Mental Health Advisory Committee
Patricia Rivas, Identity
Celia Serkin, Mental Health Advisory Committee
Lorraine Smith, Maryland Board of Examiners of Psychologists
Eric Sterling, Alcohol and Other Drug Abuse Advisory Council
John Torontow, Community Clinic
Stanley Weinstein, Maryland Board of Social Work Examiners
Kevin Young, Adventist Behavioral Health and Healthy Montgomery Behavioral Health Task Force

Chapter II. Behavioral Health Disorder Definitions and Prevalence

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as, "a state of mental/emotional being and/or choices and actions that affect wellness."[1] Behavioral health problems include mental health disorders and substance use disorders. A mental health disorder is a condition in which alterations in thinking, mood or behavior occur that may cause distress and impair functioning. A substance use disorder is the dependence on or abuse of alcohol or illicit drugs. This chapter provides information on definitions of behavioral health disorders and their prevalence to support the Council's oversight of behavioral health services planning. It is organized as follows:

- **Section A** presents definitions of behavioral health disorders; and
- **Section B** summarizes data on the prevalence of behavioral health disorders and provides population estimates for Montgomery County.

A. Behavioral Health Disorder Definitions

Mental health disorders and substance use disorders are separate but closely linked categories of health disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency charged with improving national behavioral health, reducing the impacts of behavioral illnesses and supporting recovery. To fulfill its mandates, SAMHSA has developed operational definitions of mental illness and substance abuse, a survey instrument, and a forecasting methodology and statistical model that generates behavioral health disorder estimates.

1. Definitions of mental health disorders

The 2013 NSDUH, the most recent survey from which data are available, uses questions based on definitions of mental illness and substance use disorders from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The DSM, published by the American Psychiatric Association (APA), provides standard criteria for the classification of behavioral health disorders and is widely used in the healthcare sector, the legal system and by researchers and policymakers.

Mental health disorders among adults. The NSDUH metric of Any Mental Illness (AMI) estimates how many adults have:

> *any* mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental and substance use disorders).[2]

SAMHSA's mental illness definitions further categorize the total estimate of psychological distress in the adult population, i.e., the AMI estimate, into three subgroups. These subgroups reflect the severity of functional impairment associated with the universe of predicted diagnosable psychological disorders. Functional impairment measures the extent to which a disorder interferes with an individual's ability to carry out their daily activities. The NSDUH survey instrument uses the Global Assessment Functioning scale, one

[1] "What Is Behavioral Health," Substance Abuse and Mental Health Services Administration (SAMHSA) website, < http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/1 > accessed 3/9/2015

[2] "Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings," Substance Abuse and Mental Health Services Administration, September 2014, < http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm > accessed 5/26/2015.

of many psychiatric assessment tools, to score the results of its clinical interviews.[3] Below are the terms and definitions that SAMHSA uses for its three levels of functional impairment estimates:

- **Low (mild) mental illness** provides an estimate of individuals with disorders resulting in no more than mild impairment in carrying out major life activities, based on clinical interview Global Assessment of Functioning (GAF) scores of greater than 59.[4]
- **Moderate mental illness** provides an estimate of individuals with disorders resulting in moderate impairment in carrying out major life activities, based on clinical interview Global Assessment of Functioning (GAF) scores of 51 to 59;[5] and
- **Serious mental illness (SMI)** provides an estimate of individuals with a diagnosable mental, behavioral, or emotional disorder that results in substantial impairment in carrying out major life activities where substantial impairment is defined based on clinical interview Global Assessment of Functioning (GAF) scores of 50 or less.[6]

Children and adolescents and serious emotional disturbances. SAMHSA uses a different terminology to describe severe mental health disorders among children. Specifically, a *serious emotional disturbance* refers to, "a mental health disorder among children and adolescents that involves serious impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities."[7]

2. Definitions of substance use disorders.

SAMHSA's 2013 estimates of the prevalence of substance use disorders include both substance abuse and substance dependence, defined below. Substance dependence is considered to be more severe than substance abuse:[8]

Substance abuse is a pattern substance use that leads to a recurrent failure to fulfill work, school or home obligations, recurrent substance use in physically hazardous situations (such as when operating machinery), recurrent legal problems (for example because of disorderly conduct), and/or continued substance abuse despite recurrent interpersonal or social problems related to substance use.

Substance dependence is a pattern of substance use that is manifested by three or more of the following:

[3] The GAF scale is a widely used assessment tool; however, its use and the weight given in a disability determination process varies from one agency to another. For example, the Department of Veteran Affairs uses GAF scores to determine the appropriate level of disability compensation for veterans' who suffer psychiatric disorders. By comparison, the Social Security Administration considers the GAF in its review of disability determinations as one of many clinical factors.
[4] A GAF score of 60-71 indicates some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally indicates an individual is functioning pretty well and has some meaningful interpersonal relationships.
[5] A GAF score of 50-59 indicates moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
[6] A GAF score of 50 or less spans multiple levels of functional impairment. At the high end, a GAF score of 40 to 49 indicates serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
[7] *Behavioral Health, United States, 2012,* Substance Abuse and Mental Health Services Administration, p. 16, < http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf > accessed 5/26/2015.
[8] "Appendix C: DSM-IV-TR material," *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, Substance Abuse and Mental Health Services Administration (SAMHSA), p. 115, < http://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/TOC.pdf, > accessed 5/26/2015.

(1) tolerance, which is a need for an increased amount of a substance to achieve the same effect;
(2) withdrawal, which means that the individual experiences symptoms when discontinuing or reducing intake of a substance and may use substances to avoid symptoms of withdrawal;
(3) taking a substance for more time or in larger amounts than intended;
(4) a persistent desire or unsuccessful efforts to reduce or control substance use;
(5) large amounts of time spent obtaining a substance, using the substance and/or recovering from its effects;
(6) forgoing important activities because of substance abuse; or
(7) continued substance use despite awareness that it is causing a persistent physical or psychological problem (such as ulcers or depression).

B. Behavioral Health Disorder Prevalence Estimates

The National Survey on Drug Use and Health (NSDUH) is the key SAMHSA survey that captures data about individuals' patterns of drug and alcohol use, their mental health states, and their use of substance abuse treatment and mental health services. These data provide a basis to estimate the number of people with behavioral health disorders. The estimates produced by SAMHSA are based on statistical models that use NSDUH survey results to estimate levels of psychological distress and functional impairment for a particular population.

In this section, OLO applies national behavioral health disorder prevalence rate estimates from the 2013 NSDUH to the county population to provide rough estimates of the numbers of people in the County who have experienced behavioral health disorders in the past year, including mental health, substance use, and co-occurring disorders. OLO did not use local prevalence rate estimates from the NSDUH because those estimates are imprecise and do not show a true difference between national and local prevalence rates.

The NSDUH estimates prevalence rates are based on data from a sample of the population, and as a result the estimated rates contain a level of uncertainty. Researchers use statistical analysis to estimate the level of uncertainty in a prevalence rate estimate, which depends on the size of the sample. Because national estimates are based on a larger sample than those used for local estimates, national estimates contain less uncertainty and are more precise than local estimates. For example, at the national level, researchers estimate that 18.5% of the population experienced any mental illness in the past year, but taking into account the level of uncertainty in the estimate, the true population prevalence rate could likely be between 18.1% and 19.0% (95% confidence interval). In Montgomery County, the estimate for the prevalence of any mental illness in the past year is 17.9%, but the level of uncertainty is such that the true prevalence rate could be between 14.7% and 21.6% (95% confidence interval), a much larger range.

1. County Past Year Mental Illness Estimates

This section presents population estimates of mental illness among county adults using NSDUH's national estimates of prevalence rates. The NSDUH does not provide data on overall prevalence rates of mental illness among adolescents and children. OLO applied national NSDUH mental illness rates to county census population data to estimate the number of adults 18 years or older with Any Mental Illness in the past year in the County. The results, displayed in Table 1 on the next page, produce an AMI estimate of 144,000 individuals. Further categorizing this population by the severity of its diagnosable disorders shows that in the past 12 months:

- roughly half of the County's AMI population (73,000) experienced a disorder with a mild level of functional impairment;
- just over one-quarter (37,000) experienced a disorder that was moderately disabling; and
- slightly less than one quarter (33,000) had a disorder with a severe level of impairment.

Table 1. County Any Mental Illness Among Adults Estimate by Level of Functional Impairment, 2013

Characteristic for Mental Health Concern	Census Population Estimate	NSDUH Prevalence Rates	Subgroup Estimate	Distribution by Impairment Severity
Adults Aged 18+	777,159			
Any Mental Illness		**18.5%**	**143,774**	
Severity Level of Impairment				
Mildly Disabling		9.4%	73,053	51%
Moderately Disabling		4.8%	37,304	26%
Seriously Disabling		4.2%	32,641	23%

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

2. County Estimates of Past Year Mental Illness Among Adults by Age Group

Table 2 displays the distribution of the County's adult AMI population by age group. The data show just over half of the AMI population (75,000) are between 26 and 49 years old compared to 51,000 who are 50 or older and roughly 18,000 who are ages 18 to 25.

Table 2. County Adult AMI Estimate by Age Group

Any Mental Illness	Census Population Estimate	NSDUH Prevalence Rate	Subgroup Estimates	Distribution by Age Group
18-25	92,635	19.4%	17,971	13%
26-49	342,671	21.5%	73,674	52%
50 or older	341,853	15.3%	52,304	36%

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

Table 3 provides more detailed estimates of the age group estimates in Table 2 by level of functional impairment. For example, these estimates show the AMI subgroup with a mild level of impairment has roughly 9,000 individuals ages 18 to 25, 37,000 individuals 26 to 49 and 27,000 individuals 50 and over. The data also show that the distributional pattern of the 18-25 and 26-49 year old groups by severity level is similar. In each case, half of the cohort has a mild level of impairment with the balance evenly split between the moderate and serious levels. By comparison, a higher percentage of individuals aged 50 and older with AMI have a moderate level of impairment compared with a serious level of impairment.

Table 3. County Adult AMI Estimate by Age Group and Severity of Functional Impairment

Mental Illness Estimates By Severity and Age Group	NSDUH Prevalence Rates			Subgroup Estimates		
	Mild	Moderate	Serious	Mild	Moderate	Serious
18-25	9.9%	5.3%	4.2%	9,171	4,910	3,891
26-49	10.9%	5.4%	5.3%	37,351	18,504	18,162
50 or older	7.9%	4.1%	3.2%	27,006	14,016	10,939
Subtotals				**73,528**	**37,430**	**32,992**

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

3. Estimates of Mental Health Disorders Among Children and Youth

While the NSDUH does not provide data on overall prevalence rates of mental illness among adolescents and children, SAMHSA reports data from other studies that have found the following:[9]

- Among children aged 8-11, 12.8% experienced any mental disorder in the past year and 11% experienced past year serious emotional disturbances;
- Among adolescents aged 12-15, 12% experienced past year serious emotional disturbances;
- Among adolescents aged 13-18, 50% have experienced at least one mental health disorder in their lifetime; and
- Among adolescents aged 13-18, 22% have experienced a disorder with severe impairment in their lifetime.

The NSDUH survey has administered questions to estimate depression specifically among youth aged 12-17 since 2004. The NSDUH bases its survey questions on the DSM-IV Manual's criteria for a Major Depressive Episode with some adjustments. The Manual defines a Major Depressive Episode as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had at least four of seven symptoms specified in the Manual.[10] Unlike the DSM-IV Manual, the NSDUH survey does not make exclusions for depressive symptoms caused by medical illness, bereavement, or substance use disorders.

The NSDUH survey results report two levels of severity for a major depressive episode. The less severe level is characterized as a major depressive episode and the more severe level is labelled a major depressive episode with severe impairment. NSDUH defines severe impairment for youth by role interference in one or more of four domains: chores at home, school or work; close relationships with family or social life. Table 4 presents County estimates based on the national 2013 NSDUH rates. The data show youth who have a major depressive episode are more likely to have an episode with severe impairment.

[9] *Behavioral Health, United States, 2012,* Substance Abuse and Mental Health Services Administration, pp. 16 and 74 < http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf > accessed 5/26/2015.

[10] The nine symptoms listed in the NSDUH glossary are (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death or recurrent suicide ideation.

Table 4. County Estimates of Youth that Had a Major Depressive Episode in the Past Year, 2013

Characteristic for Mental Health Concern	Census Population Estimate	NSDUH Prevalence Rates	Subgroup Estimate	Distribution by Impairment Severity
Youth Ages 12-17	80,921			
Share of Youth With Major Depressive Episode		**10.7%**	**8,659**	
Without Severe Impairment		3.0%	2,428	28%
With Severe Impairment		7.7%	6,231	72%

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

4. Estimates of Alcohol or Drug Dependence Among County Population

Table 5 presents County estimates of alcohol and drug abuse and dependence rates for the population aged 12 and over using national 2013 NSDUH data on prevalence rates. The data show about 70,000 youth and adults with a substance use disorder.

Table 5. Estimates of County Population with Past Year Drug or Alcohol Dependence or Abuse, 2013

Type of Substance Use Disorder	Census Population Estimate	NSDUH Prevalence Rate	Subgroup Estimate
Population aged 12+	857,262		
Any drug or alcohol dependence/abuse		**8.2%**	**70,363**
Illicit drug dependence or abuse		**2.6%**	**22,310**
Illicit drug dependence		1.9%	16,304
Illicit drug abuse		0.7%	6,007
Alcohol dependence or abuse		**6.6%**	**56,633**
Alcohol dependence		3.0%	25,742
Alcohol abuse		3.5%	30,033

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

5. County Estimates of Past Year Substance Use Disorders by Age Group

Table 6 displays the estimated distribution of the County's adult AMI population by age group based on national prevalence rates. The data show that the prevalence rate for young adults (individuals aged 18-25) is more than twice that of both adolescents and other adults. However, about 70% of individuals with substance use disorders were aged 26 or over.

Table 6. County Substance Use Disorder Estimates by Age Group, 2013

Substance Dependence or Abuse	Census Population Estimate	NSDUH Prevalence Rate	Subgroup Estimates*	Distribution by Age Group
12-17	80,921	5.2%	4,345	6%
18-25	92,635	17.3%	16,546	24%
26 or older	684,524	7.0%	49,472	70%

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.
*Subgroup estimates do not add up to total population with substance use disorders on previous page due to rounding.

6. Estimates of County Adult Population with Co-Occurring Mental Health and Substance Use Disorders

Table 7 provides estimates about the overlap between adults with a diagnosable substance use disorder and the presence or absence of a diagnosable mental disorder. Roughly 62% of that group did not have a diagnosable mental illness in the past 12 months. Of the 25,000 people estimated to have both a substance use disorder and any mental illness, 10,000 had a psychiatric disorder that was mildly disabling. The remaining 15,000 are evenly split between the subgroup with moderately disabling mental disorders and the subgroup with seriously disabling mental disorders. Of note:

- 17.5% of adults with any mental illness experienced a substance use disorder, compared with 6.5% of adults with no mental illness;
- An estimated 7,500 or 23.1% of adults with serious mental illness also experienced a substance use disorder; and
- Adults aged 18-25 with serious mental illness had the highest prevalence rates of substance use disorders of any subgroup at 39.6%.

Table 7. Estimates of County Population With Past Year Co-Occurring Mental Health and Substance Use Disorders, 2013

Characteristic	Mental Illness Prevalent Subgroup Estimates	Illicit Drug or Alcohol Dependence Rates	Drug and Alcohol Prevalent Population Estimates*	Distribution of Substance Use Population by Subgroup
Total Illicit Drug or Alcohol Dependence or Abuse Among Adults				
No Mental Illness in Past Year	633,385	6.5%	41,170	62%
Any Mental Illness in Past Year	143,773	17.5%	25,160	38%
Any Diagnosable Mental Disorder by Severity				
Mild	73,053	13.9%	10,154	15%
Moderate	37,304	19.6%	7,312	11%
Serious	32,641	23.1%	7,540	11%
Any Diagnosable Mental Disorder by Age				
18-25	17,971	31.1%	5,589	8%
26-49	73,674	21.0%	15,472	23%
50 or older	52,304	7.2%	3,766	6%
Estimates By Severity and Age				
Mild Mental Illness				
18-25	9,171	26.6%	2,439	4%
26-49	37,351	16.4%	6,126	9%
50 or older	27,006	5.4%	1,458	2%
Moderate Mental Illness				
18-25	4,910	32.7%	1,579	2%
26-49	18,504	25.6%	4,826	7%
50 or older	14,016	6.8%	933	1%
Serious Mental Illness			-	
18-25	3,891	39.6%	1,541	2%
26-49	18,162	25.6%	4,649	7%
50 or older	10,939	12.0%	1,313	2%

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.
*Estimates by subgroup may not add up to subgroup population total due to rounding.

Chapter III. Behavioral Health Spending, Financing and Service Coverages in the United States

In the United States, access to most behavioral health services depends on an individual's health insurance coverage status, meaning whether a person has private health insurance, has public coverage through programs such as Medicare or Medicaid, or is uninsured. The third-party insurer or government entity that pays for services is often referred to as the "payer". This chapter provides background information on the interplay of private and public funding sources that finance behavioral health services, and is organized as follows:

- **Section A** presents definitions of the major payers for behavioral health services in the United States and data on health insurance coverage among United States and Montgomery County residents;
- **Section B** provides an overview of behavioral health spending by payer or program funding sources; and
- **Section C** provides a general comparison of behavioral health coverages by payers.

A. Payer definitions and health insurance coverage data

As noted above, a "payer" is the term often used for the third-party insurer or government entity that pays for health services, including behavioral health services. The major types of payers for behavioral health services in the United States include:

- **Medicaid and CHIP Programs**: Medicaid and the Children's Health Insurance Program (CHIP) are the two primary public medical assistance programs for low-income populations in the United States and are operated by the states in partnership with the federal government.
- **Medicare:** Medicare is a nationwide federally administered health insurance program that covers the cost of hospitalization, medical care and select other services for individuals aged 65 and older, individuals who had been receiving Social Security Disability cash benefits for at least 29 months and individuals with end stage renal disease (ESRD) or Lou Gehrig's Disease (ALS).
- **Private insurance:** Individuals can obtain private health insurance coverage through their employer, by purchasing a plan directly from a health insurer, or through a health insurance exchange established as part of the Affordable Care Act.
- **State Mental Health Authorities:** SMHAs are the state agencies that historically functioned as a centralized system for administering state funding for mental health services, but now provide some state-funded mental health services as part of a complex system of public funding that also includes Medicaid, Medicare and federal grant funding.
- **Other federal:** this category includes a block grant program that supplements state-financed programs as well as additional federal programs that finance support services.

Individuals may also pay "out of pocket," in whole or in part for services if they are uninsured or if the insurer does not cover the cost of services. Table 8 displays 2013 American Community Survey (ACS) data on the numbers and percentages of non-institutionalized Montgomery County residents holding different types of health insurance coverage.

Table 8. Health Insurance Coverage Status of Non-Institutionalized Montgomery County Residents

Health Coverage Type	Montgomery County		United States
	#	%*	%*
Private health insurance	**774,807**	**77%**	**65%**
Employment-based health insurance	668,071	66%	54%
Direct-purchase health insurance	114,306	11%	12%
TRICARE/military health coverage	32,564	3%	3%
Public coverage	**231,644**	**23%**	**32%**
Medicare coverage	130,798	13%	16%
Medicaid/means-tested public coverage	113,823	11%	18%
Department of Veterans Affairs (VA) Health Care	9,487	1%	2%
Uninsured	**111,515**	**11%**	**15%**

*Percentages add up to more than 100% because an individual can hold more than one type of health insurance coverage.

It is important to note that these data, which precede the implementation of important elements of the Affordable Care Act (ACA), do not include individuals who became newly eligible for Medicaid as a result of the ACA or previously uninsured individuals who signed up for a private insurance plan on the Maryland Health Exchange for 2014 or 2015. National data suggest that the number of uninsured dropped by 25% in 2014.[1]

B. National Behavioral Health Spending by Payer and Program Sources

Table 9 displays data on the private and public sources that fund behavioral health services in the United States between 2004 and 2009, the latest year of data compiled by SAMHSA. In 2009, behavioral health spending in the United States totaled $172 billion, including $105 billion (61%) from public sources and $67 billion (39%) from private sources. Since 2004, spending increased by $40 billion or 5% annually. In 2009, the most current spending data show that the $108 billion of spending from public and private insurance spending included $44 billion from Medicaid (26%)[2], $43 billion from private insurance (25%)[3] and $21 billion from Medicare (12%).[4] Of note,

- Federal Medicaid payments ($29 billion), federal Medicare dollars ($21 billion) and other federal grants ($10.5 billion) total $60 billion. This is twice the $30 billion characterized as Other State and Local spending, a category that primarily accounts for State Mental Health Authority dollars.

- Medicare saw a five percentage point increase in its spending share between 2004 and 2009 compared to a two point decline for Medicaid. This primarily reflects a change in the way that prescription drugs are funded for individuals enrolled in both Medicaid and Medicare, specifically the transfer of retail prescription drug spending on these enrollees to Medicare's Part D prescription drug plan in 2006.

[1] Sanger-Katz, M.,"Is the Affordable Care Act Working: Has the percentage of uninsured people been reduced?" New York Times, October 26, 2014, < http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=0#uninsured > accessed May 26, 2015.
[2] Medicaid payments include any payments made on behalf of enrollees or through other programs run by the federal or individual state government agencies.
[3] Private health insurance payments are benefits paid by private health insurers (including behavioral health plans) for provision of service, prescription drugs, or the administrative costs and profits of health plans. Private health insurance benefits paid through managed care plans on behalf of Medicare and Medicaid are excluded.
[4] Medicare payments include payments made through fee-for-service and managed care plans.

- All State spending declined by 5 percentage points from 2004 to 2009 despite a $3.5 billion spending increase, showing that state resources did not keep pace with federal resources. In fact, the average annual growth rate for all federal spending was 9% compared to a 1% annual growth rate for all state spending.

Table 9. Behavioral Health Spending in the United States, Shares and Growth Rates by Payer Source, 2004 and 2009 ($ millions)

	2004	2009	2004	2009	Annualized Growth Rate
Private sources	**$51,187**	**$66,584**	**39%**	**39%**	**5%**
Private insurance	32,475	42,562	25%	25%	5%
Out of pocket	14,920	18,791	11%	11%	4%
Other private	3,793	5,231	3%	3%	6%
Public sources	**$80,889**	**$105,136**	**61%**	**61%**	**5%**
Medicare insurance	9,006	20,544	7%	12%	21%
Medicaid insurance	36,879	44,227	28%	26%	3%
Federal dollars	21,759	29,171	16%	17%	6%
State matching dollars	15,120	15,056	11%	9%	0%
Other federal grants	8,791	10,492	7%	6%	3%
Other State and Local	26,213	29,873	20%	17%	2%
Total Mental Health and Substance Abuse	**$132,077**	**$171,720**	**100%**	**100%**	**5%**
All Federal, including federal Medicaid spending	$39,556	$60,207	30%	35%	9%
All State, including state Medicaid spending	41,333	44,929	31%	26%	1%

Source: SAMHSA Spending Estimates, 2013; Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Accounts. *SAMHSA Spending Estimates 1986-2009*, Appendix A Table A.8, pp. 68-69

C. Behavioral Health Service Coverage by Payer Sources

The Kaiser Commission on Medicaid and the Uninsured characterizes financing for behavioral health services as "a patchwork of programs that – sometimes in concert and sometimes in conflict – collectively form the behavioral health system for the nation."[5] This patchwork structure exists because changes in behavioral health financing over time shifted resources from a highly centralized state authority structure to a structure that combines multiple funding sources and financing approaches.

As detailed above, this current financing structure relies on private and public insurance payments (63%), public grants (23%) and other private resources (14%). Table 10 summarizes behavioral health service coverage by payer source from research by Garfield, Lave and Donohue.[6] A close review of this chart

[5] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8182.pdf

[6] Rachel L. Garfield, PHD MHS et al. Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services. *Psychiatric Services*. November 2010 Vol 61, No. 11

highlights some defining characteristics of the current behavioral health service delivery structure which are summarized below.

- **A full behavioral health service continuum encompasses more services than medical treatments alone.** As the list of services in Table 10 shows, the full continuum of behavioral health services includes: 1) a subset of services that are similar to general medical services; 2) other medical services, e.g. residential care or crisis intervention, that are unique to behavioral health treatments; and 3) supportive services such as housing or transportation assistance, that support the ability of the mentally ill to live and function in community settings.

- **Marked differences exist in behavioral health service coverages: most treatments that serve individuals with serious mental illness fall outside general medical services and are not covered by private insurance or Medicare while Medicaid coverage typically covers these types of services.** Individuals with private insurance or Medicare are covered for significantly fewer services than individuals who are eligible for Medicaid. Private insurance or Medicare generally only covers services that align with traditional medical treatments. In contrast, most Medicaid programs cover unique behavioral health treatments, but they typically do not cover supportive employment or housing. (See pages 27-28 for details about Maryland's coverage.)

- **State Mental Health Authorities (SMHAs) finance the most complete set of behavioral health services and typically target individuals with serious mental illnesses, those who need supplemental coverage or those who lack insurance.**[7] The list of State-financed services in Column 4 encompasses the broadest set of behavioral health prevention, treatment and supportive services. Examples of these services in Maryland include Assertive Community Treatment (ACT) or Supported Employment. This breadth of services allow SMHA's to address treatment and service gaps not covered by other payers and/or target resources for specific populations such as individuals with serious mental illness.

- **The largest source of federal funding for behavioral health other than Medicaid is a block grant program that supplements state-financed programs, while additional federal programs finance support services.** The largest federal program besides Medicaid is a block grant that supplements the array of state-financed programs in Column 4. The services marked in Column 5 do not incorporate the services that receive block grant funding; instead, they only reflect those federal programs with stand-alone funding. As the Exhibit shows, these programs primarily finance support services, such as housing assistance or income support.

- **There are dozens or hundreds of federal programs that fund services for the mentally ill individuals; however, fragmentation is an issue. Although program level coordination exists, mechanisms to achieve effective interagency coordination are lacking.** A 2003 briefing document for the 2003 Presidential New Freedom Commission on Mental Health report identified 40 plus mental health support or financing programs in nine different federal agencies. More recently, GAO Report 15-113, released in February 2015, identified 112 programs across eight federal agencies that serve or support individuals with a serious mental illness.[8]

[7] State Mental Health Authorities, as defined on page 11, are the state agencies that administer funding for mental health services. In Maryland, the Behavioral Health Administration (BHA) is the SMHA.

[8] GAO found most programs addressed individuals with serious mental illness as part of a broader concern. Because agencies did not always track whether individuals with serious mental illness were served, they had difficulty providing a complete list of programs. GAO found interagency coordination for programs that target individuals with serious mental illness is lacking and recommended HHS develop a mechanism to facilitate this coordination.

Table 10. Coverage of behavioral health services in the United States, by payer as of 2010[a]

	Category and Service[b]	1. Employer-Based Coverage[c]	2. Medicare[d]	3. Medicaid[e]	4. Other State[f]	5. Other Federal[g]
Prevention						
	Screening for alcohol misuse	X	*	/	X	
	Screening for depression	X	X	/	X	
	Screening for illicit drug use	X	*	/	X	
	Screening for suicide risk				X	
Treatment						
	Diagnostic tests, psychological testing	X	X	X	X	
	Outpatient MHSA psychotherapy	X	X	X	X	
	Inpatient MH/SA hospitalization	X	X	X[h]	X	
	Partial MH/SA hospitalization	X	X	X	X	
	Inpatient detoxification	X	X	X	X	
	Outpatient detoxification	X	X	X	X	
	Pharmacological therapies	X	X	X	X	
	Medication management	X	X	X	X	
	Opiod treatment			X	X	
	Short term MH/SA residential care			X	X	
	Long term MH/SA residential care			X	X	
	Case management/intensive case management			X	X	
	Crisis intervention for MH/SA			X	X	
Supportive Services						
	Housing assistance				X	X
	Vocational training support			Limited	X	X
	Income assistance				X	X
	Nonemergency transportation services			X	X	
	Peer support services			X	X	
	Collateral services/family support services			X	X	
	Home based support services			X	X	

[a]Symbols are defined as follows: X service is covered; *, coverage only if for alcohol or drug abuse structured assessment and brief intervention services; / service is covered for children under Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit (a minority of states covers screening for adults).
[b]Service list was compiled from expert reports, service benefit plans for various payers and consultation with behavioral health experts.
[c]Based on Blue Cross and Blue Shield standard fee for service, preferred provider organization plan available under the Federal Employees Health Benefit Plan.
[d]Column indicates coverage under traditional Medicare (Parts A and B) and Medicare Part D (prescription drug coverage). Beneficiaries enrolled in Medicare supplemental plans (Medigap or Medicare Advantage) may receive additional benefits under those plans.
[e]Coverage varies by state. Column indicates services that are covered by most states.
[f]Coverage varies by state. Column indicates services that are covered by most states.
[g]Federal block grant dollars supplement the state-funded programs in the "Other state funding" column. Column indicates programs funded solely with federal dollars.
[h]Excludes services in an institution for mental diseases (IMD) for persons aged 22 to 64.

Chapter IV. Public Health Insurance and Maryland's Public Behavioral Health System

Public health insurance programs, including Medicare and Medicaid, provide behavioral health and other health services to eligible individuals. Additionally, non-eligible individuals who are uninsured may also receive publically-funded behavioral health services. As noted on page 12, 13% of non-institutionalized Montgomery County residents were Medicare enrollees in 2013, 11% were Medicaid enrollees and 11% were uninsured. This chapter summarizes these programs' structures, eligibility rules, and available behavioral health services, and is organized as follows:

- **Section A** describes behavioral health services covered under the Medicare program, which is a public health insurance program for individuals aged 65 and older, individuals with disabilities and individuals suffering from end-stage renal disease or Lou Gehrig's Disease (ALS).
- **Section B** describes Maryland's Medicaid Program and the Public Behavioral Health System, which provide behavioral health services to Medicaid enrollees and other individuals.

A. Behavioral Health Service Coverage under Medicare

Medicare is a nationwide federally administered health insurance program authorized under Title 18 of the Social Security Act that covers the cost of hospitalization, medical care and select other services. When Medicare was established in 1966, it covered individuals aged 65 and older. In 1972, coverage was expanded to individuals who had been receiving Social Security Disability cash benefits for at least 29 months and individuals with end stage renal disease (ESRD).

Table 11 presents Medicare enrollment data for Montgomery County from 2008 to 2012 for the Aged and Disability coverage groups. In 2012, there were nearly 141,000 Medicare beneficiaries, including 128,500 who were eligible because they were 65 or older and 12,300 (9%) who were eligible due to a disability.

Table 11. Medicare Enrollment for Montgomery County by Enrollee Group, 2008-2012

Enrollee Group	2008	2009	2010	2011	2012	5 year change	Avg. Annual Growth
Aged (65 and Over)	103,891	108,312	110,772	113,937	128,447	+24,556	5%
With Disablities (Under 65)	8,629	8,696	9,663	10,399	12,342	+3,713	9%
Total	**112,520**	**117,008**	**120,435**	**124,336**	**140,789**	**+28,269**	**5%**

Source: CMS Denominator File

Program Structure and Eligibility. Medicare was originally established with two parts: Part A, Hospital Insurance (HI), provides coverage for inpatient hospital, home health agency, skilled nursing and hospice care; and Part B, Supplementary Medical Insurance (SMI), provides coverage for physician, outpatient hospital, home health agency and other services. Most individuals are automatically covered for Part A if they have worked and paid Medicare payroll taxes. Coverage for Part B is voluntary and requires payment of a monthly premium. Parts A and B, referred to as Original Medicare, are administered directly by the federal government.

Part C, the Medicare Advantage program was added to Medicare in 1977 to provide an option for beneficiaries to participate in private sector health care plans. According to the 2014 Medicare Trustees

Report, about 28% of Medicare's beneficiaries were enrolled in a Medicare Advantage Plan in 2013. In 2004, a fourth part, Part D, was added to Medicare to pay for prescription drugs not covered under Parts A or B. Part D was initially a temporary plan that provided voluntary access to prescription drug discount cards; however, in 2006, it was modified to provide subsidized access to prescription drug insurance coverage on a voluntary basis with the payment of a premium.

Financing and Beneficiary Cost Sharing. Beneficiaries who enroll in Original Medicare are subject to premiums, deductibles and coinsurance payments for Parts A, B and D. These charges and fees, which vary based on an individual's work history, income level, service use and other factors, are described below. It is important to note that nearly 90% of Medicare beneficiaries carry supplemental insurance to cover the gap between the total cost of care and the amount that Medicare covers.

P**art A.** Most beneficiaries qualify for premium-free Part A. Individuals not eligible to qualify based on their work history may enroll voluntarily subject to payment of a monthly premium ($426/month in 2015). Beneficiaries who use inpatient hospital services must pay a deductible ($1,260) plus a daily coinsurance amount equal to one-fourth of this deductible for a hospital stay that extends from 61 and 90 days. Afterwards, Medicare assesses a daily coinsurance amount set at one-eighth of the deductible amount for a stay at a skilled nursing facility that lasts from 21 to 100 days. There is a coinsurance payment equal to one-eighth of the hospital deductible for days 21-100 for a stay in a skilled nursing facility. There are no coinsurance payments for home health or hospice services.

Part B. Cost sharing charges for beneficiaries enrolled in Part B include a monthly premium, a yearly deductible set by statute ($147 in 2015) plus copayments. The standard monthly premium amount is set at 25% of the average program cost for aged beneficiaries. For higher income households, the monthly premium is equal to 35%, 50%, 65% or 80% of the average program cost. The monthly premium is usually deducted from a beneficiary's social security check. Some premiums may fall below the standard rate due to a hold harmless provision that limits the increase in the Part B premium to the dollar increase in an individual's Social Security benefit. The coinsurance payment is 20% for most services.

Covered Behavioral Health Services and Costs. Behavioral health services under Original Medicare are covered under Parts A, B and D. The service continuum provides prevention and treatment services, but no supportive services. Specifically, Medicare covers screenings, tests, outpatient, clinic, inpatient and partial hospitalization services provided by psychiatrists or other doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants. Table 12 lists the covered services with a brief description of the coverage requirements and costs.

Table 12. Covered Medicare Medical Care Services

Prevention	Description and Costs
Screening for alcohol misuse	Part B covers a yearly screening for adults who use alcohol but do not meet the medical criteria for alcohol dependency by a primary care doctor. If a doctor accepts assignment, the screening is free. If the doctor determines there is alcohol misuse, Part B covers four face to face counseling services per year at no cost. These sessions must be provided in a doctor's office or a primary care clinic by a primary care provider, i.e. a doctor or nurse practitioner.
Screening for depression	Within the first 12 months of enrollment, Part B covers a one-time Wellness Visit that assesses an individual's risk for depression. Part B also covers a yearly depression screening in a primary care doctor's office or clinic that provides follow-up treatment and referrals. If the doctor accepts assignment, the screening is provided at no cost.

Treatment	Description and Costs
Diagnostic tests, psychological testing	Part B covers medically necessary diagnostic tests, psychiatric evaluations and other testing to assess current treatment outcomes. Services may be provided in a clinic, doctor's office, therapist's office or hospital outpatient department. The patient's cost is 20% of the Medicare approved amount. Services provided in a hospital outpatient facility may also incur a copayment to the hospital that ranges from 20% to 40% of the Medicare approved amount.
Outpatient Psychotherapy	Part B covers individual and group psychotherapy counseling sessions with a doctor or other licensed professionals and family counseling related to an individual's treatment. Services may be provided in a clinic, doctor's office, therapist's office or hospital outpatient department. The patient's cost is 20% of the Medicare approved amount. Services in a hospital outpatient facility may also incur a copayment to the hospital ranging from 20% to 40% of the Medicare approved amount.
Inpatient Hospitalization	Part A covers mental health services for an individual who requires treatment in an inpatient setting. Services may be provided in a general hospital or a psychiatric hospital. Part A has a 190 day lifetime limit on inpatient services provided in freestanding psychiatric hospitals. Part A coverage excludes charges for private duty nursing, phones, televisions and personal items. Inpatient hospitalization services incur charges under Part A and Part B. Patient costs under Part A include a deductible of $1,260 per benefit period and coinsurance payments of $315 for stays over 60 days. Beneficiaries treated for psychiatric conditions are covered for 90 days of care per spell of illness. Patient costs under Part B include 20% of the Medicare approved amount for mental health services provided by a doctor and other providers while hospitalized.
Partial Hospitalization	Part B covers partial hospitalization programs provided through a hospital outpatient department or community mental health center that accepts Medicare payment. For coverage to be authorized, a doctor must certify that inpatient hospitalization would otherwise be needed. Coverage under Part B includes psychotherapy and may include occupational therapy, individual patient training and patient education services that are part of a treatment plan. Coverage under Part B excludes meals; transportation to or from mental health care services; support groups that bring people together to talk and socialize; and testing or training for job skills that are not part of an individual's mental health treatment. After the Part B deductible has been satisfied, patient charges for partial hospitalization include an unspecified percentage of the Medicare approved amount for each program service provided by a doctor or other qualified mental health professional plus a per day coinsurance payment.
Inpatient Detoxification	Part A covers substance abuse services for an individual who requires treatment in an inpatient setting. Services must be medically necessary and may be provided in a general hospital or a psychiatric hospital. Inpatient hospitalization services incur charges under Part A and Part B. Patient costs under Part A include a deductible of $1,260 per benefit period and a coinsurance payment of $315 per day for days 61-90 of a stay. Costs under Part B include 20% of the Medicare approved amount for treatment services provided by a doctor and other providers while hospitalized.

Treatment	Description and Costs
Outpatient Detoxification	Part B covers substance abuse treatment and detoxification services provided at a clinic or a hospital outpatient department. Covered services include psychotherapy, patient education, post hospitalization follow-up and prescription drugs administered during a hospital stay or injected at a doctor's office. Under Part B, methadone coverage is limited to hospital inpatients; it is not provided in outpatient clinics. After the Part B deductible has been satisfied, if the provider accepts assignment, the cost to the patient is 20% of the Medicare approved amount. Part D covers outpatient prescription drugs. Part D plans must cover medically necessary drugs to treat drug abuse; however plans cannot cover methadone to treat substance abuse.
Case Management	Coordination of care provided through the Patient Centered Medical Home is covered. Benefits are provided for the associated costs for coordination of care for the Qualifying individual's medical conditions.
SBIRT	Medicare covers Structured Assessment and Brief Intervention (SBIRT) therapies for patients who show signs of drug abuse or dependency provided at a doctor's office or outpatient hospital department.

B. Medicaid and Maryland's Public Behavioral Health System (PBHS)

Medicaid and the related Children's Health Insurance Program (CHIP) are the two primary public medical assistance programs for low-income populations in the United States. These programs are jointly funded by the federal government and the states, and they are means-tested, meaning that individuals must have low incomes and few assets to enroll. Some states, including Maryland, administer Medicaid and CHIP as a single program.

Maryland's Medicaid program (which includes its CHIP program) is the principal source of State funding for behavioral health services in Maryland. Table 13 presents Medicaid eligibility data for Montgomery County from 2010 to 2014. At the end of 2014, there were nearly 176,000 Medicaid-eligible individuals, an increase of 29% from the previous year.

Table 13. Number of Medicaid-Eligibles in Montgomery County at Year-End, 2010-2014

Year	2010	2011	2012	2013	2014	5 year change	Avg. Annual Growth
# of Medicaid-Eligibles	113,008	121,080	128,204	135,985	175,892	62,884	12%

Source: Maryland Medicaid eHealth Statistics, < http://www.chpdm-ehealth.org/eligibility/index.cfm >

Maryland's Medicaid program provides specialty mental health and substance use services to Medicaid enrollees through the state's Public Behavioral Health System (PBHS), which also provides services to certain individuals who are not eligible for Medicaid. This section describes the federal framework for Medicaid and CHIP, the state's Medicaid and PBHS structure and rules, and service and expenditure data from the PBHS.

1. The federal framework for Medicaid and CHIP

Medicaid was signed into federal law in 1965 and entitles eligible individuals to access certain medical services via state Medicaid programs that cover the cost of services. All states currently participate in Medicaid, even though participation is optional. To establish a Medicaid program, states must agree to conform to requirements established in federal law as well as issuances of the federal Department of Health and Human Services that relate to provider reimbursement, eligibility standards, and the quality and scope of medical services. Additionally, the Children's Health Insurance Program (CHIP), created by Congress in 1997, provides medical assistance to uninsured children whose families earn too much money to qualify for Medicaid.[1]

The Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services is the federal agency responsible for formulating and implementing Medicaid and CHIP program policies and operations. Among its various functions, CMS approves the states' Medicaid State Plans, which are contractual agreements that describe the states' Medicaid programs, as well as proposed State Plan Amendments (SPAs) and waiver amendments. SPAs and waiver amendments can change various aspects of a state Medicaid program, such as eligibility, the benefit package or provider reimbursement.[2]

It is important to note that the Patient Protection and Affordable Care Act (ACA), enacted by Congress in 2010, made substantial changes to federal law as it relates to Medicaid. Most significantly, the ACA expanded eligibility for Medicaid to all adults under 138% of the federal poverty level as of January 1, 2014.[3] Previously, most childless adults could not receive Medicaid coverage. Appendix A provides a more detailed summary of federal rules regarding Medicaid eligibility, services and structure.

2. Structure of Maryland Medicaid and the Public Behavioral Health System

The Maryland Department of Health and Mental Hygiene (DHMH) is responsible for managing the State's Medicaid program[4], which provides behavioral health services to eligible Maryland residents through two separate systems. The first system is comprised of a group of Managed Care Organizations (MCOs) that provide Medicaid benefits for most types of medical services, including primary mental health services, through *a managed care model*.[5] The second system is the State's Public Behavioral Health System (PBHS), which provides specialty mental health services and substance abuse services for Medicaid enrollees and

[1] Substance Abuse and Mental Health Services Administration. *Medicaid Handbook: Interface with Behavioral Health Services*. HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013, pp. 2-4 to 2-10.

[2] *Medicaid Handbook: Interface with Behavioral Health Services*, pp. 2-1 to 2-3

[3] Ibid., pp. 7-5 to 7-13, and *Compilation of Patient Protection and Affordable Care Act* [as amended through May 1, 2010], Prepared by the Office of the Legislative Counsel for the use of the U.S. House of Representatives, May 2010, < http://housedocs.house.gov/energycommerce/ppacacon.pdf > accessed 11/18/2014; and "Medicaid expansion & what it means for you," HealthCare.gov, < https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/ > accessed 2/20/3025

[4] Maryland has structured its CHIP program (called the Maryland Children's Health Program) as an extension of its Medicaid program, with the same benefits. In this report, references to Maryland's Medicaid program include CHIP.

[5] Under managed care, a state will typically contract with an organization, usually referred to as a "managed care organization" (MCO), to provide services to Medicaid enrollees through a defined network of providers. Managed care structures allow states to transfer risk to MCOs, and the degree of risk that is transferred can vary. In a "full-risk" contract, the state pays the MCO a set fee per enrollee per month, known as a "capitation" payment, and the MCO provides all benefits to enrollees. The MCO must pay for services even if the cost of enrollees' use of services exceeds capitation payments, and can keep or reinvest unused funds if enrollees use fewer services.

certain uninsured individuals through *a fee-for-service model*[6] that incorporates some elements of managed care.

In the first system, a group of Managed Care Organizations (MCOs) provide benefits to enrollees through a defined group of providers, and the State makes "capitation" payments to MCOs based on the number of enrollees.[7] However, in 1997, specialty mental health services were "carved out" from the rest of the managed care system to create the second system, then known as the Public Mental Health System (PMHS).

The PMHS adopted a hybrid "managed care fee-for-service" model, whereby the State makes payments to providers in the community based on the services provided in accordance with a fee-for-service model, but a single Administrative Services Organization (ASO) is responsible for pre-authorizing treatment and payment of claims deemed "medically necessary," creating an element of managed care.[8] Medicaid substance abuse services were provided through the Medicaid program's managed care system; additionally, a large portion of publicly-funded substance abuse services were funded by grants outside of the Medicaid program.[9]

In recent years, the State has worked to integrate care for mental health and substance use disorders (a summary of this process is provided in Appendix B). This effort was the result of concerns about the existing system's ability to address the needs of the large population of individuals with co-occurring mental health and substance abuse disorders. Beginning in January of 2015, the State now provides Medicaid substance abuse services through the same fee-for-service system that provides specialty mental health services via the Administrative Services Organization (ASO), and the PMHS has been replaced by the Public Behavioral Health System (PBHS).[10] Additionally, in recent years, the expansion of the Medicaid-eligible population as a result of the Affordable Care Act has led to an increase in the number of individuals who can receive behavioral health services through Medicaid, and this has been accompanied by a decrease in grant funding for substance abuse services outside of Medicaid.[11]

Within the Department of Health and Mental Hygiene, the Medical Care Programs Administration (MCPA) is responsible for managing the State's Medicaid program, including the system of MCOs that provides most

[6] Under fee-for-service, providers (such as physicians and hospitals) deliver services to eligible individuals and then bill states for those services. Eligible individuals can typically obtain care from any provider of their choice, as long as the provider accepts Medicaid reimbursement.

[7] As of 2014, approximately 80% of Maryland Medicaid enrollees received medical assistance for somatic care through the State's managed care system. Individuals in certain categories, such as those over the age of 65, receive care through a separate fee-for-service system for somatic care that is not discussed in this report. See Maryland Department of Health and Mental Hygiene, Request for Proposals, Solitication No. DHMH OPASS – 14-13835, February 4, 2014, p. 29 < http://www.dhmh.state.md.us/procumnt/Documents/OPASS-14-13835-Final.pdf > accessed 12/19/2014.

[8] Tucker, Susan, "Maryland Medicaid's Partnership in Improving Behavioral Health Services," Office of Health Services, Maryland Department of Health and Mental Hygiene, September 8, 2014, < http://www.dhmh.maryland.gov/mha/Documents/Medicaid%20and%20BHA%20%281%29.pdf > accessed 12/12/2014.

[9] "Alcohol and Drug Abuse Administration," Department of Health and Mental Hygiene," *Analysis of the FY 2014 Maryland Executive Budget*, Department of Legislative Services, Maryland General Assembly, 2013, p. 25, < http://mgaleg.maryland.gov/pubs/budgetfiscal/2015fy-budget-docs-operating-M00L-DHMH-Behavioral-Health-Administration.pdf > accessed 12/9/2014.

[10] Maryland Department of Health and Mental Hygiene, *Report on Behavioral Health Integrated Service Delivery and Financing System Implementation*, January 30, 2014, < https://mmcp.dhmh.maryland.gov/Documents/behavioralhealthJCRfinal12-13.pdf > accessed 12/12/2014; and "Behavioral Health Integration," Maryland Department of Health and Mental Hygiene website, < http://dhmh.maryland.gov/bhd/sitepages/integrationefforts.aspx > accessed 12/12/2014.

[11] "Behavioral Health Administration, Department of Health and Mental Hygiene," *Analysis of the FY 2015 Maryland Executive Budget*, Department of Legislative Services, Maryland General Assembly, 2014, p. 29, < http://mgaleg.maryland.gov/pubs/budgetfiscal/2015fy-budget-docs-operating-M00L-DHMH-Behavioral-Health-Administration.pdf > accessed 12/9/2014.

Medicaid services. The newly formed Behavioral Health Administration (BHA) is currently responsible for managing the PBHS.[12]

Core Service Agencies and Local Addictions Authorities. The fee-for-service PBHS includes a system of county and multi-county authorities called Core Service Agencies (CSAs) and Local Addictions Authorities (LAAs) responsible for planning, managing and monitoring publicly funded mental health and substance abuse services at the local level.[13] In Montgomery County, the CSA and the LAA are both situated in the Behavioral Health and Crisis Services Area of the Department of Health and Human Services. The responsibilities of CSAs and LAAs include:[14]

- Referring individuals and families to service providers and other consumer support
- Addressing needs of individuals in crisis
- Liaising with service providers
- Monitoring provider service delivery and service utilization
- Developing the continuum of community based services
- Assisting in service coordination
- Participating in provider reviews
- Managing high-cost users
- Inspecting residential programs
- Liaising with State behavioral health authorities

3. Eligibility standards for Medicaid and the PBHS

To access the Public Behavioral Health System (PBHS) and other Medicaid-funded behavioral health services, individuals typically must be eligible for Medicaid and (for the PBHS specifically) have a qualifying diagnosis. State regulations list 270 mental health diagnoses and 107 substance use disorder diagnoses covered under the PBHS.[15] Additionally, some individuals who are not eligible for Medicaid may be able to access the PBHS specifically by qualifying as an "uninsured-eligible" for the PBHS, which also requires having a qualifying diagnosis. This section describes the eligibility rules for Medicaid and for PBHS "uninsured-eligibles".

Medicaid eligibility. Federal law defines population groups that states are required to cover as well as groups that are optional to cover through their Medicaid and CHIP programs. Table 14 summarizes eligibility standards for Maryland's Medicaid program. To qualify under any of the eligibility categories listed in the table, an individual must be a Maryland resident who is either a citizen of the United States or a non-citizen who is a "qualified alien." Qualified aliens include individuals with permanent resident status, individuals who are victims of battery or cruelty by a spouse or relative, asylees and refugees.[16]

[12] In the past, the Mental Hygiene Administration (MHA) was responsible for managing the PMHS and the Alcohol and Drug Abuse Administration (ADAA) was responsible for operating grant-funded substance abuse programs. As part of the State's behavioral health integration efforts, the MHA and the ADAA have been merged into the Behavioral Health Administration (BHA)

[13] Md. Code Ann., Health-General §10-1201

[14] Maryland Association of Core Service Agencies, "Integrated Care for Individuals with Behavioral Health Disorders," August 30, 2011, p. 2, < http://www.marylandbehavioralhealth.org/_literature_103022/MASCA_White_Paper_on_Behavioral_Health > accessed 12/19/2014; and Maryland Department of Health and Mental Hygiene, *Report on Behavioral Health Integrated Service Delivery and Financing System Implementation*, January 30, 2014.

[15] COMAR 10.09.70.02

[16] COMAR 10.09.24.05

Many of the criteria are based on whether a person's annual family income is below a certain percentage of the Federal Poverty Level (FPL). In 2015, the FPL for a family of four is $24,250.[17] Additionally, for most individuals, family income must be calculated as "Modified Adjusted Gross Income," or "MAGI," which is generally to a household's adjusted gross income from a federal tax return plus any tax-exempt income, such as Social Security Income, that the household receives.[18]

Table 14. Maryland Medicaid and CHIP Eligibility Standards

Group*	Maximum family income based on family of four**
Medicaid	
Children, parents and other adults under the age of 65 with household incomes equal to or less than 138% of the federal poverty level (as of January 1, 2014).	$33,465
Pregnant and postpartum women of any age with household incomes equal to or less than 264% of the federal poverty level.	$64,020
Former foster children younger than 26 years old who were enrolled in Medicaid at the time they aged out of foster care.	None
Aged, blind or individuals with disabilities who meet eligibility requirements for Supplemental Security Income (SSI) and related programs.	Varies by applicable program
"Medically Needy" individuals with high medical expenses whose incomes exceed thresholds to qualify under other categories, and who belong to one of the following groups (1) pregnant women; (2) individuals under 21 years old; (3) caretaker relatives and spouses; or (4) aged, blind or persons with disabilities.	Varies depending on medical expenses and the income standard for the category under which the individual would otherwise qualify
Women 40-64 years old who are uninsured with a household income below 250% of the federal poverty level***, and need treatment for breast cancer, cervical cancer, or precancerous conditions.	$60,625***
Maryland Children's Health Insurance Program (CHIP)	
Children under age 19 whose household income is at or below 322% of the federal poverty level. Families of children with household incomes between 217-322% of the federal poverty level are required to pay a monthly premium.	$78,085

Sources: COMAR 10.09.24; "State Medicaid and CHIP Income Eligibility Standards," CMS, 2014, < http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf > accessed 2/20/2015; and Md. Code Ann., Health-General § 15-301 (b).
* Percentages of the federal poverty level listed in this table reflect a "5% disregard" that is part of the Affordable Care Act, which effectively increases the maximum percentage of the federal poverty level by 5 percentage points.
** Based on 2015 Federal Poverty Level for Family of Four and use of Modified Adjusted Gross Income.
*** Eligibility for women with breast or cervical cancer is determined in part by participation in the Maryland Breast and Cervical Cancer Screening Program, which has an income limit of 250% of the federal poverty level or $60,625 for a family of four in 2015.

[17] Annual Update of the HHS Poverty Guidelines, 80 Fed. Reg. 3236 (Jan. 22 2015), available at < https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines#addresses > accessed 2/19/2015
[18] "Modified Adjusted Gross Income (MAGI)," HealthCare.Gov website, < https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/ > accessed 2/20/2015; and "MAGI: Medicaid and CHIP's New Eligibility Standards," fact sheet, Center for Medicaid and CHIP Services, U.S. Department of Health and Human Services, September 30, 2013, < http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf > accessed 2/2/2015

It is important to note that about 19,000 or 11% of the County's Medicaid-eligible individuals are dually eligible for both Medicaid and Medicare.[19] Individuals can become "dual-eligibles" if they are either elderly or have a disability and also meet applicable income/asset requirements, for example under the "Medically Needy" category in table 14. Dual-eligibles can receive Medicaid coverage for services not covered by Medicare, such as long-term care. Not all dual-eligibles are entitled to full Medicaid benefits – some only receive assistance with out-of-pocket costs associated with Medicare including premiums and coinsurance.[20]

Eligibility Standards for PBHS "Uninsured-Eligibles". The fee-for-service Public Behavioral Health System (PBHS) also provides State-funded behavioral health services on a short-term basis (three months, renewable) to certain individuals who are not enrolled in the State's Medicaid program, do not have access to other insurance or to sufficient insurance, and meet medical necessity criteria. Table 15 summarizes criteria to qualify for PBHS services as an "Uninsured Eligible" individual or an insured "Uninsured Eligible" individual.

[19] Maryland Medicaid eHealth Statistics, < http://www.chpdm-ehealth.org/eligibility/index.cfm >

[20] Young, K., Garfield, R., Musumeci M., Clemans-Cope, L. and Lawton, E. "Medicaid's Role for Dual Eligible Beneficiaries," Kaiser Family Foundation, August 2013, < https://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf > accessed 5/25/2015.

Table 15. Maryland Public Behavioral Health System Eligibility Standards for the Uninsured

Group	Maximum family income based on family of four**
Uninsured	
Individuals who meet all six uninsured criteria: 1. Require treatment for a behavioral health diagnosis(es) covered by the PBHS 2. Have a verifiable Social Security Number 3. Have applied for Medicaid (MA), the Health Care Exchange, Social Security Income (SSI), or Social Security Disability Insurance (SSDI); if not eligible for MA, SSI, or SSDI, documentation from MA or Social Security stating the reason for ineligibility must be provided and maintained in the consumer's medical record. 4. Are Maryland residents 5. Have family incomes that do not exceed 250% of the federal poverty level; and 6. Are U.S. citizens or are non-citizen approved by the CSA	$60,625
Individuals who meet only some of the criteria for uninsured but who: • Are under the age of 19; OR • Were released from prison , jail or Department of Corrections facility within the last three months; OR • Are pregnant; OR • Are injection drug users: OR • Have HIV/AIDS: OR • Were recently discharged from a Maryland-based psychiatric hospital or a residential treatment facility for substance abuse; OR • Are requesting services required by a court order or referred by Drug Court; OR • Are currently receiving SSDI for mental health reasons; OR • Are homeless in the State of Maryland; OR • Are veterans.	$60,625 (but may be higher in some circumstances)
Individuals who are in immediate need for services, such as acutely suicidal (can qualify as uninsured without documentation for one month, and can receive an additional month extension once).	None
Insured "Uninsured eligible"	
Individuals with health insurance coverage who meet all "uninsured criteria," and who: • Are Medicare beneficiaries but Medicare does not cover the required service, and do not have other insurance to cover the service; OR • Have commercial health insurance but the mental health benefits are exhausted.	$60,625

4. Behavioral Health Services Covered Through Maryland Medicaid and the PBHS

As noted above, Medicaid and PBHS-eligible individuals can receive behavioral health services through two separate systems. The first, Maryland Medicaid's managed care system, provides care through a system of Managed Care Organizations (MCOs). The second is Maryland Public Behavioral Health System, which provides care through a single Administrative Services Organization (ASO).

Behavioral health services provided through Managed Care Organizations. In Maryland's Medicaid managed care system, the State contracts with a group of Managed Care Organizations (MCOs) to provide services to Medicaid enrollees through defined networks of providers. The State prepays MCOs for services with "capitation payments," or payments made to MCOs per enrollee for a set period of time.[21]

This system of MCOs provides primarily somatic health services, which are services related to physical health. Most Medicaid behavioral health benefits are provided *outside* of this system of MCOs, in the fee-for-service PBHS. However, MCOs must provide "medically necessary primary mental health services," which are mental health services provided in a primary care setting, including referrals to specialized mental health services provided through the PBHS.[22] Additionally, MCOs must provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to enrollees under the age of 21. Within the EPSDT category, MCOs must provide comprehensive well-child services on a specified periodicity schedule, including assessments of both physical and mental health and development.[23]

Behavioral health services provided through the Administrative Services Organization. The State has established a contract with an Administrative Services Organization (ASO), currently ValueOptions, to administer the fee-for-service PBHS, which covers specialty mental health services and substance abuse services delivered by providers in the community. ASO responsibilities include:[24]

- Referring consumers to service providers
- Pre-authorizing non-emergency services by applying medical necessity criteria
- Processing claims and remitting payments
- Ensuring quality and appropriateness of services

Tables 16 and 17 summarize the specialty mental health and substance abuse services covered through the PBHS.[25]

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[21] Md. Code Ann., Health-General § 15-101 (e); and Tucker, S., "Maryland Medicaid's Partnership in Improving Behavioral Health Services," p. 8

[22] COMAR 10.09.67.26

[23] COMAR 10.09.23.04

[24] Tucker, S., "Maryland Medicaid's Partnership in Improving Behavioral Health Services," p. 12

[25] Federal law allows states to provide a different type of Medicaid coverage, called "Alternative Benefit Plans," to the population made newly eligible as a result of the ACA. Alternative Benefit Plans must be based on a "blueprint" commercial insurance plan selected by the state and may cover fewer behavioral health services compared with traditional Medicaid. Maryland's alternative benefit plan includes the same behavioral health benefits provided through traditional Medicaid. Additionally, federal law gives individuals with serious mental illness who are part of the ACA's Medicaid expansion population the right to choose traditional Medicaid coverage instead of an Alternative Benefit Plan. See *When Opportunity Knocks: How the Affordable Care Act Can Help States Develop Supported Housing for People With Mental Illnesses*, The Judge David Bazelon Center for Mental Health Law, April 2014, pp. 7-8 < http://www.bazelon.org/portals/0/Where%20We%20Stand/Community%20Integration/Olmstead/When%20Opportunity%20Knocks.%20Bazelon%20Center%20for%20Mental%20Health%20Law.pdf > accessed 11/20/14; and "Legal Notice/Public Notice: State Plan Amendment (Alternative Benefit Plan) for the Medicaid Expansion Population," Maryland Department of Health and Mental Hygiene, < http://dhmh.maryland.gov/docs/ABP5%20for%20Public%20Notice.pdf > accessed 5/21/2015

Table 16. Maryland Medicaid Specialty Mental Health Services Covered Through the PBHS

Type	Service Description
Hospital	Inpatient and outpatient mental health services including psychiatric day treatment. Medicaid does not cover inpatient services in psychiatric hospitals with more than 16 beds (known as institutions for mental disease or IMDs) for individuals aged 22 to 64, except for emergency psychiatric care in private psychiatric hospitals (see COMAR 10.09.06.04 & 10.09.06.05, and page 28)
Individual Practitioners	Mental health services provided by psychiatrists, other physicians, clinical social workers, nurse psychotherapists, psychiatric nurse practitioners, occupational therapists, professional counselors, marriage and family therapists, and alcohol and drug counselors (see COMAR 10.09.59.04)
Outpatient Mental Health Clinic	Outpatient clinical services including individual, family and group therapy, psychological evaluation and testing, co-occurring substance abuse treatment, and medication services as well as referrals to other services (see COMAR 10.21.20.08 and 10.21.20.09)
Residential Treatment Center	Services performed under the direction of a physician in a residential treatment center for emotionally disturbed children or adolescents under 21 years old (see COMAR 10.09.29.04)
Partial Hospitalization	Intensive, nonresidential psychiatric treatment for any part of a 24-hour day for a minimum of 4 consecutive hours per day in a community setting (see COMAR 10.21.02.01)
Therapeutic Behavioral Services	Behavioral assessments and one-to-one interventions for individuals under 21 years old assessed as having behaviors or symptoms related to a mental health diagnosis that places the individual's current living arrangement at risk (see COMAR 10.09.34)
Mobile Treatment Program	Flexible, assertive and intensive mental health treatment and support services delivered in various community settings by a multidisciplinary treatment team to children and adults whose needs have not been met through traditional outpatient mental health programs (see COMAR 10.21.19.01)
Psychiatric Rehabilitation Program	Services to improve or restore independent living and social skills, including rehabilitation and support services, recovery activities, medication services, supported housing services, and health promotion and training (see COMAR 10.21.29.07 and COMAR 10.21.21)
Community Options for Children, Youth, and Families	Family support, respite services, expressive and experimental behavioral services, mobile crisis response, intensive in-home services and other services for children and youth with serious emotional disturbances residing in a home and community-based setting (see COMAR 10.09.89)
Mental Health Case Management	Mental health care coordination services for children and adults with serious emotional disturbances, co-occurring disorders or serious and persistent mental illnesses who require community treatment in order to prevent the need for inpatient or residential psychiatric treatment or to prevent or address homelessness, repeated emergency room usage or incarceration (see COMAR 10.09.90.03 and COMAR 10.09.45.03)
Health homes	Care coordination and management services provided by psychiatric rehabilitation or mobile treatment programs to individuals with serious and persistent mental illnesses or serious emotional disturbances (see COMAR 10.09.33 and Appendix C)
Therapeutic Nursery	Developmental and mental health services in a preschool setting including individual, group and family therapy and daily developmental activities for children under 5 years old who are at risk for or who are emotionally disturbed, who have behavior or adjustment problems, or both, and their families (see COMAR 10.21.18.06 and 10.21.18.01)
Traumatic Brain Injury Provider	Home and community-based services, including residential habilitation, day habilitation, supported employment and medical day care, for individuals with brain injury (see COMAR 10.09.46)
Medical Laboratory	Lab services ordered by a specialty mental health provider (see COMAR 10.09.59.06)
Telemental Health	Diagnostic interviews, individual therapy including medication management, family therapy, group therapy, outpatient evaluation and maintenance, initial inpatient consultation, and emergency department services rendered via a telecommunications system (see COMAR 10.21.30.09)
Pharmacy	Prescription drugs for mental health disorders; copays of $1-$3 required

Source: COMAR 10.09.59.04

Table 17. Maryland Medicaid Substance Abuse Treatment Services Covered Through the PBHS

Type	Service Description
Comprehensive Substance Use Disorder Assessment	Assessment of drug and alcohol use and substance use disorder treatment history, referrals for physical and mental health services, and recommendations for the appropriate level of substance use disorder treatment
Level I Group and Individual Substance Use Disorder Counseling	Services for participants who require less than 9 hours weekly for adults and 6 hours weekly for adolescents
Level II.1 Intensive Outpatient Services	Services for participants who require 9 to 20 hours weekly for an adult and 6 to 20 hours weekly for an adolescent
Level II.5 Partial Hospitalization	Services for participants who require 20 to 35 hours weekly of structured outpatient treatment
Opioid Maintenance Therapy and Buprenorphine Induction and Maintenance Therapy	Medications including methadone dosing and buprenorphine and substance use disorder and related counseling for opioid-addicted participants
Ambulatory Detoxification	Administration and monitoring of medication as necessary, management of withdrawal symptoms, motivating the individual to participate in a treatment program for alcohol or other drug dependence, and monitoring of vital signs
Health Homes	Care coordination and management services provided by opioid treatment programs to individuals affected by, or at risk for, additional chronic conditions (see COMAR 10.09.33 and Appendix C)
Residential Treatment for Children and Adolescents	Residential substance abuse treatment for individuals under the age of 21 in an intermediate care facility-alcoholic (ICF-A)
Pharmacy	Prescription drugs for substance abuse disorders; copays of $1-$3 required

Source: COMAR 10.09.80.05

Significantly, federal law prohibits states from using Medicaid funds to cover inpatient care in "institutions for mental diseases" (IMD), for individuals aged between 22 and 64, unless the IMD has 16 beds or fewer. This restriction is known as the "IMD exclusion," and it applies to care in psychiatric hospitals as well as mental health disorder and addictions residential treatment facilities. Inpatient services in IMDs for individuals under age 22 are required if medically necessary as determined via EPSDT screenings (see page 26), and are optional to cover for those aged 65 and older.[26] Maryland currently participates in the three-year Medicaid Emergency Psychiatric Demonstration that allows adults to receive emergency psychiatric care in private psychiatric hospitals through the Medicaid program as an exception to the IMD exclusion.[27]

Because Medicaid restricts coverage of inpatient psychiatric care, some nursing homes provide care for Medicaid beneficiaries ages 22 to 64 who have a serious mental illness. The Pre-Admission Screening and Resident Review (PASRR) program is a federal mandate that requires state Medicaid agencies to screen individuals admitted to nursing homes for serious mental illness. The screening is designed to determine whether a nursing home is the most appropriate placement; and, if so, to address an individual's need for specialized mental health treatment. DHHS' Adult and Disability Service Area administers Adult Evaluation

[26] *Medicaid Handbook: Interface with Behavioral Health Services*. HHS Publication No. SMA-13-4773., pp. 3-1 to 3-14
[27] "Medicaid Emergency Psychiatric Demonstration," Centers for Medicare & Medicaid Services website, March 13, 2012, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2012-Fact-sheets-items/2012-03-13.html, accessed 5/21/2015.

and Review Service Assessments for the County. The trend data in Table 18 shows a steady increase in the number of assessments since FY11.

Table 18. DHHS Adult Evaluation and Review Service Assessments, FY11 to FY14

Indicator	FY11	FY12	FY13	FY14
Annual number of Adult Evaluation and Review Service Assessments	1,689	1,859	1,843	2,006

Source: DHHS Monthly Activity Reports, FY11 to FY15

Additionally, the PBHS also provides additional services that are funded separately by the State and are subject to State funding availability, including residential rehabilitation, residential crisis services, supported employment, and respite care, described on Table 19.[28]

Table 19. State-Funded Non-Medicaid Services Covered Through the PBHS

Type	Service Description
Residential Rehabilitation	Medical or remedial services provided in a residential setting and directed toward reducing the individual's psychiatric disability and maximizing the individual's ability to function successfully in the community (COMAR 10.21.22)
Residential Crisis	Intensive mental health and support services that are provided to an individual with mental illness who is experiencing or at risk of a psychiatric crisis; services are designed to prevent, provide an alternative to, or shorten the length of an inpatient stay, or to reduce the pressure on general hospital emergency departments (COMAR 10.21.17.02)
Supported Employment	Assistance in obtaining competitive employment with compensation that establishes an hours-per-week employment goal to maximize an individual's vocational potential, provides additional supports as needed, and provides transitional employment placements, as appropriate (COMAR 10.21.28.02)
Respite Care	Services designed to support an individual in remaining in the individual's home by providing enhanced support to the individual, providing a temporary alternative living situation or assisting the individual's home caregiver by temporarily freeing the caregiver from the responsibility of caring for the individual (COMAR 10.21.27.02)

Finally, individuals who are not eligible for Medicaid but have been granted eligibility for the PBHS as "eligible uninsured" individuals do not receive PBHS coverage for the same set of services as Medicaid enrollees. Additionally, "uninsured eligible" individuals are required to contribute to the cost of care for some services. Services available to this category of individuals include:[29]

- Crisis Services
- Outpatient Mental Health Clinic Services, except for Intensive Outpatient Services
- Outpatient Services (non-clinic)
- Psychiatric Rehabilitation Program Services (PRP)
- Residential Rehabilitation Program Services (RRP)
- Respite Services
- Supported Employment
- Mobile Treatment Services
- Occupational Therapy

[28] Maryland Department of Health and Mental Hygiene, Request for Proposals, Solitication No. DHMH OPASS – 14-13835, February 4, 2014, p. 34 < http://www.dhmh.state.md.us/procumnt/Documents/OPASS-14-13835-Final.pdf > accessed 12/19/2014.

[29] Provider Manual, Value Options Maryland, January 2015, < http://maryland.valueoptions.com/provider/handbook/MD-PBHS-Provider-Manual.pdf > accessed 5/21/2015

5. Public Behavioral Health System Data

As described on page 22, the County's Core Service Agency (CSA) is responsible for planning, managing and monitoring publicly funded mental health services at the local level. The CSA collects and reviews data from the Administrative Services Organization on the fee-for-service Public Behavioral Health System (PBHS), including data on persons served and expenditures by coverage type, age and services used, as shown in Table 20. As noted on page 21, substance abuse services were incorporated into the fee-for-service PBHS system beginning in 2015; data are available through FY2014 and therefore include only mental health service usage data. The data show that:

- The vast majority of individuals (almost 12,000 or 92% in FY14) receiving mental health services through the PBHS were Medicaid enrollees receiving Medicaid-funded services.
- In all four years, adults aged 22 to 64 represented just over half of all persons served while individuals aged 65 or older represented only between 1% and 2% of persons served.
- Outpatient services was by far the most commonly used service type, with between 10,000 and 12,000 persons per year using this service, and it accounted for over $19 million in expenditures in FY14.
- Psychiatric rehabilitation and inpatient services were the next two most commonly used service types; each of these two categories had between 800 and 1,500 persons served each year and between $11 million and $14.5 million in expenditures over the four year period.
- In FY14, the PBHS experienced significantly larger increases than previous years in both the number of Medicaid enrollees receiving Medicaid services (15.9%) and in total Medicaid expenditures (11.8%). Numbers of uninsured persons served and expenditures on services for the uninsured decreased both in FY13 and FY14.

Table 20. Fee-for Service Public Behavioral Health System Mental Health Services, Persons Served* and Expenditures in Montgomery County, FY11-FY14

	Persons				Expenditures ('000s)			
	FY11	**FY12**	**FY13**	**FY14**	**FY11**	**FY12**	**FY13**	**FY14**
Coverage Type								
Medicaid	9,036	9,760	10,137	11,746	$40,159	$40,446	$41,552	$46,465
Medicaid State Funded	1,851	2,170	2,289	2,374	$6,486	$7,622	$8,259	$9,731
Uninsured	1,460	1,348	1,194	894	$3,465	$3,779	$2,479	$2,021
TOTAL	**10,375**	**11,055**	**11,394**	**12,772**	**$50,111**	**$51,847**	**$52,290**	**$58,218**
Age Group								
Early Child (0-5)	462	497	463	458	$676	$717	$759	$734
Child (6-12)	1,958	2,174	2,287	2,411	$5,691	$5,234	$5,497	$6,878
Adolescent (3-17)	1,671	1,759	1,749	1,932	$8,782	$9,017	$9,437	$9,283
Transitional (18-21)	706	723	775	866	$3,176	$4,140	$3,887	$3,826
Adult (22-64)	5,461	5,761	5,933	6,866	$31,030	$31,995	$31,719	$36,009
Elderly (65 and over)	117	141	187	239	$756	$744	$990	$1,486
TOTAL	**10,375**	**11,055**	**11,394**	**12,772**	**$50,111**	**$51,847**	**$52,290**	**$58,218**
Service Type								
Case Management	117	108	105	66	$57	$75	$77	$50
Crisis	229	234	213	251	$828	$891	$974	$978
Inpatient	867	834	873	1,100	$11,302	$11,365	$12,688	$14,503
Mobile Treatment	143	147	174	187	$1,260	$1,351	$1,449	$1,436
Outpatient	9,667	10,361	10,775	12,064	$14,635	$15,013	$15,172	$19,115
Partial Hospitalization	139	132	131	144	$566	$551	$712	$565
Psychiatric Rehabilitation	1,306	1,355	1,456	1,504	$13,420	$13,704	$13,897	$14,584
Residential Rehabilitation	590	592	572	588	$1,468	$1,481	$1,479	$1,530
Residential Treatment	59	56	58	60	$3,188	$3,150	$3,016	$2,941
Respite Care	13	11	13	13	$27	$27	$25	$35
Supported Employment	671	672	735	786	$1,858	$2,032	$2,329	$2,469
Emergency Petition	17	32	22	13	$2	$5	$7	$8
Purchase of Care	203	273	65	0	$1,490	$2,148	$432	$0
PRTF Waiver	11	13	10	4	$8	$53	$30	$5
TOTAL	**10,375**	**11,055**	**11,394**	**12,772**	**$50,111**	**$51,847**	**$52,290**	**$58,218**

Source: Fiscal Years 2013 and 2014 Annual Reports, Montgomery County Core Service Agency
*Individuals may belong to multiple coverage groups and use multiple service types

Chapter V. Behavioral Health Service Coverages in Maryland's Private Insurance Market

According to data from the 2013 American Community Survey, approximately 775,000 or 77% of non-institutionalized Montgomery County residents have private insurance coverage, including 668,000 who have coverage through an employer-based plan and 114,000 who directly purchase individual coverage. For roughly 85% of those with employer based coverage plans, these plans are their only source of coverage. By comparison, 54% of individual plans are the sole coverage source and 46% provide supplemental coverage that is additional to another form of coverage.

Federal and State law establish rules regarding the type of coverage that private health insurance must provide, including behavioral health benefits. Rules apply differently to the different types of private insurance plans, which include individual plans, small group plans and large group plans. This chapter describes the rules that govern behavioral health benefits provided through private insurance plans and is organized as follows:

- **Section A** provides an overview of the structure of the private health insurance market in the United States;
- **Section B** summarizes the Federal and State rules that govern behavioral health benefits in private insurance plans and their applicability to different categories of plans; and
- **Section C** outlines the behavioral health benefit coverages required of different private health insurance market segments.

A. The Structure of the Private Health Insurance Market

This section describes the market structure of private health insurance to provide context for the descriptions of behavioral health regulations that follow. The three parts of the private insurance market are:

- Individual plans, or plans sold directly to individuals that provide individual or family coverage;
- Small group plans, or plans for employers that have between 2 to 50 employees; and
- Large group plans, or plans for employers with more than 50 employees.

Both large and small employers have the option of purchasing fully insured group plans on the commercial market or self-funding their plans. Most small employers purchase full insured group plans while most large employers self-fund their plans.[1] An employer who purchases a fully insured group plan on the commercial market contracts with a health insurer who collects premiums from enrollees in exchange for providing coverage of medical services and bearing the financial risk of paying claims.

The federal Employee Retirement Income Security Act of 1974 (ERISA) allows states to regulate insurance carriers where employers contract with those carriers to provide fully insured plans; however, it pre-empts states from enforcing these state laws for private sector plans that employers establish and fund directly to provide health coverage as an employee benefit (known as self-funded or self-insured plans). For those employers who rely on these self-insured plans, the employer bears the financial risk of paying claims, although they may contract with a third party for plan administration. The U.S Department of Labor administers the ERISA provisions. Table 21 provides an overview of the Maryland private insurance market by segment. The results show that large group plans account for two thirds of those with private coverage.

[1] "Concentration of Enrollees among Private Insurers," U.S. Government Accountability Office: GAO-15-101R, December 1, 2014, p. 9 < http://www.gao.gov/assets/670/667245.pdf > accessed 6/30/2015

Table 21. Maryland Private Insurance Coverage by Market Segment, 2013

Market Segment	Market share (%)*	Enrolled County Residents Estimate**	Self-Insured (% of enrolled)*
Individual (Non Group)	13%	100,725	NA
Small Group	22%	170,458	10%***
Large Group	65%	503,625	66%
Totals	**100%**	**774,807**	**55%**

Sources: GAO: "Concentration of Enrollees among Private Insurers," December 1, 2014, p. 9 and Agency for Healthcare Research and Quality: 2013 Medical Expenditure Panel Survey-Insurance Component, Table II.B.2.b.(1)(2013)
* Percentages are based on State market shares; self-insured data are based on private sector data only
** Estimated using 2013 American Community Survey estimate of County residents with private coverage
*** Estimated percentage is considered to be statistically imprecise

B. Federal and State Rules that Govern Behavioral Health Benefits in Private Insurance Plans

Together, provisions in three separate laws, i.e. Federal and State parity laws and the Affordable Care Act, establish the behavioral health benefits regulatory structure for private health benefit plans that enroll Montgomery County residents. The relevant laws for the employer group market are briefly described below, followed by an assessment of their applicability. The following section describes and compares specific benefit coverages and addresses mandates for individual policies.

1. The Federal Parity Act.

In 2008, the Mental Health Parity and Addiction Act (MHPAEA) was enacted to end discrimination in health insurance coverage for persons with mental health and substance use disorders. MHPAEA defines the following six categories to classify and compare health plan benefits:

- Outpatient, in-network;
- Outpatient, out of network;
- Inpatient, in-network;
- Inpatient, out of network;
- Emergency care; and
- Prescription drugs.

Within each of these classifications, MHPHEA prohibits health plans from providing behavioral health (MH/SUD) benefits that are more restrictive than medical or surgical benefits. MHPHEA addresses four specific coverage features that must be equivalent for behavioral health benefits, if provided:

- **Financial requirements**, e.g., co-pays or deductibles;
- **Quantitative treatment limitations**, e.g., day limits or visit limits;
- **Plan design features that limit the scope or duration of treatment**, e.g., medical management, medical necessity and authorization standards, provider network standards and reimbursement rates, and fail first policies; and,
- **Annual and lifetime dollar limits** on benefit payments.

MHPHEA also requires plans to disclose certain behavioral health benefit information to any current or potential plan participant, beneficiary or contracting provider upon request. These mandatory disclosures, which must be provided free of charge, require plan administrators to disclose the criteria used to make medical necessity determinations and the reasons for any denial of reimbursement or payment for service.

MHPHEA's provisions in federal law apply to all large employers that offer health insurance that provides mental health and substance use benefits, including self-insured large group plans and large group plans sold on the commercial market. Additionally, the Affordable Care Act amended the provisions of the MHPHEA to apply to individual health insurance coverage and to indirectly apply to small group health plans through the Essential Health Benefits provisions (see below). A plan that does not offer behavioral health benefits falls outside the scope of MHPHEA.

2. Maryland's Parity Law and the Maryland Comprehensive Standard Health Benefit Plan

Maryland law imposes requirements for fully-insured large group health plans and grandfathered individual plans through its parity law and for fully-insured small group plans through the Maryland Comprehensive Standard Health Benefit Plan.

Maryland's parity law is codified in § 15-802 of the Insurance Article and applies to fully-insured large group health plans and individually purchased health plans, but not to small group plans.[2] The law states that a policy or contract may not discriminate against an individual with a behavioral health disorder by "failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses."[3]

The law mandates that health plans provide certain behavioral health benefits, described in Table 26 and specifies minimum types and levels of treatment that are nondiscriminatory. For example, coverage days for inpatient MH/SUD benefits must be comparable to those for a physical illness; and, coverage for outpatient benefits must not be less than 80% for the first five visits of a calendar year or benefit period. Like the federal MHPHEA law, state law also prohibits lifetime maximums, deductibles and out of pocket limits that are separate from those for physical illness.

Fully-insured small group plans are exempt from the parity law, but must comply with the Maryland Comprehensive Standard Health Benefit Plan (CSHBP). State law requires the Maryland Health Care Commission (MHCC) to establish regulations for the CSHBP and requires that the cost of the CSHBP not exceed 10% of the state's average annual wage.[4] State regulations establish the set of CSHBP covered services, which include inpatient and outpatient mental health and substance abuse services, including detoxification, and establish cost-sharing requirements (see Table 25).[5]

[2] "Provider Parity Resource Guide," The University of Maryland School of Law: Drug Policy and Public Health Strategies Clinic, < http://madc.homestead.com/Provider_Parity_Resource_Guide_--_Distribution_Copy.pdf > accessed 6/30/2015.
[3] Insurance Article § 15-802(c)
[4] Insurance Article § 15-1207
[5] COMAR 31.11.06.03

3. The ACA's Essential Health Benefits for Individual Plans and Fully Insured Small Group Plans

Under the ACA, fully insured small group plans sold through an exchange must cover a set of ten defined health benefits, one of which includes mental health and substance abuse treatments. States are authorized to select the specific benchmark plans that comply with the "essential health benefits" established in federal regulation.[6]

According to the Maryland Insurance Administration, the list of Essential Health Benefits are subject to limitations and exclusions in COMAR 31.11.06.06 and Bulletin 13-01. Of note, COMAR 31.11.06.06 B. (50) excludes "Treatment for mental health or substance abuse not authorized by the carrier through its managed care system, or a mental health or substance abuse condition determined by the carrier through its managed care system to be untreatable," indicating that insurance carriers and their Managed Behavioral Health Organizations maintain some administrative decision making authority regarding these service mandates.

Applicability of the Behavioral Health Benefit Regulatory Structure by Market Segment. The applicability of federal and state parity law and the ACA Essential Health Benefit provisions vary by market segment and plan funding. Table 22 shows how federal and state parity law and the various state and ACA essential health benefit mandates vary by market segment and funding. Of note,

- Minimal mandates exist for the self-insured market, which accounts for 55% of statewide enrollees, ranging from no mandates for the small group market (at 19% of statewide enrollment) to a federal parity mandate but no substantive benefit mandates for the large group market; and

- Both parity and specific coverage mandates exist for the commercial market, which accounts for 21% of statewide enrollees, with the small group market (3% of enrollees) required to comply with benefit coverage mandates set forth in the Maryland Benchmark plan and the large group market required to provide coverage benefits specified in Maryland law.

It is important to note that the ACA has grandfather provisions that protect insurance coverages that predate the law from many of the ACA's health reform mandates, such as the requirement to cover Essential Health Benefits. This means benefit plans in place as of March 2010 that remain essentially unchanged are exempt from many ACA mandates, including the requirement to provide behavioral health benefits. The ACA envisions that as changes are made to these pre-existing grandfathered policies, they will lose their grandfathered status and fall under the scope of the ACA's health reforms.

[6] In Maryland, the Health Care Reform Coordinating Council selected the state's largest small group plan, CareFirst of Maryland (Blue Cross Blue Shield)-HMO HSA Open Access plan as the benchmark plan, and designated the GEHA Standard Option federal employee plan for the behavioral health benefit.

Table 22. Applicability of Federal and State Parity Law and ACA Essential Health Benefit Provisions

Market Segment and Plan Type	Applicable laws	MH/SUD Required Benefits Coverage
Individual Health Policies		
Individual Policies – New	ACA/EHB	Maryland Benchmark Plan
Individual Policies – Grandfathered	Maryland Parity Law	Maryland – MH/SUD Benefits
Employer Group Plans		
Self-Insured Plans		
Small Group	No law applies	None
Large Group	Federal Parity Act	If plan provides MH/SUD benefits, they must be at parity
Commercial Market Plans		
Small Group - New	ACA/EHB	Maryland Benchmark Plan
Small Group - Grandfathered	Maryland Parity Law	Maryland – MH/SUD Benefits
Large Group	Federal Parity Act Maryland Parity Law	Parity Compliance Maryland – MH/SUD Benefits

Sources: OLO, NAIC, MHCC and Kaiser Family Foundation

As workers' coverage transitions from grandfathered small group (and individual plans) to either new or exchange plans, their behavioral health benefits coverage is upgraded because their plans must comply with the ACA's essential health benefits mandate. The data in Table 23 below shows there have been substantial reductions nationally in the share of covered workers in grandfathered plans for both small (28 pts) and large (31 pts) firms since 2011.

Table 23. Percentage of U.S. Covered Workers Enrolled in Plans Grandfathered under the ACA by Size

Firm Size	2011	2012	2013	2014
All small firms (3-199 workers)	63%	54%	49%	35%
All large firms (200 or more workers)	53%	46%	30%	22%
All firms	56%	48%	36%	26%

Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2011-2014

C. Specified Behavioral Health Benefit Coverages by Market Segment

This section offers details of behavioral health coverages by private insurance subgroup. Table 24 presents a summary of parity and benefit mandates and County enrollee estimates for each subgroup based on state market shares (see Table 21). A review of the table suggests that three tiers of behavioral health benefit coverages exist in Maryland's private health insurance market. Ranked from fewest to most benefit mandates,

- The **lowest tier** of behavioral health coverage mandates applies to plans in the **small group commercial grandfathered market**. These mandates are set forth in COMAR regulations and described on Table 25. More data is needed on the grandfathered status of small group commercial plans to develop an estimate of County residents who have plans that would be included in this

coverage tier. If all small group commercial plans are grandfathered, this could include up to 154,100 county residents.

- The **middle tier** of behavioral health coverage mandates, described in Table 26 applies to plans in **the individual grandfathered market** and **the large group plan commercial market**. These mandates are codified by Maryland's parity law in Insurance Article §15-802. Large group plans are also subject to additional mandates for mandatory offerings specified in §15-801. If most individual policies are grandfathered policies, this tier could include up to 100,700 residents with individual policies and 169,700 residents with new large group commercial plans.

- The **highest tier** of behavioral health coverage mandates, described on Table 27, applies to new individual and small group commercial market plans, which must comply with the ACA Essential Health Benefits Maryland Benchmark Plan. This tier includes residents who just purchased private exchange plans plus an undetermined portion of the 154,100 residents with new small group commercial plans.

In sum, about 424,500 County residents are in private insurance plans that are subject to mandates that specify behavioral health coverages. Additionally, about 333,900 residents are in self-insured large group plans that must comply with parity laws only if their plans provide MH/SUD benefits.

Table 24. Crosswalk Summary of Private Insurance Subgroups and Behavioral Health Coverage Tiers

Market Segment	Funding and Grandfather Status	Parity Mandate	Benefit Mandate	Substantive Benefit Tier	County Estimate[1]
Individual					**100,700****
	Grandfathered	√	√	Middle	
	New Plans	√	√	High	
Small Group Plans (50 or fewer employees)					**170,500**
	Self-Insured			None	16,400
	Fully-Insured Grandfathered		√	Low	154,100 (combined)**
	Fully-Insured New	√	√	High	
Large Group (50 + employees)					**503,600**
	Self-Insured	√*		None	333,900
	Fully-Insured	√	√	Middle	169,700

[1]These estimates reflect state market shares multiplied by the 2013 ACS estimate of County private coverage for non-institutionalized County residents of all ages

*Parity applies if the plan provides MH/SUD benefits

** Data on the shares of individuals with grandfathered plans are not available

Service Mandates in the Lowest Coverage Tier. Maryland regulations for the lowest tier of coverage cover outpatient, inpatient and hospitalization services, described on Table 25. For outpatient services, plans must specify in- network cost sharing assignments of 70% carrier/30% enrollee; and out-of-network assignments of 50% carrier/50% enrollee.

Service Mandates in the Middle Coverage Tier. As noted on page 34, State law mandates that certain health plans, specifically large group plans and grandfathered individual plans, provide certain health benefits. The mental health and substance abuse benefits mandated by State law for the middle tier of coverage are displayed in Table 26 on the next page.

Service Mandates for the Highest Coverage Tier. The Essential Health Benefits Chart, prepared by the Maryland Insurance Administration and displayed in Table 27 on pages 40-41, shows the Maryland Benchmark Plan's mandated medical and mental health services for new individual and small group plans offered on the exchange. The services include prevention, medical care and specialty behavioral health services, including crisis intervention and stabilization services for acute episodes and partial hospitalization. The Benchmark Plan mandates require coverage of case management services and patient centered medical homes, two benefits that provide care coordination and other important supports for individuals with a serious mental illness.

Table 25. Maryland's Mandated Mental Health and Substance Abuse Benefits for Small Group Grandfathered Plans (Low Tier)

Benefit	Requirement
Inpatient Services	Inpatient mental health and substance abuse services, including residential crisis services, are covered up to a maximum of 60 days per covered person per year in a hospital, related institution, or entity licensed by the Department of Health and Mental Hygiene to provide residential crisis services.
Partial Hospitalization	Two partial hospitalization days may be substituted for one inpatient day in a hospital or related institution.
Outpatient Services	Mental health and substance abuse outpatient services are covered with no limits on visits.
Detoxification	Detoxification in a hospital or related institution is covered.
Residential Crisis Services	Residential crisis services are covered as part of the inpatient services category (see above).

Source: COMAR 31.11.06.03

Table 26. Maryland's Mandated Mental Health and Substance Abuse Benefits for Large Group Plans and Grandfathered Individual Plans (Middle Tier)

Benefit	Description
Inpatient Services	Coverage must be at least equal to the coverage for inpatient services for physical illness under the contract or policy.
Partial Hospitalization	A minimum of at least 60 days of partial hospitalization under the same terms and conditions that apply to the benefits available under the policy or contract for physical illness.
Outpatient Services	Coverage for expenses arising from services to treat mental illness, emotional disorders, or drug or alcohol abuse, including psychological or neuro psychological testing for diagnostic purposes, at a rate, after the applicable deductible is not less than 80% for the first five visits in any calendar year or benefit period of not more than 12 months; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st.
Medication Management	Coverage for office visits to a physician or health care provider for medication management are covered under the same terms and conditions under the policy for physical illness.
Methadone Maintenance Treatment	A copayment that is greater than 50% of the daily cost for methadone maintenance treatment may not be charged.
Residential Crisis Services	Coverage for medically necessary residential crisis services, defined as intensive mental health and support services: 1) Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis; 2) Designed to prevent or provide an alternative to a psychiatric inpatient admission or shorten the length of inpatient stay; 3) Provided out of the individual's residence in a community-based residential setting; and 4) Provided by DHMH-licensed entities.

Source: "Maryland's Mandated Benefits," Maryland Insurance Administration, < http://www.mdinsurance.state.md.us/sa/docs/documents/consumer/publicnew/mandatedbenefits.pdf < Accessed May 6, 2015.

Table 27. Maryland Insurance Administration Essential Health Benefits for Behavioral Health for Individual Insurance Policies and Small Group Plans (High Tier)

Behavioral Health Benefit	Description
Detoxification in a Hospital or Related Institution	This benefit covers detoxification whether it is in a hospital or other related institution. "Related institution" means an organized institution, environment or home that: (i) Maintains conditions or facilities and equipment to provide care for two or more unrelated individuals; and (ii) Admits or retains the individuals for overnight care.
Mental Health and Substance Abuse Outpatient Services	Professional services by licensed professional mental health and substance use practitioners when acting within the scope of their license. Services include: 1) Diagnostic evaluation; 2) Crisis intervention and stabilization for acute episodes; 3) Medication evaluation and management (Pharmacotherapy); 4) Treatment and counseling (including individual and group therapy visits); 5) Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; 6) Professional charges for intensive outpatient treatment in a provider's office or other professional setting; 7) Electroconvulsive therapy; 8) Inpatient professional fees; 9) Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner; 10) Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; 11) Psychological and neuro psychological testing necessary to determine appropriate psychiatric treatment.
Mental Health and Substance Abuse: Inpatient Hospital Services	Inpatient hospital and inpatient residential treatment centers services, which includes 1) Room and board, such as: i. Ward, semiprivate, or intensive care accommodations; ii. General nursing care; iii. Meals and special diets. 2) Other facility services and supplies – services provided by a hospital or residential treatment center.
Mental Health and Substance Abuse: Outpatient Hospital or Partial Hospitalization	Outpatient hospital – services such as partial hospitalization or intensive day treatment programs.
Mental Health and Substance Abuse: Emergency room	Outpatient services and supplies billed by a hospital for emergency room treatment.

Table 27. (cont.) Maryland Insurance Administration Essential Health Benefits Chart Behavioral Health Excerpts for Individual Insurance Policies and Small Group Plans

Care Coordination and Other Benefits	Description
Patient Centered Medical Homes	For individuals with chronic conditions, serious illnesses and complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as: a) Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team; b) Creation and supervision of a care plan; c) Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and d) Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.
Services Approved by a Carrier's Case Management Program	Case management is a form of utilization review used with high cost cases to monitor and manage treatment and suggest appropriate medical services.
Prescription Drugs	Includes prescription drugs and insulin. Must permit a 90 day supply for a maintenance drug (except for first prescription of the maintenance drug).
Preventive Services	**Description**
Preventive Services	These services include annual screenings for depression and alcohol misuse with no cost sharing.
Wellness Benefit	A health risk assessment that is completed by each individual on a voluntary basis with written feedback with recommendations for lowering risks identified in the completed assessment.

Source: http://www.mdinsurance.state.md.us/sa/docs/documents/consumer/publicnew/essentialbenefitschart.pdf

Chapter VI. Behavioral Health Services for Justice-Involved Individuals in Montgomery County

Montgomery County residents can receive behavioral health services as a result of being "justice-involved", which typically means that an individual is or has been incarcerated, but can also include other individuals who have interacted with law enforcement. Inmates in prisons and jails have a constitutional right to adequate health care, including behavioral health care,[1] and evidence indicates that a significant proportion of justice-involved individuals suffer from behavioral health disorders. One study, which collected data between 2002 and 2006 from five jails in New York and Maryland, including the Montgomery County Correctional Facility (MCCF), estimated that 14.5% of male inmates and 31% of female inmates suffered from serious mental illness.[2]

Within the County Government, the Montgomery County Police Department (MCPD), the Department of Correction and Rehabilitation (DOCR), and the Department of Health and Human Services (DHHS) are involved in the provision of behavioral health services to justice-involved individuals. Additionally, the Montgomery County Circuit Court Adult Drug Court Program provides substance abuse services to justice-involved adults. The State's Attorney's Office, and the Office of the Public Defender, and the Sherriff's Office are also involved in addressing the needs of this population. At the State level, the Department of Public Safety & Correctional Services (DPSCS) and the Department of Juvenile Services (DJS) provide behavioral health services to individuals in their custody.

This chapter summarizes the behavioral health services provided in Montgomery County by County and State agencies at different points in the criminal and juvenile justice processes. The Sequential Intercept Model, which is a framework designed to help jurisdictions organize strategies to address the behavioral health needs of justice-involved individuals, identifies five "intercepts" or stages in the justice process at which opportunities exist to link individuals to behavioral health interventions if appropriate and potentially prevent further justice involvement.[3] This chapter is organized based on those five intercepts as follows:

- **Section A. Law enforcement (intercept 1)**: prior to a potential arrest, including when a 911 dispatcher receives a call about the individual and when the police interact with the individual.
- **Section B. Initial detention/initial court hearings (intercept 2)**: after an individual has been detained up through the individual's initial court appearances.
- **Section C. Jails/prisons/courts (intercept 3)**: after initial court appearances, including time in jail, prison, or forensic hospitalization, and further court proceedings in non-specialty courts or specialty courts (such as a drug court or mental health court).
- **Section D. Reentry (intercept 4)**: the transition from jail, prison or forensic hospitalization to the community.
- **Section E. Community corrections and community support (intercept 5)**: following reentry, including community corrections (parole or probation) and interactions with community behavioral health providers.[4]

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[1] Cohen F, Dvoskin J, "Inmates with mental disorders: a guide to law and practice," *Mental and Physical Disability Law Reporter* 16:339–346, 1996.

[2] Steadman, H.J., Osher, F. C., Robbins P. C., Case, B., and Samuels, S., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60 (6), June 2009, p. 764, < https://www.pacenterofexcellence.pitt.edu/documents/PsySJailMHStudy.pdf > accessed 12/23/2014

[3] Griffin, Patty,"A Tool for Systems Transformation: Sequential Intercept Mapping," SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (presentation), March 14, 2013, < http://gainscenter.samhsa.gov/cms-assets/documents/103893-516686.sim.pdf > accessed 12/23/2014

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) GAINS Center for Behavioral Health and Justice Transformation, "Developing a Comprehensive Plan for Behavioral Health & Criminal Justice Collaboration: the Sequential

A. Law enforcement

Prior to potential arrests of individuals with suspected behavioral health issues, jurisdictions can employ pre-booking diversion, which links individuals to behavioral health services in the community as an alternative to arrest. In Montgomery County, the MCPD Crisis Intervention Team (CIT) is a group of police officers who have completed a voluntary 40-hour training program on handling crisis mental health situations, including de-escalation techniques and diversion of individuals (who would otherwise be arrested) to community resources. CIT officers are decentralized, with the aim of having at least one CIT officer in every shift in each district. The Emergency Communications Center, which answers 911 calls, is responsible for assessing whether a call involves a person with mental illness and for dispatching CIT officers as appropriate. CIT officers can employ any of the following strategies as alternatives to arrest, or "diversions":[5]

- **Petition for Emergency Evaluation**: If the individual meets criteria established in State law for a Petition for Emergency Evaluation, including posing a danger to self or others, the police officer must transport (with assistance of MCFRS – Fire and Rescue Services - as appropriate) the individual to the nearest emergency room, where an evaluation will determine whether the individual meets the criteria for involuntary admission to a psychiatric hospital (if not, the individual must be released within 30 hours).[6]

- **Referrals and/or voluntary transport to facilities**: police officers, with an individual's consent, can provide referrals or transportation (with assistance of MCFRS as appropriate) to shelters or mental health facilities, such as the Montgomery County Crisis Center.

- **Referral of minors to DHHS Juvenile Justice Services**: Police can refer minors for screening, who are being charged with a misdemeanor offense and are first-time offenders, to the Juvenile Justice Services program of DHHS. This program is a voluntary alternative to formal juvenile justice system involvement through the Maryland Department of Juvenile Services (DJS). DHHS conducts behavioral health assessments and drug screenings and makes treatment recommendations for referred youth who meet program eligibility requirements.

- **"Contact only"**: police officers can provide the individual and/or the individual's family with information about community resources for meeting the individual's behavioral health needs.

CIT officers work closely with the Mobile Crisis Team of the Department of Health and Human Services, which provides emergency behavioral health services in the community including crisis evaluations and stabilization, facilitation of hospitalization where necessary, and recommendations regarding further treatment and community resources. Additionally, the Montgomery County Fire and Rescue Service (MCFRS) may be dispatched along with police and can assist in transporting individuals to a hospital.

MCPD does not track the number of individuals who are diverted from the criminal justice system by CIT officers. Staff report that over a one year period, over 5,000 calls for police involved behavioral health issues, and of those about half resulted in a formal report. DHHS tracks data, shown on Table 28, on

Intercept Model," (pamphlet), < https://www.nami.org/Template.cfm?Section=cit2&template=/ContentManagement/ContentDisplay.cfm&ContentID=101341 > accessed 12/23/2014

[5] *Montgomery County Master Facilities Confinement Study*, RicciGreene Associates and Alternative Solutions Associates, January 15, 2014, p. 254, < http://www.montgomerycountymd.gov/COR/Resources/Files/PDF/MasterFacilitiesConfinementStudy-01-15-2014.pdf > accessed 1/11/2015

[6] Md. Code Ann., Health-General § 10-622 (a), § 10-622 (b), § 10-620 (d), § 10-624 (a), and § 10-624 (b)

juveniles who receive services through its Juvenile Justice Services program. An average of 49 youth were diverted from involvement with the Maryland Department of Juvenile Services (DJS) each month in 2014.

Table 28. Number of Youth Served by DHHS Juvenile Justice Services, 2014

# of Individuals…	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*Monthly Average*
Received behavioral health screens	75	62	83	97	78	64	80	53	91	92	66	97	*78*
Diverted from DJS	50	23	53	63	42	42	51	41	68	48	52	52	*49*
Treatment/drug education referrals	68	59	69	88	75	62	64	45	66	81	60	90	*69*
# with co-occurring disorders	9	12	9	18	12	14	18	3	13	23	11	20	*14*

Source: DHHS Monthly Trends Report

B. Initial detention/initial court hearings

If an individual has been arrested, further opportunities exist to decrease criminal justice system involvement through post-booking diversion. Additionally, individuals can receive screening and assessment of behavioral health disorders and treatment within the criminal justice system.

DOCR and DHHS services. The Montgomery County Detention Center (MCDC) of the Department of Correction and Rehabilitation (DOCR) is responsible for the booking, intake, and holding for up to 72 hours of adults[7] who have been arrested, and provides behavioral health screening, assessment, and diversion services. Within the MCDC, the Central Processing Unit (CPU) conducts processing, which consists of fingerprinting and photographing of individuals and verifying their identification, prior arrests and outstanding warrants. After processing, the District Court Commissioner, located in the Central Processing Unit, is responsible for determining whether to release until trial an individual charged with a crime on their own recognizance, or on the condition that the individual makes a bail payment, or to detain an individual who has been charged with a crime.

For individuals who cannot meet bond conditions, CPU correctional officers fill out a screening form on suicide risk, history of mental illness or self-destructive behavior, and use of psychotropic medications, and nursing staff provide a basic mental health screening if officers observe signs of mental illness. Individuals released by the District Court Commissioner do not receive a formal screening or assessment of behavioral health conditions prior to being released.

The Clinical Assessment and Transition Services (CATS) unit, located at the MCDC conducts full evaluations of all inmates identified by correctional staff, outside providers, families or other interested parties, who require a mental health evaluation. The purpose of the evaluation is to identify and minimize risk of self-harm and providing alternative community-based resources to the court at the time of bond review. CATS staff make diversion recommendations to Pre-Trial Assessment Unit (see below), arrange for expedited transports to MCCF for those who cannot be safely housed at MCDC due to elevated risk of harm (see page 47 on the MCCF Crisis Intervention Unit), make referrals to the correctional psychiatrist and mental health staff and provide full assessment information to the next receiving provider.

[7] Youth under the age of 18 who are arrested are generally held in juvenile detention facilities managed by the Maryland Department of Juvenile Services (DJS). However, youth may be charged as adults under certain circumstances, and in these cases they may be detained in adult facilities, including the MCDC. Refer to "Department of Juvenile Services: Overview of the Youth Charged as Adults Population," Maryland Department of Juvenile Services, December 2012, < http://www.djs.maryland.gov/docs/DJS_Report%20on%20Youth%20Charged%20as%20Adults.pdf > accessed 12/30/2014.

The Pre-Trial Assessment Unit (PTAU) located at the MCDC conducts assessments of individuals who are not released by the District Court Commissioner. Assessments are used to make a recommendation to the judge at bail review hearings, which reexamine the District Court Commissioner's decision on the bail set for an individual. The assessment includes questions about prior hospitalizations, prescribed medications and prior suicide attempts.

In cases where there is an indication of a mental health problem, including if PTAU staff believe that the individual may be incompetent to stand at the bail review hearing due to a mental illness[8], the Clinical Assessment and Transition Services (CATS) program of DHHS conducts an official evaluation. At the bail review hearing, the judge receives the results of the CATS evaluation and, where appropriate, a recommendation of release until trial with options for inpatient or outpatient treatment in the community. CATS will only recommend diversion in this manner if the individual has been assessed by the PTAU to meet diversion/release criteria if there is an agreement between PTAU and DHHS. Additionally, appropriate treatment options must be available in the community. Table 29 displays data on services provided by the CATS program. Alternatively, if the individual is found to be incompetent to stand trial and presents a danger to self or others, the court may commit the individual to a facility designated by the Maryland Department of Health and Mental Hygiene (see page 46).

Table 29. Screening and Assessment Services Provided by CATS, 2014

# of…	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*Monthly Average*
Individuals Oriented/Screened	678	519	636	685	624	598	640	625	625	611	535	537	*609*
Assessments	194	146	168	189	181	190	191	183	197	206	152	167	*180*
Community Treatment Placements	69	34	49	62	77	90	86	69	79	83	60	65	*69*

Source: DHHS Monthly Trends Report

The Pre-Trial Supervision Unit (PTSU), located in Rockville, supervises individuals who have been charged with a crime and released to the community awaiting trial with a condition of pre-trial supervision. In collaboration with DHHS staff, the PTSU conducts intake screening and assessment, including a behavioral health assessment, to determine the appropriate level of supervision, and provides behavioral health treatment referrals. Within the PTSU, the Intervention Program for Substance Abusers (IPSA) provides substance abuse treatment during pre-trial supervision to individuals with substance use disorders who meet certain conditions and have been referred by the State's Attorney's Office. The program includes an intensive treatment track for individuals with co-occurring mental health disorders. Prosecution is delayed for individuals participating in IPSA, and their criminal records may be expunged if they complete the program.

[8] Incompetence to stand trial means that a defendant is unable to understand or participate rationally in a court process due to a mental health disorder or mental retardation.

Incompetence to stand trial and verdicts of not criminally responsible

State law establishes the processes for assessing whether defendants in criminal cases are competent to stand trial and whether they are criminally responsible for criminal conduct. A determination that a defendant is incompetent to stand trial or is not criminally responsible for criminal conduct can lead the court order that the defendant be committed to a psychiatric facility.

Incompetence to stand trial means that a defendant is unable to understand or participate rationally in a court process due to a mental health disorder or mental retardation. If a defendant in a criminal case appears or claims to be incompetent to stand trial, the court may order the Department of Health and Mental Hygiene to conduct an examination in order to make a competency determination. If a defendant is found to be incompetent to stand trial and, "because of mental retardation or a mental disorder, is a danger to self or the person or property of another," the court may order the defendant to be committed to a facility designated by the Department of Health and Mental Hygiene until the defendant is competent to stand trial or is no longer dangerous. If the defendant is not dangerous, the court has the option to set bail for the defendant or release the defendant under the condition that the defendant return when summoned.[9]

A verdict that a defendant is *not criminally responsible for criminal conduct* means that, due to a mental health disorder or mental retardation at the time a crime was committed, the defendant lacked capacity to understand that the act was a crime or the capacity to act within the limits of the law. If a defendant in a criminal case files a plea of not criminally responsible by reason of insanity, the court may order the Department of Health and Mental Hygiene to conduct an examination in order to determine whether the defendant was criminally responsible and to provide a report of its findings to the court. If the jury reaches a verdict of "not criminally responsible", the law states that the court must commit the defendant to the Department of Health and Mental Hygiene for inpatient care. However, if the report of the Department of Health and Mental Hygiene finds that, "the person would not be a danger, as a result of mental retardation or mental disorder, to self or to the person or property of others if released," then the court has the option to order that the defendant be released, and can set conditions for the defendant's release.[10] Additionally, a person who has been committed to the Department of Health and Mental Hygiene may be released if it is determined that the individual would not present a danger to themselves, others or to the property of others, and the court may also set conditions for the individual's release in these cases.[11]

DJS Services. The Maryland Department of Juvenile Services (DJS) manages intake and detention of children accused of committing delinquent acts (crimes committed by juveniles). DJS operates seven secure juvenile detention facilities in Maryland, including the Alfred D. Noyes Children's Center located in Montgomery County. During the initial detention and court hearings phase, DJS provides behavioral health screening, assessment, diversion and treatment services.

After a child is arrested, DJS initiates the intake process to assess the merits of a juvenile complaint, determine whether judicial action is appropriate, and determine whether to release or detain the child. As part of the intake process, the intake officer completes the Maryland Comprehensive Assessment and Service Planning (MCASP) Intake Risk Screen, which includes "social history" questions related to mental health, substance use, home life, peer relationships and education. This tool generates a delinquency history score, a social history score, and a recommended intake decision.

If the intake officer determines that the case can be resolved outside of the court system, the officer can close the case or refer the child to 90-day Informal Adjustment, which is a form of community supervision that functions as a diversion of the child from the juvenile justice system. An Informal Adjustment agreement may require the child to receive mental health or substance abuse counseling or other treatment in the

[9] Md. Code Ann. Criminal Procedure § 3-101 (f), § 3-104, § 3-105, and § 3-106
[10] Md. Code Ann. Criminal Procedure § 3-109, § 3-110, § 3-111, § 3-112
[11] Md. Code Ann. Criminal Procedure § 3-114

community, to pay restitution and/or to complete community service hours. If the case proceeds to the court system instead, the child may be released to the custody of his/her parents or placed in detention while awaiting hearings in court. Detention can consist of detention in a DJS facility, detention in a non-secure facility in the community (shelter care), detention at the child's home with the requirement to report daily to a reporting center, or community detention.[12] DJS facilities provide behavioral health screening, assessment and treatment services to detained children.[13] Table 30 displays data on DJS intake decisions for Montgomery County youth between FY12 and FY14.

Table 30. DJS Intake Decisions in Montgomery County, FY12-FY14

Decision	FY12	FY13	FY14
Authorized Formal Petition (court system)	45%	44%	46%
Informal Adjustment	28%	26%	27%
Resolved/No Jurisdiction (case closed)	27%	31%	28%
Total Complaints	2,808	2,441	1,696

Source: Maryland Department of Juvenile Services Data Resource Guide, FY 2014, p. 80

C. Jails/Prisons/Courts

Following initial detention and/or court hearings, additional opportunities exist to divert individuals from the justice system and provide linkages to treatment, and individuals can receive treatment during incarceration. Diversion and treatment can be provided in collaboration with state and local health departments via correctional systems and court systems.

DOCR and DHHS services. The DOCR Montgomery County Correctional Facility (MCCF) is the County's jail and houses individuals who have been arrested, are awaiting trial, and have not been released on personal recognizance or by posting bail, as well as individuals who have been convicted of a crime and are serving sentences of 18 months or fewer.[14] Within MCCF, the Mental Health Services section and the Crisis Intervention Unit (CIU) of DOCR as well as the Jail Addiction Services (JAS) program of DHHS provide behavioral health treatment to MCCF inmates.

The Mental Health Services section provides mental health and psychiatric assessments, crisis intervention, brief counseling, skills groups and medications to treat mental health disorders to individuals with less severe mental illnesses who are housed in the general population. The Mental Health Services section is also responsible for coordinating commitments of incarcerated individuals to state psychiatric hospitals for individuals who present a danger to self or others and for facilitating court-ordered competency screenings, used to determine whether an individual is competent to stand trial (see page 46). The Crisis Intervention Unit (CIU) serves up to 40 males and 15 females with severe chronic or acute mental health conditions who cannot be housed in the general population, providing medication management, counseling services, and intensive group and individual therapy. Finally, JAS, an eight-week state-certified addiction treatment and education program staffed by DHHS employees, followed by ongoing aftercare while the individual is incarcerated, for individuals with substance abuse disorders. JAS participants are housed in a dedicated unit

[12] Community detention allows children to live at home and participate in school or work, but DJS provides supervision through telephone and face-to-face contacts as well as unannounced visits to school or work.
[13] *Data Resource Guide Fiscal Year 2013*, Maryland Department of Juvenile Services, December 2013, pp. 17-18, 93 < http://www.djs.maryland.gov/drg/Full_DRG_With_Pullouts_2013.pdf > accessed 12/31/2014
[14] *Legislative Handbook Series 2014 Volume VIII: Maryland's Criminal and Juvenile Justice Process*, Department of Legislative Services, 2014, p. 55 < http://mgaleg.maryland.gov/Pubs/LegisLegal/2014-legislativehandbookseries-vol-8.pdf > accessed 1/2/2015.

and are assigned a State Care Coordinator who provides recovery support for individuals transitioning out of incarceration. Table 31 displays data on individuals served by the JAS program.

Table 31. Individuals Served by DHHS Jail Addiction Services, 2014

# of Individuals…	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Average
Oriented / Screened	31	52	45	24	12	5	63	30	63	43	46	52	39
Treated	92	95	106	91	83	70	68	87	86	119	99	73	89
Successful Completions	10	16	21	13	17	13	11	24	18	27	24	22	18

Source: DHHS Monthly Trends Report

Services of the Maryland Department of Public Safety and Correctional Services. The Maryland Department of Public Safety and Correctional Services (DPSCS) operates 20 correctional facilities across the state that house individuals who are serving sentences of 12 months or more. The DPSCS Office of Treatment Services' Mental Health and Substance Abuse Units oversee the delivery of behavioral health services to inmates including behavioral health screening, assessment and treatment services.

DPSCS operates two administrative centers that receive newly sentenced inmates. DPSCS uses a case management process to identify and assess inmate needs and classify each inmate to a security level. The assessment process includes a substance abuse assessment and can also include psychological assessments or evaluations.[15] A reclassification hearing occurs for each inmate at least annually in which staff examine different variables including drug or alcohol abuse and behavior in order to make a determination as to the appropriate security level for the inmate. In some cases, inmates may be segregated from the general population for mental health reasons through "administrative segregation."[16]

DPSCS contracts with health providers to provide medical services, including mental health services, to inmates through a managed care program for all facilities. DPSCS psychologists in each region work with contracted providers to ensure that mental health services are appropriate. Additionally, many correctional facilities offer structured substance abuse treatment programs.[17]

Many behavioral health services for DPSCS inmates are delivered at the Patuxent Institution, which is an independent agency of DPSCS and a maximum security correctional treatment facility with a 1,113 bed capacity (primarily for men) that receives inmates from all regions in the State. Three types of inmates are housed at the Patuxent Institution, which is located in Jessup:

1. *"Eligible" persons*: general population inmates with at least three years remaining on a sentence who have an intellectual deficiency or emotional imbalance, are likely to respond favorably to the institution's treatment programs, and can be better remediated at the Patuxent Institution than by other types of incarceration.
2. *Youthful offenders*: individuals under the age of 21 at the age of referral (including violent juvenile offenders waived to adult criminal courts) who also meet the criteria for "eligible" persons.

[15] COMAR 12.02.24.04 and *Legislative Handbook Series 2014 Volume VIII: Maryland's Criminal and Juvenile Justice Process*, Department of Legislative Services, 2014, p. 177
[16] *Legislative Handbook Series 2014 Volume VIII*, p. 171
[17] *Division of Correction Annual Report Fiscal Year 2013*, < http://www.dpscs.state.md.us/publicinfo/publications/pdfs/DOC2013AnnualRpt.pdf > accessed 1/14/2015

3. *General population inmates*: inmates housed at the Patuxent Institution while awaiting assessment or evaluation, to participate in a specific program located at the Patuxent Institution, or to receive inpatient mental health treatment.

To determine whether an individual can be admitted as an "eligible" person or as a youthful offender to the Patuxent Institution, a team of staff conducts a six-month evaluation that includes psychiatric and psychological testing and a social history review. Once admitted, treatment teams composed of a multi-disciplinary staff that can include social workers, psychologists and psychiatrists are responsible for implementing individualized treatment plans for individuals in these two categories. During treatment, individuals can progress through four levels of a system that promotes socially acceptable behavior using communications and learning theory. In progressing to the next level, individuals are accorded additional privileges and responsibilities.

General population inmates housed at the Patuxent Institution do not participate in the treatment system described above, but many receive behavioral health services at the Patuxent Institution. The Correctional Mental Health Center at the Patuxent Institution is DPSCS's inpatient mental health unit, which has a 192-bed capacity in the acute and sub-acute units combined. Additionally, the Step-Down Mental Health Unit has a 32-bed capacity for inmates unable to function in the general population due to substance abuse problems or life skill deficiencies. This unit provides a structured environment to help inmates develop skills and ultimately return to the general population.

Montgomery County Circuit Court Adult Drug Court Program. Certain courts in Maryland operate "problem-solving" court programs that aim to relieve overcrowded dockets, expedite cases and prevent recidivism by addressing underlying issues faced by offenders. Two different types of problem-solving court programs that specifically target behavioral health issues exist in Maryland:

- **Drug courts**: specialized dockets that handle drug and dependency-related cases through judicial intervention, intensive monitoring, and substance abuse treatment.
- **Mental health courts**: specialized dockets that coordinate treatment services for individuals with psychiatric disabilities to promote rehabilitation and reduce recidivism.

No mental health courts exist in Montgomery County. Judge John Debelius, Administrative Judge of the Montgomery County Circuit Court, recently established the Mental Health Court Planning and Implementation Task Force, which will issue a report by the end of 2015, with the goal of establishing a mental health court in the Circuit Court in 2016. Additionally, the Circuit Court operates the Adult Drug Court Program, which provides coordinated substance abuse interventions with judicial oversight. State law allows the State's Attorney to enter into agreements with criminal defendants whereby the State's Attorney either dismisses charges or indefinitely postpones a trial if the defendant completes a drug or alcohol abuse treatment program. Defendants who have been convicted of a violent crime within the previous five years are not eligible. In order for the defendant to qualify, the Department of Health and Mental Hygiene or a private licensed provider must find that the defendant is amenable to treatment and recommend an appropriate treatment program.[18]

The Adult Drug Court Program lasts a minimum of 20 months and consists of four phases, each of which includes treatment, drug testing, case management, and regular court attendance.[19] In FY13, 134 individuals

[18] Md. Code Ann. Criminal Procedure § 6-229

[19] *Adult Drug Court Policies and Procedures Manual*, Montgomery County, Maryland, June 2012, < http://www.montgomerycountymd.gov/circuitcourt/Resources/Files/drugcourt/Adult_Drugcourt_Policies_and_Procedures_Manual.pdf > accessed 1/2/2015.

received outpatient treatment through the Drug Court program. Of those, 49 individuals received intensive outpatient treatment. 26 individuals graduated from Drug Court in FY13.[20]

DJS Services. If a juvenile court determines in an adjudication hearing that a child has committed a delinquent act (an act that would be a crime if committed by an adult), the court, with guidance from DJS, will then determine how to manage, supervise and treat the child. "Treatment" can include behavioral health services, and in some cases certain behavioral health services can be used as an alternative to more restrictive options. During a disposition hearing, which follows the adjudication hearing, the court can:

1. Commit the child to the custody of DJS for treatment in an out-of-home placement;
2. Place the child on probation under DJS supervision; and/or
3. Order restitution (monetary compensation to the victim).

Either before or after the disposition hearing, DJS staff examine the child's delinquency history, educational records, clinical assessments, and whether any other state agency is involved with the youth. Staff also complete the Maryland Comprehensive Assessment and Service Planning (MCASP) Risk Needs Assessment, which is a tool to assess a child's risk and needs. For children being considered for an out-of-home placement, a Multidisciplinary Assessment and Staffing Team (MAST) that includes a psychologist, social worker, community case manager, detention facility case manager, supervisor, resource specialist, Maryland State Department of Education (MSDE) representative, and others as needed is responsible for assessment.

DJS staff use the assessment to develop a Treatment Service Plan, which is a recommended plan required by State law to be presented to the court. The plan must include the recommended level of supervision for the child, specific goals for the child and the child's family, any changes that the child's parent or guardian must make to reduce risk for the child, a statement of services to be provided, and any other relevant information to guide the court's decision with respect to the appropriate care of the child.[21]

Children in out-of-home placements can receive behavioral health services such screening, assessment and treatment services, including suicide prevention, crisis intervention and stabilization, medication evaluation and monitoring, brief therapy (individual, group or family), and crisis counseling within their placements. Specific services depend on the type of placement. Out-of-home placement types include:[22]

1. *Traditional and Treatment Foster Care Homes*: Placements of children with families in the community; in treatment foster care homes, families are recruited, trained, and closely supervised to provide youth with treatment and intensive supervision at home, in school, and in the community.
2. *General Service Group Homes or Therapeutic Group Homes*: Residential programs licensed by the State to provide 24-hour supervised out-of-home care for 4 or more youth, including a formal program of basic care, social work, and health care services, or more depending on the group home type. Therapeutic group homes provide diagnostic and therapeutic mental health services to children who are moderate- to high-risk and have emotional or developmental disabilities.
3. *Residential Treatment Centers (RTCs):* A mental health facility for children and adolescents with long-term serious emotional, behavioral, and psychological problems.

[20] *Fiscal Year 2013 Annual Report*, Montgomery County Core Service Agency, March 3, 2014, p. 8
[21] Md. Code Ann. Courts and Judicial Proceedings § 3-8A-20.1
[22] *Data Resource Guide Fiscal Year 2013*, p. 121 and "Treatment Programs," Department of Juvenile Services website, < http://www.djs.maryland.gov/out-of-home-treatment.asp > accessed 1/5/2015

4. *Intermediate Care Centers for Addictions (ICFAs*): the most intensive level for residential substance abuse services providing drug and alcohol abuse assessment, treatment, and/or education for moderate-to-high risk youth.
5. *DJS-operated Youth Centers*: four facilities located in Western Maryland that provide treatment services to male children in a staff-secure setting, meaning that children's movements are managed through staff supervision.
6. *Secure Confinement (both DJS-operated and privately contracted)*: treatment facilities for children who pose safety risks to themselves or others and have significant behavioral health needs; these facilities are hardware-secure, meaning that in addition to staff supervision, hardware such as locks, bars and fences are used to manage children's movements.

Children placed on probation under the supervision of DJS and children committed to the custody of DJS in an out-of-home placement may also receive behavioral health services in the community. DJS contracts with a limited number of providers that offer community-based services, but also refers children to services that are funded outside of DJS or accessed through insurance. The array of community-based services varies by jurisdiction. One category of services often used to divert children from out-of-home placements as well as for children on probation is Evidence-Based Services (EBS), which includes the following types of family therapy:

1. *Functional Family Therapy*: A short-term (3-4 months) intervention focusing on family interactions, communications, problem-solving, parenting skills and pro-social interactions.
2. *Multisystemic Therapy*: An intensive 3 to 5-month treatment program for chronic and violent juvenile offenders aged 12-17 and their families, in which a therapist meets with a family frequently (potentially more than once a week) and is available 24 hours a day.
3. *Family-Centered Treatment*: A flexible in-home treatment model for children at risk of out-of-home placements or children returning home from placements that aims to help at-risk families learn and adopt positive behavioral patterns through services such as counseling, skills training, trauma treatment, community resource coordination, and wraparound services.[23]

D. Reentry

At the reentry stage, individuals prepare to return to the community from jails, prisons or commitment in a psychiatric hospital. For individuals with behavioral health disorders, opportunities exist to plan for a smooth transition from receiving behavioral health services during incarceration to receiving services in the community.

DOCR and DHHS services. The County provides reentry services at both the Montgomery County Correctional Facility (MCCF) and the County's Pre-Release Center (PRC).

DOCR and DHHS provide several types of re-entry services at MCCF. The Re-Entry Collaborative Case Management Group meets on a bi-weekly basis to identify service needs for individuals who are close to their release date, including substance abuse treatment, mental health treatment, family reintegration, and housing, and to plan and coordinate care. Where relevant, community behavioral health service providers

[23] *Maryland Department of Juvenile Services Residential and Community-Based Services Gap Analysis*, Department of Juvenile Services, December 2013, pp. 9-10< http://www.djs.state.md.us/docs/2013_GAP%20analysis.pdf > accessed 1/6/2015.

are included in meetings, which aim to match individuals with the most appropriate services and plan to initiate service delivery as soon as possible.

Additionally, the Clinical Assessment and Transition Services (CATS) program of DHHS conducts discharge planning at MCCF for individuals with behavioral health disorders housed in the Crisis Intervention Unit (CIU) and the Jail Addiction Services Unit (JAS), in order to link them to community-based behavioral health treatment providers. CATS also provides linkages to psychiatric providers in the community for general population inmates receiving psychotropic medications or who otherwise require psychiatric services. Table 32 displays data on transition services provided by CATS. Finally, the Projects Assisting Transition from Homelessness (PATH) program, jointly funded by the State and the federal government, also provides discharge planning for incarcerated individuals with chronic mental illness.

Table 32. Individuals Served by CATS Transition Services, 2014

# of Individuals…	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Average
Oriented / Screened	82	56	100	79	87	75	78	96	104	90	84	86	85
Eligible for Services	49	36	56	54	53	51	45	62	74	56	52	58	54
Cases Assigned	38	35	46	60	36	32	34	23	49	51	35	31	39
Released from DOCR	43	24	39	41	26	40	29	35	33	24	26	32	33

Source: DHHS Monthly Trends Report

The DOCR Pre-Release and Re-entry Services (PRRS) Division provides re-entry services at the Pre-Release Center (PRC) for eligible soon-to-be released individuals in local, State and Federal correctional facilities. Individuals must volunteer and apply to participate. PRRS services provide an alternative to secure confinement for individuals nearing the end of their sentences, either through a residential program at the PRC or through home confinement with PRRS supervision, including the use of electronic monitoring.

PRRS has a consulting psychiatrist available five hours per week for medication management and provides referrals to providers in the community for counseling, and the Jail Addiction Services (JAS) coordinator provides drop-in services and runs aftercare groups at the PRC. Additionally, PRRS provides programs and classes at the PRC, including Thinking for Change (T4C), a cognitive behavioral change program aimed at changing criminal thinking. However, the 2014 Master Facilities Confinement Study produced for DOCR reports that many PRRS services are not designed specifically for individuals with mental illness; individuals with a "serious psychological or medical problem" that would inhibit full participation are not eligible for PRRS services, thereby excluding many individuals with behavioral health disorders.[24]

DPSCS Services. The Maryland Department of Public Safety and Correctional Services (DPSCS) develops a discharge plan for every offender and, where relevant, provides linkages to community-based services, including residential substance abuse treatment. For individuals with serious medical or mental health needs, social workers provide release planning services including pre-release counseling and group therapy, and apply for benefits for which the individual is eligible in anticipation his or her release.[25]

[24] *Montgomery County Master Facilities Confinement Study*, 2014, p. 275; and *Pre-Release and Reentry Services (PRRS) Division Program Guidebook*, Revised August 18th, 2014, Montgomery County Department of Correction and Rehabilitation, pp. 12, 54, < http://www.montgomerycountymd.gov/COR/Resources/Files/PRCGuidebook.pdf > accessed 1/11/2015

[25] *Legislative Handbook Series 2014 Volume VIII*, p. 178-179

Additionally, the Patuxent Institution houses two programs for individuals with behavioral health disorders who are nearing release to the community: (1) the Mental Health Transition Unit at the Patuxent Institution provides assessment, inpatient and outpatient treatment, and aftercare planning for mentally ill inmates nearing release to the community; and (2) the Regimented Offender Treatment Center at the Patuxent Institution is a four-month treatment and transition program for men with substance abuse problems preparing for parole or release that includes cognitive behavioral therapy, relapse prevention, anger management and transition planning.[26]

DJS Services. The Maryland Department of Juvenile Services (DJS) provides re-entry services for children who were adjudicated delinquent and committed to treatment in out-of-home placements. DJS case managers are responsible for assessing the child's progress during treatment and linking children and their families to services, including community-based behavioral health services, when treatment is completed. Throughout the process, case managers use the Maryland Comprehensive Assessment and Service Planning (MCASP) Risk Needs Assessment to aid decision-making.[27]

E. Community corrections and services in the community

After an individual is released from jail or prison, or while an individual is on probation (community supervision used as an alternative to incarceration), opportunities exist to provide behavioral health services in the community that may prevent repeated involvement in the justice system.

DOCR and DHHS services. Staff report that, after individuals with behavioral health disorders are released from DOCR custody, limited resources are available to ensure that they receive the services they need. The Projects Assisting Transition from Homelessness (PATH) program follows a small number of individuals with severe and persistent mental illness for three to six months after they have been released to ensure an effective transition to the community. Additionally, DOCR and DHHS have been awarded a federal grant for a 24-month demonstration project to create a Forensic Assertive Community Treatment (FACT) team. The FACT team will provide intensive case management to individuals with co-occurring mental health and substance abuse disorders beginning before they are released from MCCF and continuing after release. The program will also provide temporary housing at the Pre-Release Center (PRC) as well as permanent housing location services.[28]

DPSCS Services. The Maryland Department of Legislative Services reports that DPSCS has partnerships for aftercare transition, residential substance abuse treatment, institutional-based programs and services, and community-based programs and initiatives for individuals who are being released from DPSCS custody.[29]

DJS Services. The DJS Community Services subdivision is responsible for monitoring children in the community who have completed treatment in out-of-home placements (a period called "aftercare") as well as children placed on probation by the juvenile court, and linking them to appropriate services. For children in aftercare, DJS links the child and family to appropriate services, including mental health and substance abuse treatment, monitors the child's adjustment to the community, and ensures compliance with court directives as relevant. For children placed on probation, DJS conducts a social history investigation and completes the Maryland Comprehensive Assessment and Service Planning (MCASP) Risk Needs Assessment, in order to

[26] Ibid., p. 198
[27] *Data Resource Guide Fiscal Year 2013*, p. 18
[28] PRRS Quarterly Chief's Report, 3/6/2014, Department of Correction and Rehabilitation, < http://www.montgomerycountymd.gov/COR/Resources/Files/prrs/ChiefsReport3-6-14.pdf > accessed 1/15/2015
[29] *Legislative Handbook Series 2014 Volume VIII*, p. 179

develop a Treatment Services Plan (TSP) and link the child to appropriate services. As noted on page 51, DJS contracts with a limited number of providers that offer community-based services, but also refers children to services that are funded outside of DJS or accessed through insurance. The array of community-based services varies by jurisdiction.[30]

Additionally, the Violence Prevention Initiative provides intensive supervision for children on probation or in aftercare believed to be at high risk for violent offending or victimization, including facilitating and case managing referrals to drug treatment.

[30] *Data Resource Guide Fiscal Year 2013*, Maryland Department of Juvenile Services, p. 19

Chapter VII. Behavioral Health Promotion, Prevention and Recovery Support Services in Montgomery County

Public and private insurance programs provide coverage for the treatment of behavioral health disorders, but the Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes that treatment is merely one element of a continuum of care for behavioral health.[1] The other elements are:

- **Promotion**, which includes strategies to create conditions that support behavioral health and resilience, or the ability of individuals to withstand challenges, and to reinforce the entire continuum of behavioral health services;
- **Prevention**, which includes interventions aimed at reducing the risk of developing behavioral health problems such as substance use disorders; and
- **Recovery**, which includes services to support individuals' compliance with long-term treatment and after care.

In Montgomery County, outside of formal treatment settings, government agencies, non-profit organizations and self-help groups provide a variety of services aimed at promoting behavioral health and wellness, preventing behavioral health disorders, referring individuals to behavioral health treatment services, and supporting the recovery of individuals with behavioral health disorders. Most services are provided free of charge and are supported with a combination of State, County and private foundation funding. Therefore, access does not depend on an individual's health coverage status. This chapter describes services in these categories provided in Montgomery County, and is organized as follows:

- **Section A** describes behavioral health promotion, prevention, and referral services; and
- **Section B** describes recovery support services and groups.

A. Behavioral Health Promotion, Prevention, and Referral Services

As noted above, behavioral health promotion and prevention are two elements of the continuum of care for behavioral health that aim to support behavioral health and prevent the development of behavioral health problems. Promotion and prevention are closely related and the terms are often used interchangeably, but can be distinguished in that promotion activities are aimed at strengthening determinants of mental wellness such as social-emotional competence and strengthening an individual's ability to cope with adversity, while prevention focuses on averting behavioral health problems, particularly substance use disorders. Significantly, SAMHSA notes that specific types of interventions do not necessarily fit neatly into one category or another.

For example, treatment for depression may prevent the development of a substance use disorder and may thus be considered a prevention activity as well as a treatment service.[2] Similarly, activities that promote behavioral health may have other goals outside of behavioral health. For example, the Oregon Health Authority identifies "parenting classes" and "community activities promoting inclusion" as behavioral health promotion activities, but these activities often have additional policy goals outside of behavioral health.[3]

[1] "A Behavioral Health Lens for Prevention," Center for the Application of Prevention Technologies, Substance Abuse and Mental Health Services Administration, < https://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/3 > accessed July 2, 2015.
[2] Ibid.
[3] "The Significance of Behavioral Health Promotion in Preventing Behavioral Health Disorders Incidence," Oregon Health Authority, Addictions and Mental Health Division, November 2012, < http://www.oregon.gov/oha/amh/docs/behavioral-health-promotion-paper.pdf > accessed July 2, 2015.

This section describes services and activities with an explicit focus on behavioral health promotion or prevention, and does not necessarily represent a comprehensive listing of all activities in the County that may contribute to behavioral health promotion and prevention.

Access to promotion, prevention and referral services described below typically does not depend on an individual's health coverage status, but services are often targeted to specific populations. Most of these services are provided by either Montgomery County Public Schools (MCPS), the Department of Health and Human Services (DHHS) in collaboration with MCPS as well as Police (MCPD), or organizations with contracts with DHHS and/or MCPS, and are often targeted at children, youth and their families. This section summarizes the services provided by:

1. Montgomery County Public Schools (MCPS)
2. Department of Health and Human Services (DHHS)
3. Montgomery College
4. Organizations in the community
5. Online behavioral health service databases

1. Montgomery County Public Schools

MCPS behavioral health services include the school's health curriculum, the student services program, and partnership programs.

Health curriculum. State regulations require all local public school systems to provide comprehensive health education for all students in pre-kindergarten to grade 8 and offer comprehensive health education in grades 9 to 12.[4] State standards for health education content that relate to behavioral health include:

- **Mental and Emotional Health**: "Students will demonstrate the ability to use mental and emotional health knowledge, skills, and strategies to enhance wellness."[5]
- **Alcohol, Tobacco, and Other Drugs**. "Students will demonstrate the ability to use drug knowledge, decision-making skills, and health enhancing strategies to address, the non-use, use, and abuse of medications, alcohol, tobacco, and other drugs."[6]

MCPS provides health education in all grades from pre-kindergarten through grade 8, and for one semester in grade 10. Concepts in mental and emotional health and in alcohol, tobacco and other drugs are taught progressively in each year beginning in kindergarten, with performance indicators established for each year.[7]

Student Services. State regulations require all local school systems to "provide a program of pupil services for all students which shall include but not be limited to: (1) School counseling; (2) Pupil personnel; (3) School psychology; and (4) Health Services."[8] The MCPS Department of Student Services is responsible for the first three functions, which include certain services related to students' mental health and wellbeing as well as student enrollment and student discipline (see page 59 for information on school health services). Each school has access to a school psychologist, school counselors, and pupil personnel workers. These professionals provide certain behavioral health promotion, prevention, referral and early intervention services, including crisis response and support, as described below.

[4] COMAR 13A.04.18.01 (A)
[5] COMAR 13A.04.18.01 (C)
[6] COMAR 13A.04.18.01 (D)
[7] See MCPS Comprehensive Health Education Website: http://www.montgomeryschoolsmd.org/curriculum/health/
[8] COMAR 13A.05.05.01(A)

School psychologists. The goal of a school psychological program as per State regulations is, "to prevent or remediate educational, emotional, or behavioral problems by identifying, analyzing, and reporting psychoeducational needs through consultation, observation, or through psychological and educational assessment."[9] State regulations establish the certification requirements for school psychologists, which are mental health professionals with advanced graduate (such as doctoral) training in both psychology and education.[10] All Montgomery County Public Schools have access to a school psychologist, but some school psychologists are assigned to more than one school (psychologists are typically assigned to between one and three schools). MCPS school psychologists' responsibilities include:[11]

- Conducting psychological assessments of students for different reasons, such as a suspected educational disability or to review a private psychological evaluation;
- Providing interventions such as psychological counseling, social skills training and behavior management for students and families;
- Providing prevention activities such as programs for children at risk of failure, programs to promote appreciation of diversity, and programs to promote a safe school environment;
- Educating families and school staff on effective conflict resolution, social skills development, mental wellness and behavioral health, and crisis management; and
- Conducting research on the effectiveness of academic programs, behavior management systems and other services.

School counselors. State regulations define a school counseling program as, "a planned, systematic program of counseling, consulting, appraisal, information, and placement services for students, grades K—12," and state that counseling services are intended to help students (1) "Demonstrate personal and academic growth," (2) "Make appropriate educational and career decisions," and (3) "Have productive interactions with others."[12] Like school psychologists, school counselors must meet certification requirements established by state regulations, including a master's degree in school counseling.[13] MCPS school counselors are responsible for providing the MCPS Comprehensive Counseling Program to all students, which, "delivers prevention and intervention services that support the academic, career, health interpersonal, and personal development of all students."[14] As defined in MCPS regulations, "Prevention and intervention activities" include:[15]

- Support for effective student decision-making about academic programs and career opportunities;
- Instructional group or classroom guidance activities on specific topics; and
- Individual or group counseling activities to address specific student needs for counseling consultation, crisis support or referrals to community agencies.

Pupil personnel workers. A pupil personnel program as defined in State regulations is, "a systematic approach to programs and services that use the resources of the home, school, and community to enhance the

[9] COMAR 13A.05.05.04 (A)
[10] COMAR 13A.12.03.08; and "Who Are School Psychologists," National Association of School Psychologists website, < http://www.nasponline.org/about_sp/who-are-school-psychologists.aspx > accessed 1/20/2015.
[11] "Frequently Asked Questions," MCPS School Psychological Services, MCPS Website, < http://www.montgomeryschoolsmd.org/departments/studentservices/mentalhealth/psych.aspx?id=335452 > accessed 1/20/2015
[12] COMAR 13A.05.05.02 (A)
[13] COMAR 13A.12.03.02
[14] "School Counseling Programs and Services," Montgomery County Public Schools Regulation IJA-RA, (IV)(2)(a).
[15] Ibid. (IV)(A)(2)(b) and (III)(F), (J), (K), and (Q)

social adjustment of students," that provides, "comprehensive casework management."[16] State regulations establish certification requirements for pupil personnel workers, who are required to hold a master's degree in pupil personnel or related fields such as counseling, psychology or human growth and development.[17] The responsibilities of MCPS pupil personnel workers include:[18]

- Collaborating with school staff in developing interventions to address chronic attendance issues and dropout prevention;
- Implementing strategies to maintain a positive home-school connection such as home visits and conferences;
- Collaborating with families and school staff on MCPS and community programs designed to prevent, intervene in, and treat alcohol and other drug use;
- Referring students, families, and school staff to community resources;
- Providing crisis support services;
- Assisting in the case management process for students referred to the Department of Health and Human Services and Juvenile Justice Services;
- Assessing and supporting the needs of homeless families; and
- Assisting in the special education identification and placement process.

Partnership programs. MCPS contracts with two organizations that provide behavioral health promotion and prevention services for students, and also has an agreement with DHHS Behavioral Health and Crisis Services, which : [19]

- *The Mental Health Association of Montgomery County* (MHA) offers a depression and suicide awareness program, called *Red Flags*, for students and staff members in MCPS middle and high schools, and provides 12-hour Mental Health First Aid workshops for MCPS staff to train staff on accessing services for individuals experiencing mental health issues. The contract amount was budgeted at $62,500 for FY 2015. These services form part of the Mental Health Association's Hotline Outreach and Programming for Emotional Support (H.O.P.E.S.) program (see page 62).
- *Identity, Inc.* provides services to 50 Gaithersburg and Watkins Mill high school students through a contract with MCPS ($62,500). Services are targeted at students who receive English for Speakers of Other Languages (ESOL) services and Multidisciplinary Educational Training and Support (METS) services, which are designed for English-language learners who may have had limited or no previous schooling or gaps in schooling. The Identity program aims to increase school attendance, improve school and community adjustment, and reduce the risk of dropping out. Students participating in this program may be referred to mental health services provided by Identity outside of the MCPS contract or to the County's behavioral health services (see page 61).
- *DHHS Behavioral Health and Crisis Services* receives referrals for school-age children and adolescents in crisis, who can access the Crisis Center for assessment, stabilization and referrals. In FY2014 MCPS referred over 1000 children to the Crisis Center.

[16] COMAR 13A.05.05.03 (A)
[17] COMAR 13A.12.03.04 (A)
[18] "Pupil Personnel Services," MCPS website, < http://www.montgomeryschoolsmd.org/departments/studentservices/mentalhealth/pupil.aspx?id=333016 > accessed 1/21/2015
[19] *Montgomery County Public Schools FY 2015 Program Budget*, p. 98

2. Department of Health and Human Services

In addition its behavioral health treatment services, the Department of Health and Human Services provides a variety of behavioral health promotion, prevention, referral and early intervention services. Some services are school-based, while others are targeted at specific populations. This section describes the following DHHS services:

- School Health Services
- Linkages to Learning and Regional Youth Services Centers
- Positive Youth Development
- Child Welfare

School Health Services. The DHHS School Health Services Program provides basic health services, typically staffed by a registered nurse, in Montgomery County Public Schools, including referrals for psychological and behavioral problems. Additionally, nine elementary schools have School-Based Health Centers and three high schools have High School Wellness Centers. These centers provide additional medical services targeted at specific school needs, including primary health care services provided by nurse practitioners and physicians and individual, family, and group mental health counseling.

Linkages to Learning and Regional Youth Service Centers. Linkages to Learning (LTL) is a partnership initiative of DHHS, MCPS and non-profit providers that aims to address barriers to learning by offering school-based prevention and early intervention services at 23 high-poverty elementary schools and six high-poverty middle schools. School counselors and other staff can refer students and families to LTL services, which include behavioral health assessments, child and family therapy, and group counseling. For students who do not attend LTL schools, Regional Youth Service Centers that serve multiple schools provide a similar set of services (often through the same providers).

Positive Youth Development. DHHS's Positive Youth Development program provides services for youth involved in gangs or at risk of gang involvement through the Street Outreach Network (SON), two Youth Opportunity Centers located in Takoma Park and Gaithersburg and operated through a County contract with Identity, Inc., as well as through the three High School Wellness Centers located at Watkins Mill, Gaithersburg and Northwood High Schools.

The SON, staffed and operated by HHS, works in schools and in the community to provide gang and youth violence prevention and crisis intervention for elementary, middle and high school youth, including identifying behavioral health issues and making referrals. Youth Opportunity Centers serve at-risk youth by providing GED preparation, sports and recreation activities, workforce development, mentoring and tutoring, mental health counseling, and linkages to social services. In addition to their primary health care services, High School Wellness Centers provide a variety of prevention and intervention activities for youth including crisis intervention, individual, family, and group mental health counseling, and after school programming.

Child Welfare. Child Welfare Services provides services for maltreated children and their families, including behavioral health evaluations and referrals to behavioral health services. After an Assessment Unit investigates an allegation of physical abuse, sex abuse, or neglect of a child, a Continuing Unit conducts a detailed evaluation of the child's needs and makes referrals to behavioral health providers, including DHHS Behavioral Health and Crisis Services and providers in the community who accept Medicaid.

Child Welfare Services works in collaboration with the Tree House Child Assessment Center, a partnership between DHHS and the Primary Care Coalition that provides mental health assessments and therapy for maltreated children and family members. Additionally, children may be placed in the Treatment Foster Care

Program, which provides intensive case management and treatment for children with serious health needs, including mental health needs and behavioral issues, in a home environment with specially trained foster parents. Finally, the Home-Based Mental Health Team of DHHS Behavioral Health and Crisis Services is composed of six therapists who work in concert with Child Welfare Services to provide specialized in-home mental health services for children and families in the Child Welfare system and for up to three months after exiting the system.

3. Montgomery College

Montgomery College provides the following behavioral health promotion, prevention and early intervention services for students:

- Student Health 101 is a monthly wellness newsletter for students that includes content on emotional health and stress management.[20]
- The College hosts substance abuse prevention education events, including a workshop on how drugs and alcohol affect the brain and DWI/DUI prevention events.[21]
- The Behavioral Intervention Team (B.I.T) is a multi-disciplinary group that aims, "to maintain a healthy, safe, and secure environment, free of intimidation and harm, by systematically addressing behaviors of concern".[22] This team includes a contracted licensed mental health professional who assists in responding to students in crisis, refers students to outside resources for evaluation, support and intervention, liaises with service providers, and tracks student concerns.

4. Organizations in the Community

This section describes behavioral health promotion, prevention, referral and early intervention services provided by organizations in the community outside of the County Government and County agencies. Many of these organizations receive funding through contracts with the County to provide services.

Montgomery County Collaboration Council – Many Voices for Smart Choices. The Montgomery County Collaboration Council for Children, Youth and Families coordinates the Montgomery County Alliance to Prevent Youth Substance Abuse, also known as Many Voices for Smart Choices (MVSC). MVSC partner organizations include Montgomery County Behavioral Health and Crisis Services, Montgomery County Public Schools, Montgomery County Police Department, Department of Liquor Control, State's Attorney's Office, Keeping it SAFE Coalition, Brave and Bold, Heroin Action Coalition, City of Rockville Youth Services, YMCA Youth and Family Services, Family Services, Inc., Adventist Behavioral Health, and Community of Concern.

DHHS provides funding for the initiative through a contract with the Collaboration Council. The contract requires the Collaboration Council to adhere to the Communities Mobilizing for Change on Alcohol (CMCA) model, which is an evidence-based program certified by SAMHSA. The CMCA model is designed

[20] Student Health 101 Archives, Montgomery College website, < http://montgomerycollege.readsh101.com/ > accessed 1/21/2015
[21] *Drug-Free Schools and Community Act, 2013 Biennial Review*, Montgomery College, July 24, 2013, < file:///C:/Users/carrin01/Downloads/2013%20DrugAlcohol%20Biennial%20Review_FINAL1.pdf > accessed 1/21/2015
[22] "Behavioral Intervention Team (B.I.T)," Montgomery College website, < http://cms.montgomerycollege.edu/BIT/ > accessed 1/20/2015

to limit youths' access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable.[23]

MVSC includes the Strengthening Families Program, which is a family skills training program also based on a national model certified by SAMHSA as an evidence-based practice. The model consists of 14 two-hour sessions aimed at preventing behavioral, emotional, academic, and social problems in children 3-16 years old. 15 teachers completed training in the model and seven families completed the program in FY13.[24] Additionally, as part of the MVSC initiative, the Collaboration Council administers the Under-21 Substance Abuse Prevention Activity Mini-Grant program, which provides grants of amounts between $500 and $1000 to community-based groups to deliver educational substance abuse prevention activities targeted at middle or high school-aged youth. MVSC and its members also conduct additional substance abuse prevention outreach activities, including a student video contest on the dangers of underage drinking and presentations at afterschool programs and high school health fairs.[25]

Family Services, Inc. – DARE To Be You. Family Services, Inc. operates DARE To Be You (DTBY), a 10-week substance abuse prevention education program funded by DHHS for 60 high-risk preschool age children (such as Head Start participants), their parents and siblings. This program is based on a national model certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice. The DTBY model targets child development and aspects of parenting that contribute to youth resilience to substance abuse later in life.[26]

Identity – Latino Wellness Program. Identity, Inc. is a community-based organization whose mission is to "provide opportunities for Latino youth to believe in themselves and realize their full potential."[27] Identity provides a Latino Wellness Program that receives funding through a contract with DHHS. The contract requires Identity to recruit 65 low-income families with high-risk youth between the ages of 11 and 15, complete a quantitative health assessment for each participating youth, work with youth to develop a family-based intervention plan to address issues identified in the assessment, offer training to parents and youth on topics such as health education, reestablishing family bonds, and communication skills and conflict resolution, and provide 450 one-on-one counseling or case management sessions annually to address identified issues.[28] Identity's services focus on addressing specific issues such as family reunification and conflict resolution, and do not include diagnosis or treatment of behavioral health disorders. Identity therapists refer individuals with serious behavioral health issues to Family Services, Inc. for treatment.

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[23] Contract # 1014374, Montgomery County, Maryland; and "Communities Mobilizing for Change on Alcohol," National Registry of Evidence-Based Programs and Practices (NREPP), Substance Abuse and Mental Health Services Administration (SAMHSA), < http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=117 > accessed 2/6/2015;

[24] *2013 Annual Report*, Montgomery County Collaboration Council for Children, Youth and Families, < http://www.collaborationcouncil.org/2013annualreportweb.pdf > accessed 1/28/2015

[25] *2014 Annual Report*, Montgomery County Collaboration Council for Children, Youth and Families, < http://www.collaborationcouncil.org/fy14annualreportfinal.pdf > accessed 1/28/2015; "Strengthening Families Program," National Registry of Evidence-Based Programs and Practices (NREPP), Substance Abuse and Mental Health Services Administration (SAMHSA), < http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=44 > accessed 1/28/2015; and "Announcement of Funding Availability: Under 21 Substance Abuse Prevention Activity Mini-Grans FY 2015," Many Voices for Smart Choices and the Montgomery County Collaboration Council, < http://www.collaborationcouncil.org /fy15under21minigrants2.pdf > accessed 1/28/2015

[26] "DARE To Be You," Family Services website, < http://www.fs-inc.org/services/programs/dare-to-be-you > accessed 1/28/3015; "DARE To Be You," National Registry of Evidence-Based Programs and Practices (NREPP), Substance Abuse and Mental Health Services Administration (SAMHSA), < http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=65 > accessed 1/28/2015; and Contract # 0646070114AA, Montgomery County, Maryland.

[27] "Our Mission and Goals," Identity, Inc. website, < http://www.identity-youth.org/#!our-mission-and-goals/c14ax > accessed 2/2/2015.

[28] Contract # 1015012, Montgomery County, Maryland.

Commission for Women Counseling & Career Center. At its center in Rockville, the Commission for Women has in the past provided short-term individual and couples counseling on personal and work-related issues, with the aim of providing the skills and tools necessary to manage challenging life situations. Multilingual services (English, Spanish, French, Arabic and Portuguese in FY14) were provided at no cost to uninsured Montgomery County residents aged 18 and over who meet maximum income criteria. In FY14, the Commission for Women received $140,000 from the County to provide counseling services and provided 809 counseling sessions to 104 clients.[29] However, the Commission has determined that it will no longer be providing counseling services beginning in FY16. The center also offers workshops on a wide range of topics and referrals to other services in the community.

Mental Health Association – Hotline Outreach and Programming for Emotional Support (H.O.P.E.S.). The H.O.P.E.S. program of the Mental Health Association of Montgomery County (MHA) includes a free 24-hour suicide prevention and crisis hotline for callers in Montgomery County and the Red Flags Program, which is a depression and suicide awareness education program delivered in MCPS middle and high schools (see page 58). The MHA receives funding for these services through contracts with MCPS, and DHHS and the State Department of Health and Mental Hygiene (DHMH).[30]

Washington Youth Foundation – Behavioral Health Outreach and Education. The Washington Youth Foundation (WYF) is a non-profit organization that offers youth education and welfare services targeted at Korean-American students in the Washington, DC metropolitan area. WYF provides behavioral health outreach and education in Montgomery County with support from a contract with DHHS. Outreach services required by the contract include a bilingual media campaign on mental health issues and services, production and distribution of bilingual posters and brochures on behavioral health, interactive seminars on mental health issues, and referrals to behavioral health providers.[31]

Brave and Bold. Brave and Bold is a community coalition that was formed in response to a 2011 fatal car crash involving five students associated with Magruder High School. The coalition aims to raise awareness of the multiple dangers associated with underage substance abuse. Brave and Bold hosts parent forums each semester and provides informational materials to Magruder High School parents on parenting strategies for substance abuse prevention.[32]

Community of Concern. Community of Concern is an organization founded in 1997 by parents at the Georgetown Preparatory School in Bethesda. The organization produces materials for parents on substance abuse prevention, including the "A Parent's Guide for the Prevention of Alcohol, Tobacco and Other Drug Use" booklet published in 1999 and most recently revised in 2014, as well as e-learning courses on the negative effects of substance abuse.[33]

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[29] *Montgomery County Commission for Women Annual Report: Fiscal Year 2014,* < http://www.montgomerycountymd.gov/cfw/Resources/Files/FY14AnnualReport.pdf > accessed 4/10.2015.
[30] Contract #11887AA, Montgomery County, Maryland; and *Montgomery County Public Schools FY 2015 Program Budget*, p. 98
[31] Contract #1043931, Montgomery County, Maryland; and FY15 Approved Operating Budget
[32] "Brave and Bold FAQs," Magruder High School website, < http://www.montgomeryschoolsmd.org/schools/magruderhs/administration/braveandbold.aspx > accessed 2/5/2015
[33] "Who We Are," Community of Concern website, < http://thecommunityofconcern.org/who-are-we-parent-to-parent-2/who-are-we/ > accessed 2/5/2015

5. Online Behavioral Health Service Databases

Individuals seeking behavioral health services may be referred to providers by the agencies and organizations listed above, but may also search for providers online. The following online databases contain behavioral health service provider listings for Montgomery County:

- **infoMontgomery** is an online database of health, education and human service resources managed by the Montgomery County Collaboration Council for Children, Youth and Families in collaboration with the County Government, MCPS and private agencies. At the time of writing, the database contained 147 separate listings in the categories of counseling settings, mental health evaluation and treatment, mental health facilities, outpatient mental health care, psychiatric/mental health support services, and substance abuse services. This database includes several listings of programs that are located outside of Montgomery County.
- **Maryland Community Services Locator (MDCSL)** is an online database of approximately 9,000 health, social service and criminal justice resource programs in Maryland created by the University of Maryland Center for Substance Abuse Research (CESAR) with funding from the Governor's Office for Crime Control and Prevention. Individuals can search for programs in Montgomery County in a variety of categories including mental health services (80 listings), substance abuse treatment programs (35 listings), substance abuse prevention and recovery programs (31 listings), support groups (50 listings), and buprenorphine certified physicians and treatment providers (39 listings). Listings may be duplicated across categories.
- **Maryland Certified Treatment Locator** is an online substance abuse services database on the website of the Maryland Behavioral Health Administration that included 43 listings in Montgomery County at the time of writing.
- **SAMHSA Behavioral Health Treatment Services Locator** is an online database accessible on the website of the Substance Abuse and Mental Health Services Administration that contained 53 listings of substance abuse and mental health treatment facilities in Montgomery County at the time of writing.
- **Network of Care** is a health and social services online database operated by Trilogy Integrated Resources LLC that lists behavioral health resources in Montgomery County (and Maryland more broadly) in the categories of crisis (27 listings), depression (3 listings), substance abuse (20 listings) and housing (31 listings). Listings may be duplicated across categories.

B. Recovery Support Services and Groups

Recovery is the process of ameliorating the negative impacts of behavioral health disorders, including not only the direct effects of the disorder on the individual through compliance with long-term treatment and after care but also indirect effects such as discrimination and poverty. Recovery supports can be provided by individuals who are not behavioral health professionals, such as other individuals with behavioral health disorders, friends and family.[34]

In Montgomery County, individuals receiving treatment for and/or recovering from behavioral health disorders can participate in a variety of community groups that offer self-help or mutual support networks to assist individuals in managing their lives and to support recovery. Groups include peer-run centers and

[34] Anthony, W., "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s," *Psychosocial Rehabilitation Journal*, 1993, 16(4), 11-23.

recovery support groups for individuals suffering from serious mental illness and their families and recovery support services and groups for individuals recovering from addictions and their families.

1. Services and Groups Focused on Mental Health

Wellness and Recovery Centers. On Our Own of Montgomery County and the Affiliated Sante Group operate the two Wellness and Recovery Centers in the county, which are located in Gaithersburg and Silver Spring. Wellness and Recovery Centers provide services for adults experiencing mental health issues and are consumer-run (also known as "peer-run"), meaning that the individuals delivering services are also current or former consumers of mental health services. Center services include Wellness and Recovery Action Planning (WRAP) classes, peer support groups, educational workshops, field trips and outings, socialization activities, wellness activities, computer and internet access, and resource libraries. Services are free to consumers, and both centers receive funding through contracts with DHHS. [35]

National Alliance for the Mentally Ill of Montgomery County (NAMI). NAMI offers free classes and support groups facilitated by peers for individuals with mental illness and their families. Classes include Peer-to-Peer, a class on wellness and recovery for individuals living with serious mental illness, Family-to-Family, which provides information for caregivers on supporting a loved one with mental illness, and NAMI Basics, a class for parents and caregivers of children and adolescents living with mental illness. NAMI receives funding through contracts with DHHS to provide these services.[36]

Montgomery County Federation of Families for Children's Mental Health (Federation). The Federation's mission is to improve the lives of families raising children with emotional, behavioral and/or mental challenges, and it provides family and youth peer-to-peer support, education, advocacy, leadership opportunities, and information and referral services. Mo County ALL STARS was founded under the Federation as a youth-driven group that aims to prepare transitional-age youth and young adults for life challenges and help them to be successful in school, work and life. The group conducts advocacy, and leadership and life skills training for youth and young adults with emotional, behavioral and/or mental health challenges. Workshops and programs help youth tell their story in their own words, learn life skills, and help de-stigmatize mental health challenges.

Depression and Bipolar Support Alliance (DBSA) Montgomery County. DBSA is a national organization whose mission is to support individuals suffering from depression and bipolar disorder. Four support groups meet in the Washington, DC area including two that meet in Montgomery County. A peer support group for adults with depression or bipolar disorder meets twice a month in Bethesda, and a support group for family, friends and loved ones of individuals with mood disorders meets twice a month in Rockville.[37]

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[35] "On Our Own of Montgomery County Wellness and Recovery Center," On Our Own brochure, < http://www.ooomc.org/wp-content/uploads/2014/09/brochure2014-06-20-150445.pdf > accessed 2/11/2015; "Consumer-Run Wellness and Recovery Center," Affiliated Sante Group website,< https://www.thesantegroup.org/silver-spring-wellness-and-recovery-center > accessed 2/11/2015; Contract # 9642040021AA, Montgomery County; and Contract # 8648050168AA, Montgomery County

[36] "Our Programs," National Alliance for the Mentally Ill of Montgomery County website, < http://www.namimc.org/our-programs-2/> accessed 2/11/2015; Contract # 0648001002AA, Montgomery County; and Contract # 1013014, Montgomery County

[37] "Depression and Bipolar Support," Meetup Group page, < http://www.meetup.com/depression-and-bipolar-support/ > accessed 2/11/2015; and "Calendar," DBSA NCA Family Support Group website, < http://www.dbsanca-family.org/calendar.html > accessed 2/11/2015.

2. Services and Groups Focused on Substance Abuse

Recovery Partners Montgomery (RPM). In the field of substance abuse, "recovery-oriented systems of care," (ROSC) refers to all services and relationships that support long-term recovery from addiction. The ROSC model is often contrasted with the acute care model for substance abuse, which focuses on acute addiction treatment and recovery initiation and does not include long-term recovery management.[38] The Maryland Behavioral Health Administration mandates and provides funding local jurisdictions (approximately $140,000 annually to Montgomery County) to promote and implement ROSC. RPM is the umbrella organization for Montgomery County under which the State-mandated ROSC efforts operate. These include:

- The Change Leadership Team, which is a consortium of providers, self-identified consumers and advocates that meets to direct efforts related to RPM's strategic goals and to plan community events;
- The Peer Leadership Institute (PLT), which encompasses the nationally-accredited Recovery Coach Academy (RCA) 30-hour training as well as the continued development of the "Recovery Coach Manual" and the RCA+ 3 hour classes, which focus on core competencies for certification;
- Peer-2-Peer Progress In Recovery (PPIR), which is an alliance of people in recovery who have completed the Recovery Coach Academy and are developing local volunteer and employment opportunities;
- The "Front Porch," which provides recovery activities at scattered sites in order to offer a "roving community center";
- The Warm Line, which is a phone service operated three evenings per week by Recovery Coaches and Certified Peer Recovery Specialists; and
- Employment Support, which provides "Recovery Works," a seven-week job development course.

Twelve-Step Groups. A twelve-step group is a mutual-aid recovery support group for individuals with addictive, compulsive or other behavioral problems. These groups follow some or all of Alcoholics Anonymous'[39] guiding principles for recovery, including some spiritual (but not religious) components. Membership in groups is typically free of charge. The American Psychological Association (APA) summarizes the twelve-step process as follows:[40]

- Admitting that one cannot control one's addiction or compulsion;
- Recognizing a higher power that can give strength
- Examining past errors with the help of a sponsor (experienced member);
- Making amends for these errors
- Learning to live a new life with a new code of behavior; and
- Helping others who suffer from the same addictions or compulsions.

[38] White, W., Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices, Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health/Mental Retardation Services, 2008. < http://www.naadac.org/assets/1959/whitewl2008_recovery_management_and_recovery-oriented_systems_of_care.pdf > accessed 5/1/2015

[39] Alcoholics Anonymous is an international mutual aid fellowship group founded in 1935.

[40] VandenBos, Gary R. (2007). *APA dictionary of psychology* (1st ed.). Washington, DC: American Psychological Association. ISBN 1-59147-380-2 in "Educational Materials," Center for Students in Recovery, University of Texas Arlington website, < http://www.uta.edu/csr/education/index.php > accessed 2/12/2015

Numerous meetings of groups including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and Sex Addicts Anonymous occur throughout the County on a weekly basis. For example, the Rockville Metro Club, a recovery clubhouse located near the Twinbrook Metro Station, hosts over thirty meetings per week, primarily for Alcoholics Anonymous (including meetings for Spanish-speakers) but also for Narcotics Anonymous and Cocaine Anonymous.[41] Similarly, the website of the Chesapeake & Potomac Region of Narcotics Anonymous lists about 20 NA meetings occurring each day of the week in different locations in Maryland including Montgomery Village, Silver Spring, Rockville, Olney, Gaithersburg, and Chevy Chase.[42]

Al-Anon and Alateen. Al-Anon and Alateen are support groups for friends and relatives of individuals who abuse alcohol. Alateen is specifically designed for young people. Like twelve-step groups, Al-Anon and Alateen have important spiritual components, and they follow an adopted version of the twelve-step program originally developed by Alcoholics Anonymous. The Washington Metropolitan Area Al-Anon/Alateen Information Service lists approximately fifty different Al-Anon or Alateen meetings that occur throughout Montgomery County on a weekly basis. Participation is free of charge.[43]

SMART Recovery (Self Management and Recovery Training) Groups. SMART Recovery groups are mutual-aid groups that, like twelve-step groups, provide recovery support for individuals facing addiction. However, SMART Recovery groups follow a different approach to that used by twelve-step groups; they seek to use scientific knowledge to provide members with a set of tools and skills around the following "four-point program":[44]

- *Motivation to abstain* – enhancing and maintaining motivation to abstain from addictive behavior;
- *Coping with urges* – learning how to cope with urges and cravings;
- *Problem solving* – using rational ways to manage thoughts, feelings and behaviors; and
- *Lifestyle balance* – balancing short-term and long-term pleasures and satisfactions in life.

The website of the DC metro area chapter of the nation-wide SMART Recovery Self-Help Network lists weekly meetings occurring in the DC metro area, including four meetings located in Silver Spring, Rockville, Potomac and Gaithersburg.[45] Participation is free of charge.

[41] "Metro Club Meeting Schedule," Rockville Metro Club website, < http://www.rockvillemetroclub.org/newschedule.html > accessed 2/12/2015
[42] "Online Meeting List," Chesapeake & Potomac Region of Narcotics Anonymous website, < http://www.cprna.org/find-a-meeting/meeting-list/?dayofweek=3&state=md > accessed 2/12/2015.
[43] "Montgomery County Al-Anon/Alateen Directory," September 2014, Washington Metropolitan Area Al-Anon/Alateen Information Service website, < http://www.al-anon-alateen-dcmd.org/images/uploads/Directory-Mont-SEPT-2014.pdf?phpMyAdmin=bRjjpjWsf2FT5BbGMafi2jb2hg5 > accessed 2/12/2015; and "About Al-Anon Family Group Meetings," Al-Anon Family Groups website, < http://www.al-anon.org/about-group-meetings > accessed 2/12/2015
[44] "An Introduction to SMART Recovery," slide show, SMART Recovery: Self-Management and Recovery Training website, < http://www.smartrecovery.org/resources/learnaboutsmart.htm > accessed 2/12/2015
[45] "Local Meetings," SMART Recovery Capital Region website, < http://capitalsmart.org/ > accessed 2/12/2015

Chapter VIII. Montgomery County's Behavioral Health Workforce

Workforce supply is an important determinant of access to behavioral health services. Whether or not an individual can obtain services depends in part on the availability of behavioral health professionals including psychiatrists, psychologists, social workers, mental health and addictions counselors, and advanced practice psychiatric nurses.

At the national level, the current workforce of behavioral health professionals does not meet the existing need for services. A set of studies commissioned by the Health Resources and Services Administration (HRSA) estimated that the national need for psychiatrist was about 80,000 compared to an estimated 48,000 psychiatrists practicing in the United States in 2010.[1] HRSA's estimate assumed an average of 25.9 psychiatrists per 100,000 would be needed to serve a population that had rates of mental illness comparable to the national prevalence rates.

At the local level, the County has currently has 331 psychiatrists currently practicing in the County or an estimated 214 full-time equivalent psychiatrists (when taking into account self-reported work hours), and 3,155 licensed behavioral health professionals. Using estimates of need based on a set of studies commissioned by the Health Resources and Services Administration, the County has a shortage of psychiatrists, while all methods show that the County has a sufficient number of other licensed behavioral health professionals. However, it is important to note that these data do not include information on whether providers accept public or private health insurance or on the language skills of providers. These factors can impact whether the workforce meets the needs of County residents, particularly among low-income individuals and individuals with limited English proficiency.

Two factors are predicted to affect the demand for mental health professionals in the future both nationally and locally. First, the Affordable Care Act is increasing the number of individuals who can obtain health care coverage through Medicaid or through private insurance on the exchanges. As a result, more individuals may have the means to obtain behavioral health services, and more individuals will be screened for behavioral health conditions, potentially leading to increased demand for services. Secondly, a large portion of the existing workforce, particularly among psychiatrists, is aging and will enter retirement in the near future.[2]

This chapter defines the behavioral health workforce and describes workforce data for Montgomery County. It is organized as follows:

- **Section A** describes the occupations that form part of the behavioral health workforce in Maryland;
- **Section B** presents data on the behavioral health workforce in Montgomery County; and
- **Section C** summarizes methods for determining the need or demand for behavioral health professionals

[1] Konrad, T.R. et al.,"County-Level Estimates of Need for Mental Health Professionals in the United States," *Psychiatric Services* 60, no. 10 (2009), p. 1312; and Flaum, M., "Telemental Health as a Solution to the Widening Gap Between Supply and Demand for Mental Health Services," in Myer, K and C.L. Turvey (Eds.) *Telemental Health: Clinical, Technical and Administrative Foundations for Evidence-Based Practice*. Elsevier Inc, 2013, pp 11-25.

[2] "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues," Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, January 24, 2014 http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf > accessed 3/6/2015

A. Behavioral Health Occupations in Maryland

A variety of health professionals are involved in delivering behavioral health services, and definitions of the behavioral health or mental health workforces vary with respect to which occupations are included. The Health Resources and Services Administration (HRSA), the federal agency charged with increasing access to health care, has established a set of core mental health occupations, listed on Table X, and uses data on these occupations to designate Mental Health Professional Shortage Areas (MHPSAs), which are defined in page 83. HRSA defines the mental health workforce narrowly, with the aim of targeting federal investments at extreme shortages.

The Substance Abuse and Mental Health Services Administration (SAMHSA) includes a similar, though slightly longer list of occupations in its data on the behavioral health workforce. Finally, the Institute of Medicine IOM, a national nonprofit health policy organization, offers a significantly more expansive list of occupations in its definition of the behavioral health workforce[3], as shown on Table 33 in order to include all professionals that provide services related to behavioral health. Many of the occupations listed by the IOM are not exclusively focused on behavioral health, such as primary care physicians.

Table 33. Occupations in the Behavioral Health Workforce as Defined by National Organizations

HRSA: Core Mental Health Professionals	SAMHSA: Behavioral Health Treatment Providers	IOM: Mental Health and Substance Abuse Professions
Psychiatrists	Psychiatrists	Psychiatrists
Clinical psychologists	Child and adolescent psychiatrists	Psychologists
Clinical social workers	Psychologists	Social workers
Psychiatric nurse specialists	Clinical social workers	Licensed practical nurses
Marriage and family therapists	Psychiatric nurses	Registered nurses
	Marriage and family therapists	Advance practice registered nurses
	Substance abuse counselors	Marriage and family therapists
	Counselors	Counselors
		Primary care physicians
		Physician assistants
		Pharmacists
		Occupational therapists
		Peer support specialists
		Community health workers
		Direct care workers
		Family and other unpaid caregivers

Sources: HRSA Guidelines for Mental Health HPSA Designation (see http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaguidelines.html; *Behavioral Health, United States, 2012*. HHS Publication No. (SMA) 13-4797. 2013, Rockville, MD: SAMHSA; *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Institute of Medicine, 2012, Washington, DC: The National Academies Press.

Regulation of the behavioral health workforce occurs primarily at the state level. In Maryland, State law and regulations establish State licensing boards in the Department of Health and Mental Hygiene and define licensing requirements for health occupations. Table 34 displays licensing requirements and role descriptions for occupations in Maryland which correspond to the occupations included by SAMHSA as behavioral health treatment providers, as well as primary care physicians, who play a key role in the treatment of behavioral health disorders.

[3] The IOM's list of behavioral health occupations comes from a report on behavioral health for older adults

Table 34. Behavioral Health Occupations: Maryland Licensing Requirements and Roles

Occupation and Licensing Board	Education and other licensing requirements	Role
Adult, child and adolescent, and addiction psychiatrists[4] (Board of Physicians)	Degree of doctor of medicine or doctor of osteopathy, passing score on the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination and completion of psychiatric residency requirements in a program approved by the American Board of Psychiatry and Neurology	• Diagnose behavioral health conditions; • Provide psychotherapy; • Prescribe medication; and • Can also diagnose and treat physical conditions.
Primary care physicians (Board of Physicians)[5]	Degree of doctor of medicine or doctor of osteopathy, passing score on the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination and at least 1 year of postgraduate training at an accredited training program	• Screen for behavioral health issues and provide referrals • Treat mild or moderate behavioral health disorders or severe but stable disorders • Address physical health needs of individuals with behavioral health disorders
Psychiatric nurse specialists (nurse psychotherapists & psychiatric nurse practitioners)[6] (Board of Nursing)	Master's degree in psychiatric mental health nursing or equivalent, which typically includes a minimum of 500 faculty-supervised clinical hours, and passing of relevant exam offered by the American Nurses Credentialing Center	• Diagnose mental health conditions; • Evaluate and manage medications (if certified as a nurse practitioner, can also prescribe certain medications); and • Provide psychotherapy, behavioral rehabilitation care, case management, and health promotion and prevention.
Psychologists[7] (Board of Examiners of Psychologists)	Doctoral degree in psychology and at least 2 years of supervised experience in psychology	• Diagnose, prevent, and treat psychological problems, emotional conditions, or mental conditions • Use psychological methods to assist an individual in acquiring greater human effectiveness or to modify feelings, conditions, attitudes, or behavior; and • Use biofeedback instruments to measure physical and mental functioning.
Clinical social workers[8] (Board of Social Work Examiners)	Master's degree in social work including completion of 12 credits in clinical coursework, and two years of supervised experience with at least 3,000 hours in total including 1,500 hours of face-to-face client contact and 144 hours of supervision in the diagnosis and treatment of mental disorders and provision of psychotherapy	• Evaluate, diagnose, and treat biopsychosocial conditions, mental and emotional conditions and impairments, and mental disorders; • Provide psychotherapy; and • Supervise other social workers.

[4] Md. Code Ann., Health Occupations §14-307 and §14-311; COMAR 10.32.04.02 and Heisler, E. and Bagalman, E., "The Mental Health Workforce: A Primer," Congressional Research Service, January 7, 2014.
[5] Md. Code Ann., Health Occupations §14-307 and §14-311; and COMAR 10.32.04.02
[6] COMAR 10.27.12.03 and 10.27.12.05
[7] Md. Code Ann., Health Occupations §18-302 and §18-101
[8] Md. Code Ann., Health Occupations §19-302 and §19-101

Occupation and Licensing Board	Education and other licensing requirements	Role
Licensed clinical marriage and family therapists[9] (Board of Professional Counselors and Therapists)	A master's or doctoral degree in a marriage and family field, a passing score on the Examination in Marital and Family Therapy of the Association of Marital and Family Therapy Regulatory Boards, and two years with a minimum of 2,000 hours of supervised experience in marriage and family therapy	Apply marriage and family systems theory, principles, methods, therapeutic techniques, and research in: • Resolving emotional conflict and modifying perception and behavior in the context of marriage and family life; • The identification and assessment of client needs and the implementation of therapeutic intervention
Licensed clinical professional counselors[10] (Board of Professional Counselors and Therapists)	A master's or doctoral degree in a professional counseling field, passing score on the National Counselors Examination of the National Board for Certified Counselors, and not less than three years, with a minimum of 3,000 hours (or two years with a minimum of 2,000 hours with a doctoral degree) of supervised experience in counseling	Assist individuals, families, or groups to: • develop understanding of intrapersonal and interpersonal problems; • define goals and make decisions; • plan a course of action; and • use informational and community resources.
Licensed clinical alcohol & drug counselors[11] (Board of Professional Counselors and Therapists)	A master's or doctoral degree in a health and human services counseling field, with a minimum of 26 credit hours in alcohol and drug counselor training, a passing score on the Examination for Masters Addiction Counselors of the National Board for Certified Counselors , and three years with a minimum of 2,000 hours of supervised experience in alcohol and drug counseling	Assist individuals, families, or groups to: • develop understanding of intrapersonal and interpersonal substance abuse problems; • define goals and make decisions relating to substance abuse; • plan a course of action; and • use informational and community substance abuse resources.

B. The Behavioral Health Workforce in Montgomery County

OLO examined behavioral health workforce supply in Montgomery County using data from a variety of sources, including state licensing boards, the Health Resources and Services Administration (HRSA), and a study commissioned by the Maryland Health Care Commission. This section describes data on the current supply of behavioral health professionals in Montgomery County, trends in the supply of psychiatrists, and the geographical distribution of the behavioral health workforce. Additionally, this section describes the HRSA-designated Mental Health Professional Shortage Areas in Montgomery County.

1. Current supply of behavioral health professionals in Montgomery County

Data from state licensing boards provides the most complete set of information on the supply of behavioral health professionals in Montgomery County. OLO received data on psychiatrists, psychiatric nurse specialists, psychologists, clinical social workers, marriage and family therapists, professional counselors, and alcohol and drug counselors from state licensing boards. Table 35 displays the number of professionals

[9] Md. Code Ann., Health Occupations §17-303 and §17-101
[10] Md. Code Ann., Health Occupations §17-304 and §17-101
[11] Md. Code Ann., Health Occupations §17-302 and §17-101

in each category along with the ratio of professionals to every 100,000 in population in Montgomery County. The data show that the County has:

- 33 psychiatrists for every 100,000 population
- 313 behavioral health professionals for every 100,000 population
- Over 1,700 clinical social workers, the most numerous among the occupations
- 26 alcohol and drug counselors, the least numerous among the occupations

Table 35. Licensed Behavioral Health Professionals in Montgomery County, 2014

Occupation	#	Professionals Per 100,000 Population*
Psychiatrists**	331	33
Psychiatric Nurse Specialists	64	6
Psychologists	635	63
Clinical Social Workers	1,708	169
Marriage and Family Therapists	49	5
Professional Counselors	354	35
Alcohol and Drug Counselors	26	3
TOTAL* **	**3,155**	**313**
Core Mental Health Professionals* **	***2,787***	**276**

Sources: Maryland Board of Physicians, Board of Nursing, Board of Examiners of Psychologists, Board of Social Work Examiners, and Board of Professional Counselors and Therapists
* Based the 2013 American Community Survey One-Year Estimate for the county civilian non-institutionalized population of 1,008,246
** Includes 46 licensees with a specialty in addiction psychiatry
*** Excludes duplicate records of individuals with multiple types of counselor or therapist licenses
**** Includes psychiatrists, psychiatric nurse specialists, psychologists, social workers, and marriage and family therapists based on HRSA's definition of the core mental health workforce.

It is important to note that these data do not include information on which professionals accept reimbursement from public or private health insurance, or on the number of professionals that speak languages other than English. Additionally, these data do not include information on hours worked by professionals; certain professionals may work part-time rather than full-time, effectively reducing workforce supply.

A 2014 study of health workforce supply in Maryland prepared for the Maryland Health Care Commission offers an alternative source of data on the supply of psychiatrists. This study reports numbers of psychiatrist full-time equivalents (FTEs) based on the self-reported hours worked by licensed psychiatrists. For Montgomery County, the study reports that there were 214 psychiatrist FTEs in 2012 or 21 per 100,000 population, lower than the 33 psychiatrists per 100,000 population shown from the unadjusted licensing board data. Significantly, as a caveat to psychiatrist data presented in their report, the authors noted that, "… the effective supply of psychiatrists in Maryland is likely lower than this analysis suggests because many psychiatrists do not currently participate with private and public health insurance plans."[12] Work hour data were not available for other types of licensed behavioral health professionals.

[12] *Maryland Health Workforce Study Phase Two Report: Assessment of Health Workforce Distribution and Adequacy of Supply*, prepared by IHS Global Inc. for the Maryland Health Care Commission, January 26, 2014, p. iv < http://mhcc.dhmh.maryland.gov/workforce/Documents/MD_Health_Workforce_Study_Phase_2_Report.pdf > accessed 4/9/2015

Finally, a large portion of behavioral health services are provided by primary care practitioners, rather than behavioral health specialists. According to data on the primary care workforce from the Maryland Health Care Commission's health workforce supply study, Montgomery County is one of six jurisdictions statewide where workforce supply exceeds service demand, suggesting the County has an adequate supply of primary care providers to provide a level of care that meets the national average. However, data are not available on the amount of behavioral health services delivered by primary care providers in Montgomery County.

2. Comparison to Other Counties

As noted above, the 2014 health workforce report prepared for the Maryland Health Care Commission found that Montgomery County had 21 psychiatrist FTEs per 100,000 population in 2012. Table 36 shows that of the 22 counties for which data were provided, Montgomery County had the fifth highest ratio of psychiatrists to population in the State, tied with Howard County. Psychiatrist FTE ratios ranged from 3 per 100,000 population in Somerset County to 37 per 100,000 population in Baltimore City.

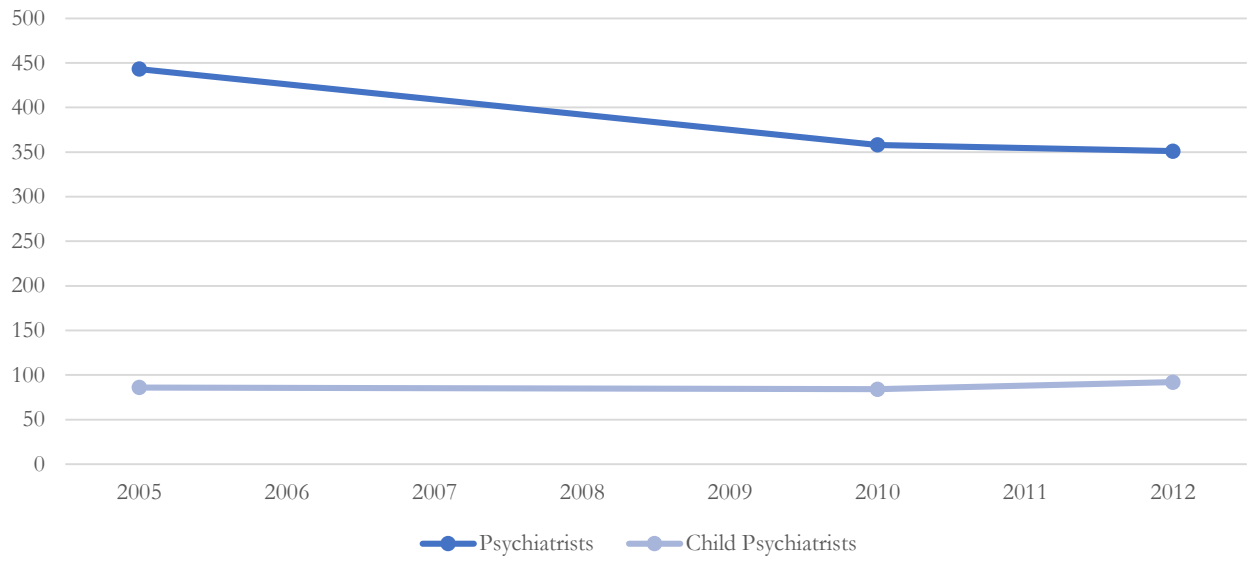
Table 36. Maryland County Ratios of Psychiatrist FTEs to 100,000 population

County	Psychiatrist FTE Ratio	County	Psychiatrist FTE Ratio
Baltimore City	37	Anne Arundel	7
Baltimore County	30	Calvert	7
Dorchester	25	Cecil	6
Talbot	22	Harford	6
Montgomery	21	Queen Anne's	6
Howard	21	Garrett	5
Carroll	16	Prince George's	5
Allegany	14	Worcester	5
Washington	12	Charles	4
Frederick	8	St. Mary's	4
Wicomico	8	Somerset	3
Maryland	**17**		

3. Trend over time in the supply of psychiatrists

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services compiles the Area Health Resources File (AHRF), which includes data from over 50 sources on health resources across the United States, including data on psychiatrists from the American Medical Association from past years. Chart 1 displays trends in the numbers of non-federal psychiatrists and child psychiatrists (which are a subset of psychiatrists) between 2005 and 2012. The chart shows a decrease in the number of psychiatrists in the County from 433 in 2005 to 351 in 2012. The number of child psychiatrists increased slightly from 86 to 92 over the same period.

Chart 1. Non-Federal Psychiatrists and Child Psychiatrists in Montgomery County, 2005-2012



4. Geographic distribution of behavioral health professionals in Montgomery County

OLO also examined the geographic distribution of licensed behavioral health professionals using State licensing board data. The exhibits on the following pages display maps showing the areas of the County with higher (darker) and lower (lighter) concentrations of each type of professional. While many of the maps show that the highest concentrations of professionals exist in the densely populated areas of the southern part of the County (Bethesda, Chevy Chase and Silver Spring), some variation exists among different types of professionals. Significantly, psychiatrists are most concentrated in Bethesda and Chevy Chase, while clinical social workers are most concentrated in Silver Spring.

Exhibit 1. Licensed Psychiatrists Per Square Mile

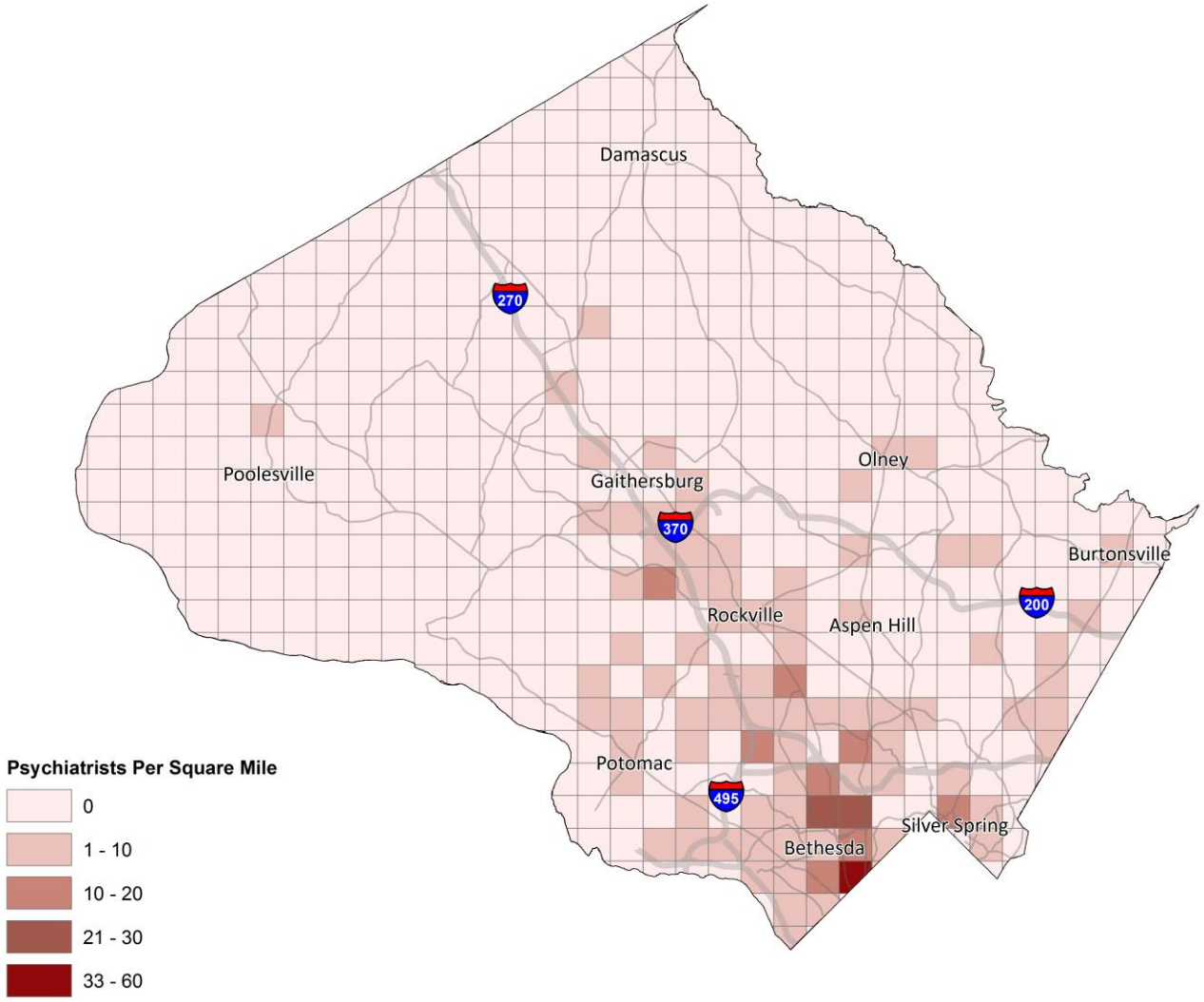
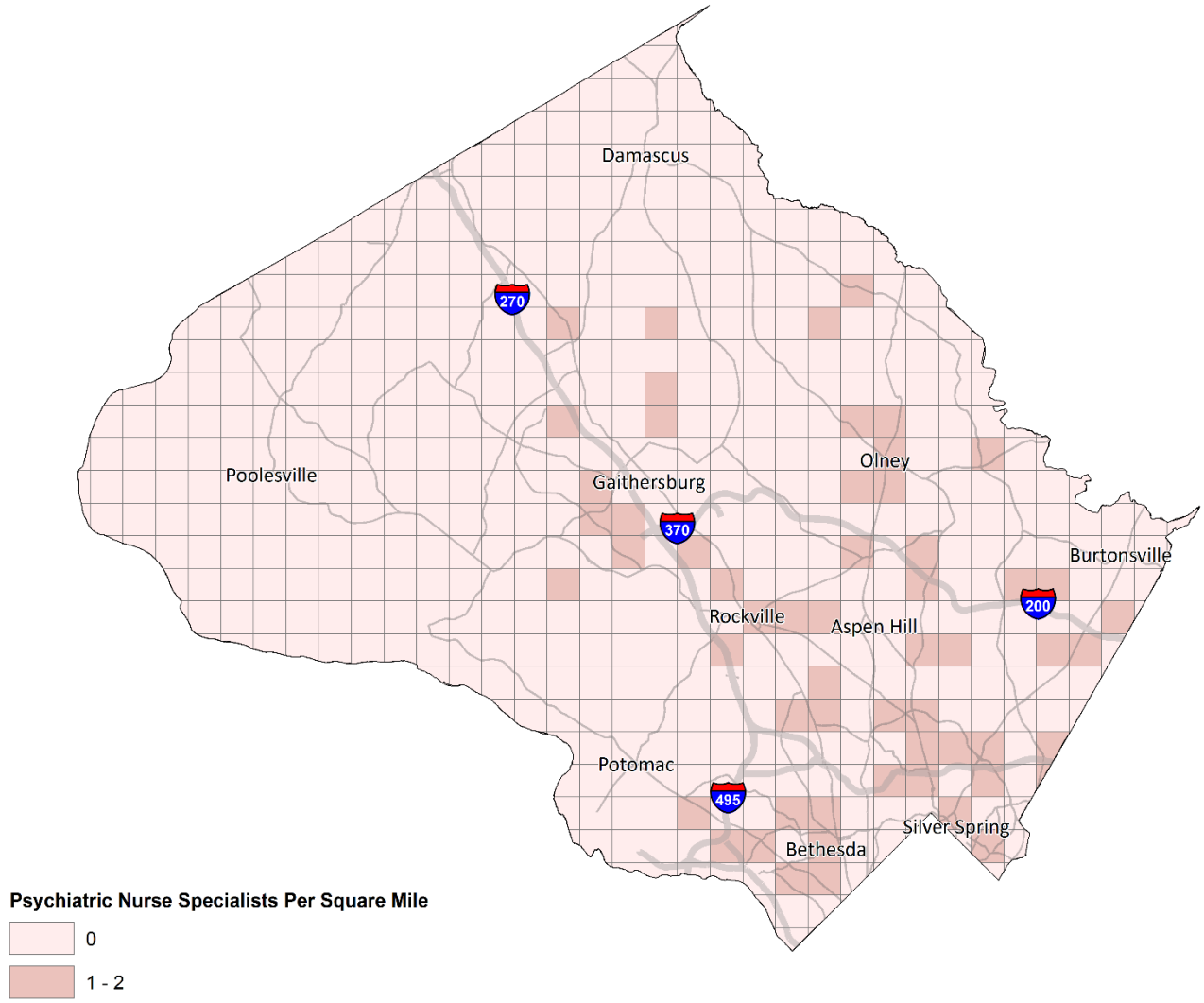


Exhibit 1 shows that the 331 licensed psychiatrists in the County are concentrated primarily in Bethesda and Chevy Chase as well as, to a lesser extent, along the I-270 corridor.

Exhibit 2. Licensed Psychiatric Nurse Specialists Per Square Mile



As noted on page 71, OLO received data on 64 psychiatric nurse specialists in the County, including nurse psychotherapists and psychiatric nurse practitioners. No strong geographic concentrations of psychiatric nurse specialists exist in the County.

Exhibit 3. Licensed Psychologists Per Square Mile

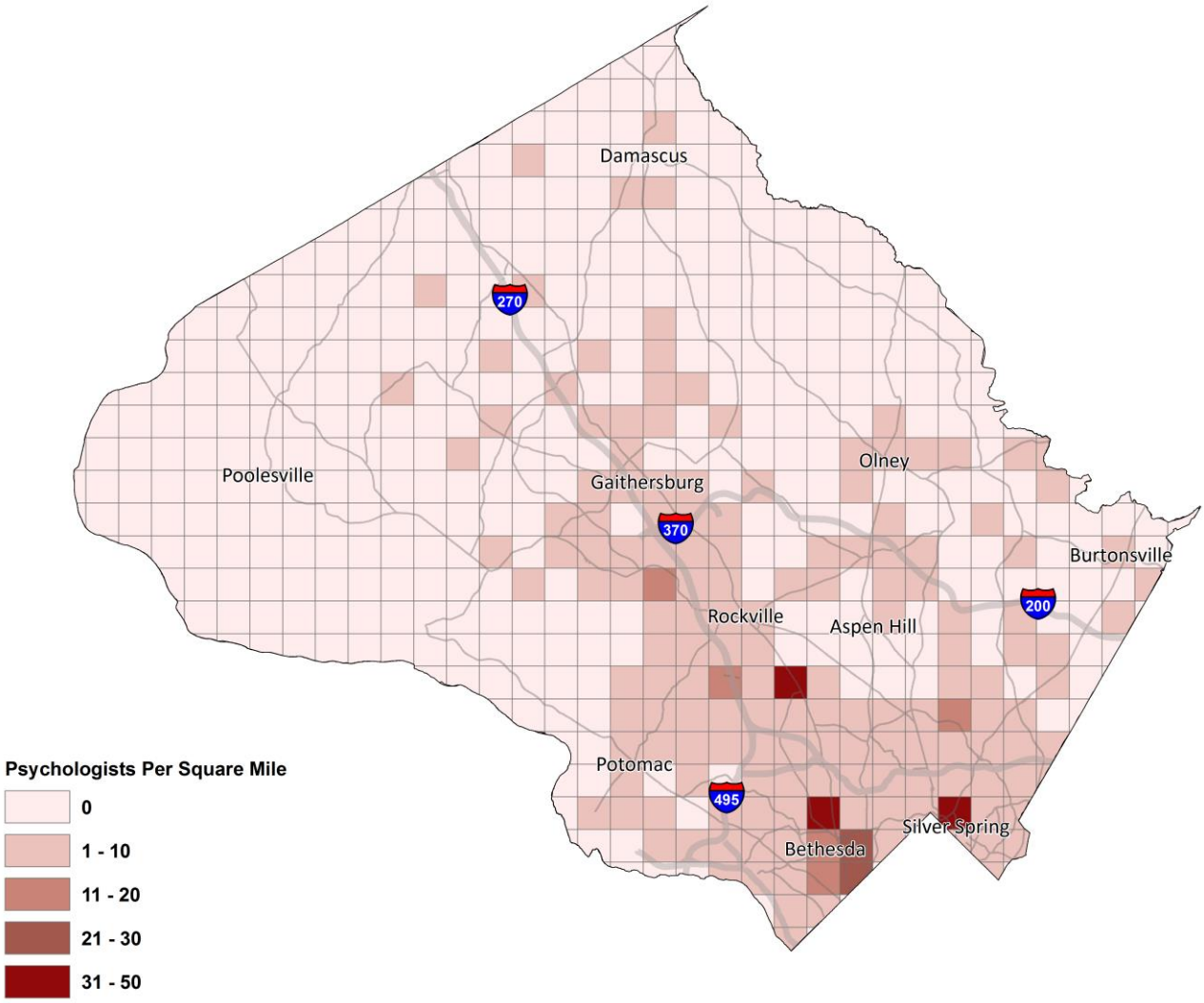
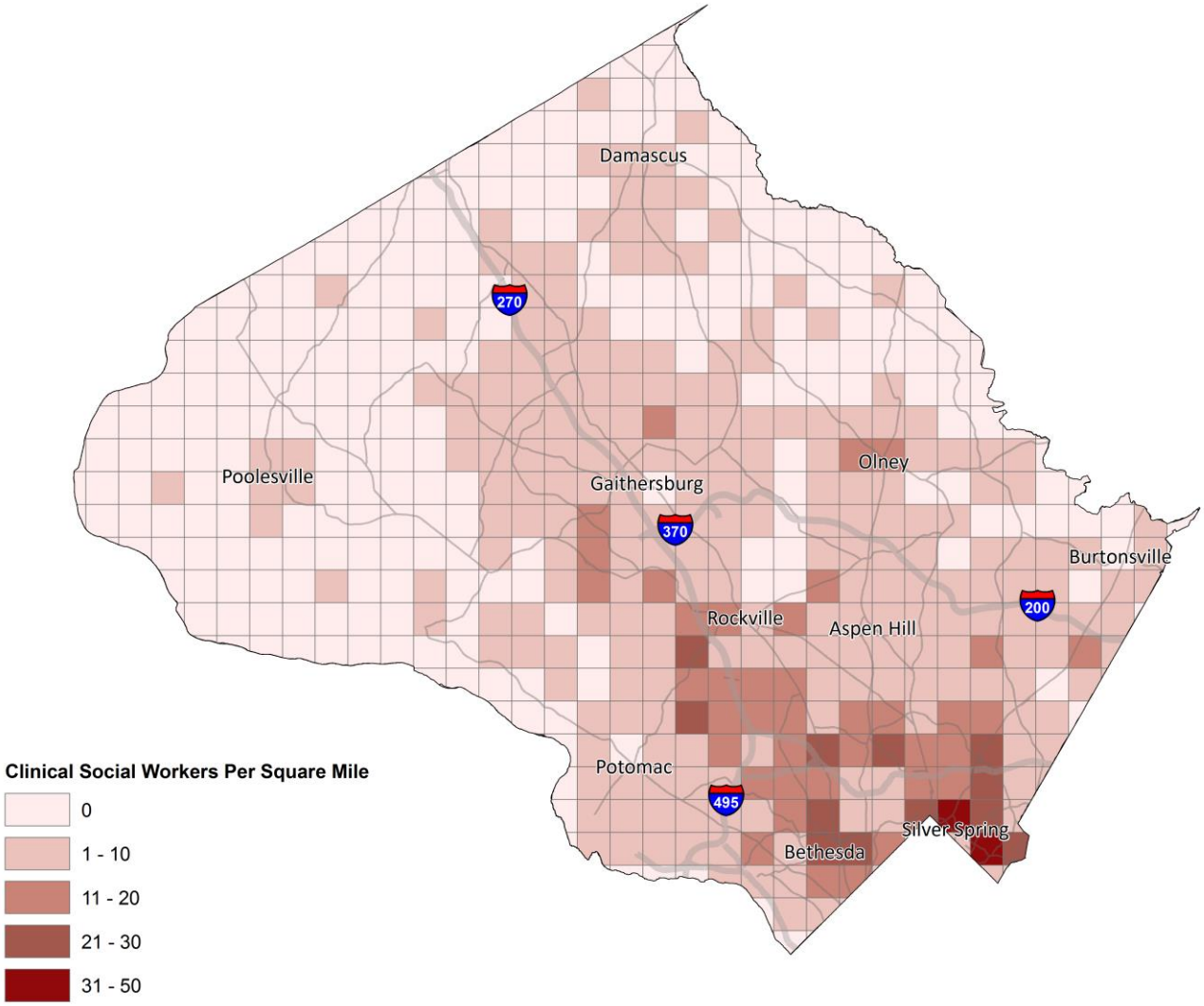


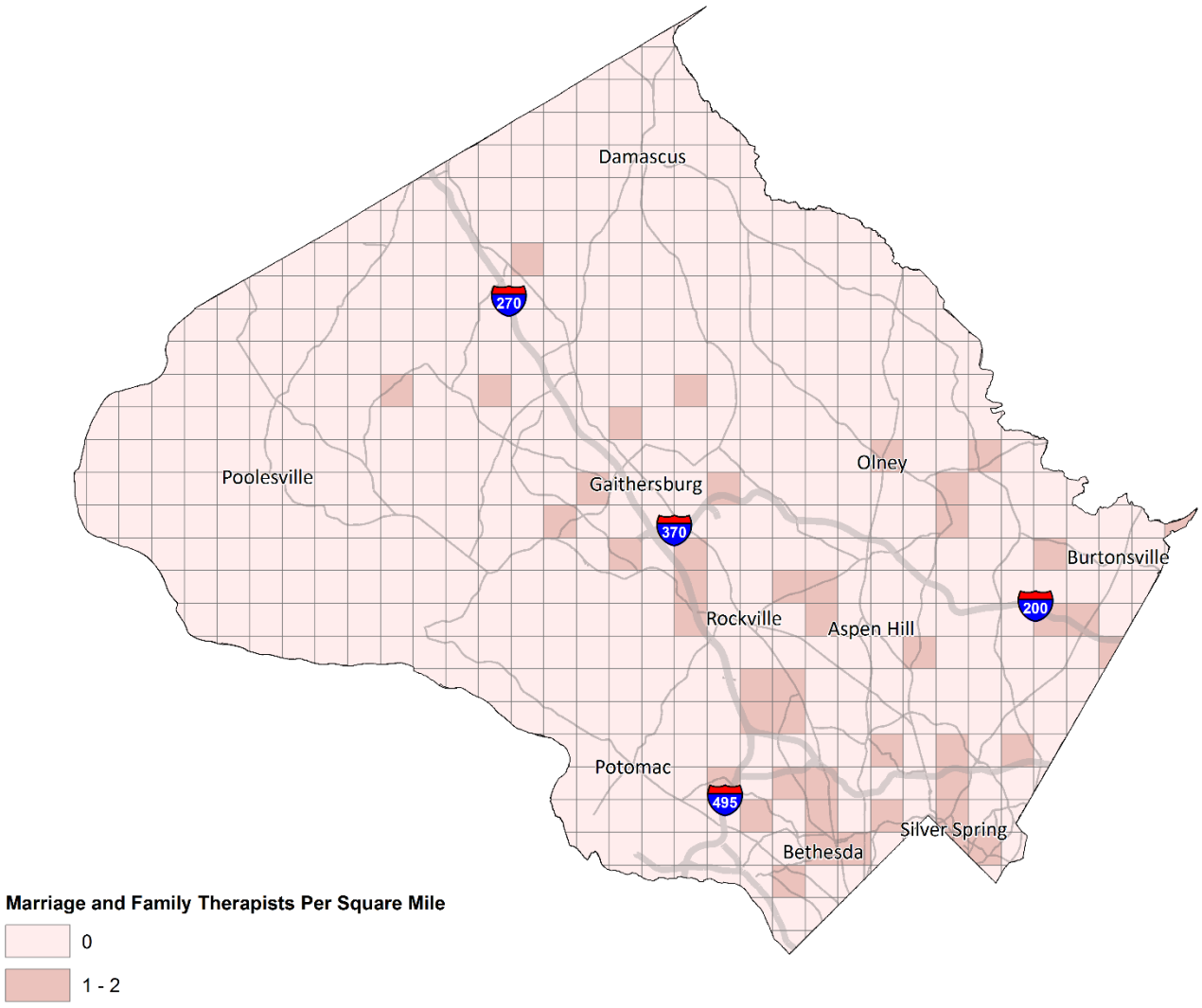
Exhibit 3 shows that the 635 licensed psychologists in the County are concentrated primarily in Bethesda, Chevy Chase and Silver Spring as well as, to a lesser extent, along the I-270 corridor.

Exhibit 4. Licensed Clinical Social Workers Per Square Mile



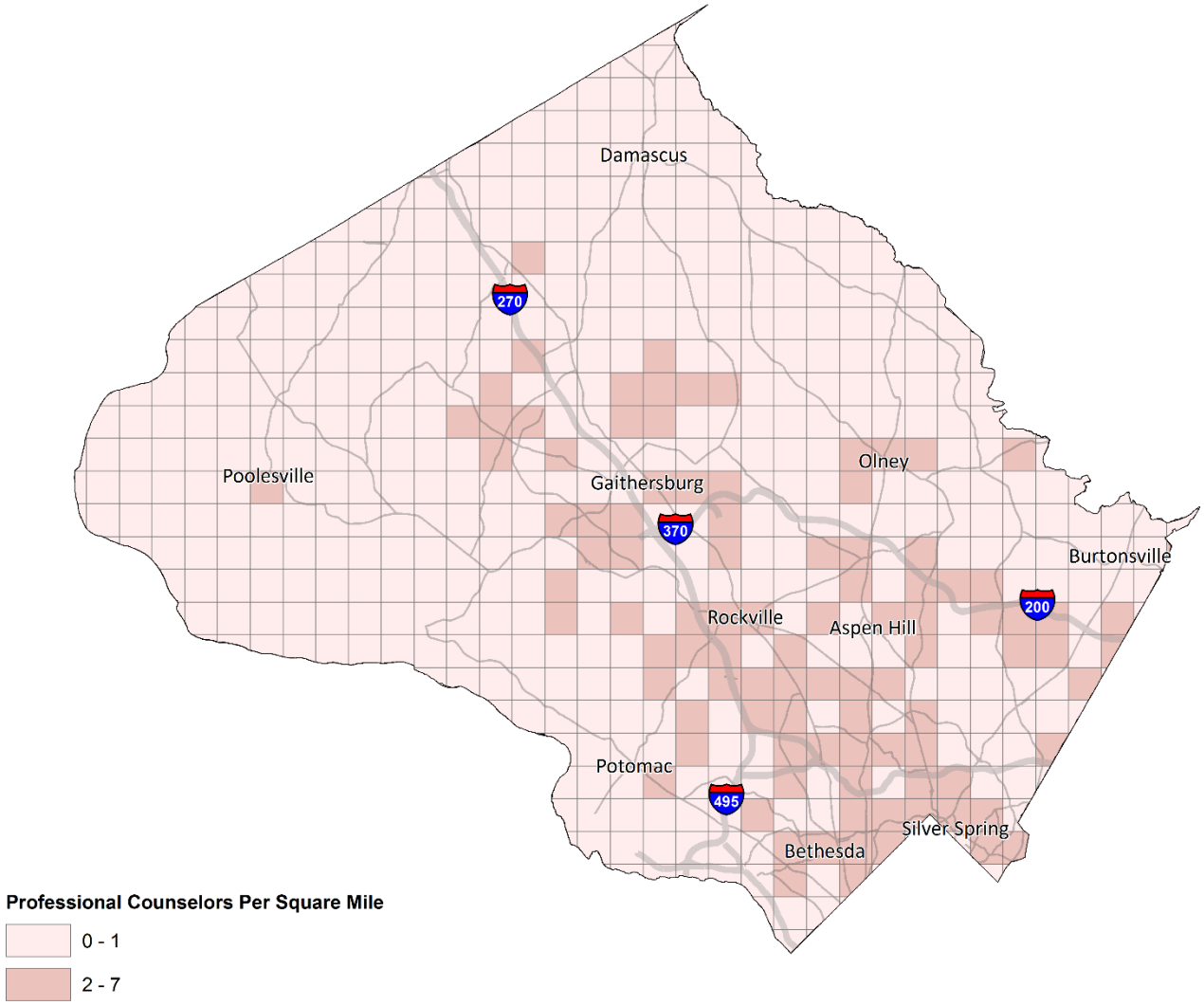
As shown in Exhibit 4, the highest concentrations of licensed clinical social workers in the County (of which there are a total of 1,708) are located in Silver Spring as well as, to a lesser extent, in Bethesda and along the I-270 corridor.

Exhibit 5. Licensed Marriage and Family Therapists Per Square Mile



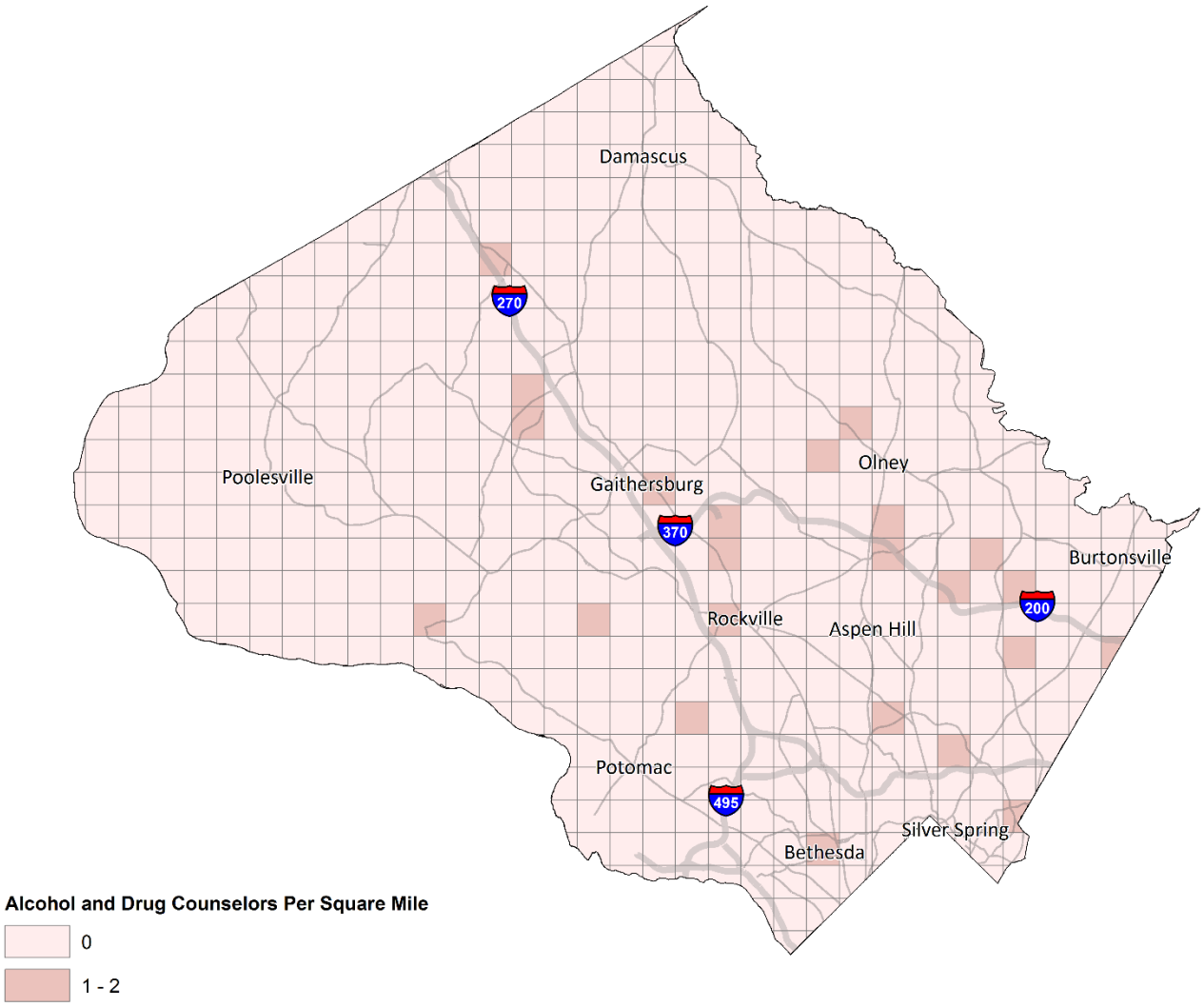
As noted on page 71, OLO received data on 49 licensed marriage and family therapists in the County. No strong geographic concentrations of this group of professionals exist in the County.

Exhibit 6. Licensed Professional Counselors Per Square Mile



As noted on page 71, OLO received data on 354 licensed professional counselors in the County. This group of professionals is somewhat evenly spread among Bethesda, Chevy Chase, Silver Spring, Aspen Hill, Olney and the I-270 corridor.

Exhibit 7. Licensed Alcohol and Drug Counselors Per Square Mile



As noted on page 71, OLO received data on 26 licensed alcohol and marriage counselors in the County. No strong geographic concentrations of this group of professionals exist in the County.

5. Designated Mental Health Professional Shortage Areas (MHPSAs) in Montgomery County

While no whole geographic areas in Montgomery County are designated MHPSAs, the Health Resources and Services Administration has designated one population group and a related facility in Montgomery County as Mental Health Professional Shortage Areas (MHPSAs). Specific populations in a geographic area may receive the federal designation if that group faces access barriers in obtaining services from core mental health professionals in the area (see page 84). Additionally, a specific facility such as a community mental health center may be designated as a MPHSA if it serves that MHPSA population group.

The Medicaid-eligible population in certain census tracts located in Kensington and Wheaton, as well as the Community Clinic, Inc., a nonprofit community-based health care agency, are designated MHPSAs.[13] MHPSAs receive certain benefits as a result of this federal designation including National Health Service Corps placements and Medicare bonus payments for psychiatrists.

C. Methods to Estimate Need for Behavioral Health Professionals

To determine the adequacy of the behavioral health workforce or whether shortages exist, planners must estimate how many behavioral health professionals are needed to serve a given population. The calculations vary based on factors such as the prevalence rates for mental illness in the general population or other population characteristics such as age or poverty. This section describes three different methods and applies their respective rates to offer perspectives on the adequacy of the County's mental health workforce.

- The first approach is based on a set of 2009 studies commissioned by HRSA to develop mental health workforce forecast rates based on the mental illness prevalence and service use rates of various subpopulations;

- The second approach is based on the maximum population-to-core-mental-health-professional ratios HRSA has established designate Mental Health Professional Shortage Areas (MHPSAs).

- The third approach was developed by HIS Global Inc. as part of its 2014 study on health workforce demand in Maryland prepared for the Maryland Health Care Commission.

These data, along with the licensing information described earlier, indicate that the behavioral health workforce supply in Montgomery County currently exceeds estimated workforce needs, with the possible exception of psychiatrists, as summarized on Table 37. However, it is important to note that these data do not include information on whether providers accept public or private health insurance or on the language skills of providers. These factors can impact whether the workforce meets the needs of County residents, particularly among low-income individuals and individuals with limited English proficiency. The remainder of this section describes each of the three methods in detail.

[13] "Find Shortage Areas: HPSA by State & County," Health Resources and Services Administration website, U.S. Department of Health and Human Services, < http://hpsafind.hrsa.gov/HPSASearch.aspx > accessed 3/19/2015

Table 37. Comparison Between Estimated Need for Behavioral Health Professionals and Number of Existing Licensed Professionals in Montgomery County

	Psychiatrists	Any Mental Health Professional	"Core" Mental Health Professionals
Estimated Need for Professionals Per 100,000 Population based on:			
1. HRSA Studies	27	62	NA
2. MHPSA Criteria	5	NA	17
3. HIS Global Inc. Study	13	NA	NA
Licensed Professionals Per 100,000 Population in Montgomery County	***33***	***313***	***276***
Estimated FTEs per 100,000 population	***21***	***NA***	***NA***

1. 2009 HRSA Research on Need for Behavioral Health Professionals.

A set of 2009 studies commissioned by HRSA estimated the need for, supply of and corresponding shortages of behavioral health professionals in the United States at the county level as of 2006. To develop their estimate of need for mental health services and corresponding workforce forecast rates, researchers examined mental health disorder prevalence rate data for adults and data from surveys on adult patients' use of outpatient mental health services. Researchers used these data to forecast the number of service hours needed; and then used these service hour estimates to forecast the number of full-time equivalent (FTE) rates of psychiatrists and other mental health professionals needed to deliver mental health services to a given population. They adjusted these workforce rates to reflect mental health care provided by primary care providers, time spent by professionals not in direct contact with patients, and the fact that not all individuals with mental illness access services.

These estimated workforce rates reflect the need for outpatient mental health services only; they do not address inpatient or substance abuse services. They also vary widely by county depending on their population size and prevalence rates. Additionally, since the estimates reflect prevalence data and usage rates for noninstitutionalized adults, estimates for children may be different. Disaggregated data on individual counties are not provided in the published study.

Table 38 displays two sets of estimated rates for the mental health professional workforce based on national data. The first set shows workforce rates based on mental illness prevalence estimates from the 2009 study and the second shows rates given the 2013 prevalence rates as described in Chapter 2. For the 2009 mental illness prevalence estimates, the workforce forecast rate for psychiatrists for the United States as a whole is 25.9 psychiatrists per 100,000 adult population; and the workforce forecast rate for all mental health professionals is 57.3 of per 100,000 adult population.[14]

[14] Konrad, T.R. et al.,"County-Level Estimates of Need for Mental Health Professionals in the United States," *Psychiatric Services* 60, no. 10 (2009).

Table 38. Rates of Mental Health Professional Workforce Forecast Rates for Different Population Groups Every 100,000 U.S. Population*

Population Group	FTEs needed per 100,000 individuals for…		
	Psychiatrists	Other Mental Health Workers**	Total
General population-- researchers' prevalence estimates* **	25.9	32.5	**57.3**
General population – 2013 prevalence rates** **	27.3	34.4	**61.7**

* Calculated based on estimates and assumptions in Konrad et al. (2009) p. 1,311
**Psychologists, social workers, counselors, mental health nurses and other mental health professionals
***Researchers used a 3.7% prevalence rate for serious mental illness.
**** Data from a national survey indicate that 4.2% of the population had serious mental illness in 2014. See Chapter 2.

2. HRSA criteria for Mental Health Professional Shortage Areas

According to Federal regulations, any agency or individual may request the designation of a geographic area, population group or facility as a Mental Health Professional Shortage Area (MHPSA). As noted above, one population group and a related facility in Montgomery County are designated Mental Health Professional Shortage Areas (MHPSAs), but no whole geographic areas are designated as such. Certain Federal programs, including the National Health Service Corps and Medicare Physician Bonus Payments, use MHPSA designations to target resources.

MHPSA criteria recognize two types of geographic areas: standard geographic areas and high-needs geographic areas. For a standard geographic area to qualify as a MHPSA, it must meet criteria established in Federal regulations, which establish maximum population-to-mental health professional ratios. MHPSA designations can be based on the number of psychiatrists or on the total number of "core mental health professionals," which include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. A geographic area may qualify as a shortage area if it meets one of the following three conditions:

- The area has a core-mental-health-professional-to-population ratio less than or equal to 16.7 per 100,000 and a psychiatrist-to-population ratio less than or equal to 5 per 100,000; or
- The area has a core-mental-health-professional-to-population ratio less than or equal to 11 per 100,000; or
- The area has a psychiatrist-to-population ratio less than or equal 3.3 per 100,000

However, if an area has a high rate of poverty, a large number of children or elderly individuals relative to the number of adults aged 18-64, or high rates of substance abuse, it is deemed to have "unusually high needs for mental health services" that merit higher per capita rates of mental health professionals. The criteria HRSA applies to calculate the workforce requirements for a high need area assume:

- The area has a core-mental-health-professional-to-population ratio less than or equal to 22 per 100,000 and a psychiatrist-to-population ratio less than or equal to 6.7 per 100,000 ; or
- The area has a core-mental-health-professional-to-population ratio less than or equal to 16.7 per 100,000; or
- The area has a psychiatrist-to-population ratio less than or equal 5 per 100,000.[15]

[15] Criteria for Designation of Areas Having Shortages of Mental Health Professionals, 42 C.F.R. Appendix C to Part 5.

Significantly, the workforce rates for a severe mental health shortage area implied in MHPSA's criteria are one-fourth the general population rates developed in the set of 2009 studies described earlier (on page 82). Specifically, in 2009 researchers' estimated workforce rate to meet the general population's mental health needs in the United States was 25.9 psychiatrists per 100,000 population. By comparison, the federal regulations for geographic areas with an unusually high need for mental health services use a rate of less than 7 psychiatrists per 100,000 population.

As is the case in Montgomery County, MHPSAs can also be designated for a specific population and/or facility in a geographic area rather than for the geographic area as a whole. A population group may be designated if that group faces access barriers in obtaining services from core mental health professionals in the area and if the ratios of population-to-core-professional and/or population-to-psychiatrist for professionals serving that population meet certain criteria, which are less stringent than those used to designate whole geographic areas. Additionally, a specific facility such as a community mental health center may be designated as a MPHSA if it serves a MHPSA population group or MHPSA geographic area. Finally, separate criteria exist for the designation of correctional facilities and youth detention facilities as MHPSAs.[16]

3. 2014 Maryland Health Workforce Demand Estimates for Psychiatrists

As part of its study for the Maryland Health Care Commission on the health workforce supply in Maryland, IHS Global estimated the demand for health professionals in Maryland at the county level, including demand for psychiatrists. This analysis examined national survey data on use of psychiatrists in order to estimate demand for psychiatrists, adjusted for certain socioeconomic and health risk characteristics of each county's population. For Montgomery County, the study estimated a demand for 13 psychiatrists per 100,000 population.

In contrast to the HRSA study, this analysis did not examine prevalence rates of behavioral health disorders to estimate need, but rather examined national rates of usage of psychiatrists and compared those rates alongside the supply of psychiatrists in each Maryland county. As a caveat to their findings with respect to supply and demand for psychiatrists, the authors note that, "although there appears to be sufficient supply of psychiatrists to provide a level of care equivalent to that provided at the national level, a national level of care might be considered substandard."[17]

[16] Ibid.

[17] *Maryland Health Workforce Study Phase Two Report: Assessment of Health Workforce Distribution and Adequacy of Supply*, prepared by IHS Global Inc. for the Maryland Health Care Commission, January 26, 2014, pp. 12-13 < http://mhcc.dhmh.maryland.gov/workforce/Documents/MD_Health_Workforce_Study_Phase_2_Report.pdf > accessed 4/9/2015

Chapter IX. The Behavioral Health Treatment Facilities Infrastructure for Montgomery County

Individuals can receive a variety of different types of outpatient, residential and inpatient care in behavioral health treatment facilities, as summarized in Table 39 below. Additionally, some facilities provide specific services for individuals in crisis. This chapter describes the many types of facilities and diverse settings where behavioral treatments are provided in Montgomery County. Each entry provides a description of the facility or service and information about the availability of the service within the County. The key sources for this chapter include the National Mental Health Services Survey (N-MHSS), the National Survey of Substance Abuse Treatment Services (N-SSATS), the SAMHSA Behavioral Health Treatment Facility Locator, and data from the Maryland Health Care Commission. This chapter has five parts:

- **Section A** provides information about outpatient facilities;
- **Section B** describes residential facilities;
- **Section C** describes inpatient hospital facilities;
- **Section D** describes crisis facilities;
- **Section E** describes behavioral health services provided by other health-related institutions; and
- **Section F** provides a brief summary of the information in the chapter.

Table 39. Behavioral Health Treatment Facility Service Categories

Setting	Types of Services
Outpatient	• Regular outpatient treatment • Intensive outpatient treatment • Partial hospitalization • Outpatient detoxification • Medication-assisted outpatient addictions treatment
Residential	• Residential treatment centers for children and adolescents with severe emotional disturbances • Residential rehabilitation programs for individuals with severe and persistent mental illness • Residential substance use treatment • Residential detoxification
Inpatient	• Inpatient psychiatric care in acute care general hospitals • Inpatient care in psychiatric hospitals • Inpatient substance use disorder treatment • Inpatient detoxification
Crisis	• Crisis hotlines • Crisis walk-in centers • Mobile crisis teams • Residential crisis care • Crisis teams within behavioral health facilities
Other health institutions	• Emergency departments of acute care general hospitals • Montgomery Cares

Data Sources on Behavioral Health Treatment Facilities in Montgomery County

OLO combined information from several data sources for this chapter because no one source provides comprehensive data on behavioral health treatment facilities in Montgomery County.

Two national surveys collect information on different types of behavioral treatment facilities, including outpatient, residential and inpatient settings as well as crisis services. The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census of facilities providing substance abuse treatment conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The 2013 N-SSATS had a 94% response rate. The National Mental Health Services Survey (N-MHSS) is a survey of mental health facilities and services conducted in 2010 by Mathematica Policy Research on behalf of SAMHSA that compiled information about specialty mental health treatment facilities and the clients they serve. The survey had a 91% response rate. A 2014 update of the 2010 N-MHSS is currently underway. State and national-level data from both surveys are publicly available.

SAMHSA's Behavioral Health Treatment Facility Locator, available online, is populated with data from the N-SSATS and the N-MHSS, as well as information from new facilities that have filled out an abbreviated survey and updated information for facilities that provide SAMHSA with changes. Data are added to the Locator on a monthly basis. To be listed in the Locator, a facility must be licensed or accredited to provide mental health and/or substance abuse treatment by a state agency or national treatment accreditation organization (most but not all of N-SSATS and M-MHSS respondents are licensed or accredited). Individual facility data are available online and include information from survey responses on the specific services and populations served at each facility. However, certain facilities are not included, such as facilities that are not licensed or accredited and facilities that did not respond to the N-SSATS or the N-MHSS or submit an abbreviated survey to SAMHSA. OLO examined data from the Locator alongside other sources of data and found that the data in the Locator do not include some key behavioral health treatment facilities in Montgomery County, such as services provided by DHHS. Nonetheless, this source provides the most specific and consistent data compared with other sources for many treatment facility categories.

OLO also used data from the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC), which track and regulate statewide licensed bed capacity in acute care hospitals, including psychiatric bed capacity. The MHCC's Annual Report on Selected Maryland Acute Care and Special Hospital Services provides detailed information on inpatient psychiatric beds in Maryland acute care general hospitals and special psychiatric hospitals as well as capacity data for certain outpatient mental health programs provided by hospitals. However, specific information on inpatient substance abuse beds is not available, and the report does not provide information on non-hospital facilities.

A. Outpatient Settings and Services

Outpatient psychiatric services provide treatment to individuals living in the community who do not require residential or inpatient care. Because psychiatric treatments are highly customized, outpatient services vary widely in their service intensity, settings and service types. For example, some individuals access outpatient services at an outpatient walk-in clinic to resolve an evolving or troubling concern. Others use partial hospitalization services after they have been discharged from hospitalized inpatient services.

1. Definitions

The hierarchy of outpatient services typically encompasses general outpatient programs, intensive outpatient programs and partial hospitalization programs as well as specific types of services for substance abuse. The

following definitions from SAMHSA and the Commission on Accreditation of Rehabilitation Facilities (CARF International) describe these categories.[1]

- **General outpatient treatment programs** provide a variety of services that may include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. Outpatient programs may address a variety of needs including situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.
- **Intensive outpatient treatment programs** consists of a scheduled series of sessions that may include services provided during evenings and on weekends and/or interventions delivered by a variety of service providers in the community. The program may function as a step-down program from partial hospitalization, detoxification, or residential services; may be used to prevent or minimize the need for a more intensive level of treatment; and is considered to be more intensive than traditional outpatient services.
- **Partial hospitalization programs** are time-limited, medically supervised programs that offer therapeutically intensive and structured clinical services. Partial hospitalization programs are available at least five days per week but may also offer half-day, weekend, or evening hours. They are typically for individuals who experience increased symptomatology but do not pose an immediate risk to themselves or others. Services provide diagnostic evaluation, active treatment or to prevent relapse, hospitalization or incarceration.[2]
- **Medication-Assisted Treatment** (Opioid Treatment Programs) is treatment for addiction, typically for opioid addiction, provided on an outpatient basis that includes the use of medications to block the effects of opioids (such as heroin and hydrocodone) along with counseling and other support. Common medications include methadone, buprenorphine, and naltrexone.
- **Outpatient detoxification** provides interventions, including medically-monitored medications, aimed at managing acute intoxication and withdrawal through the clearing of toxins from the body of the patient while minimizing physical harm. Outpatient detoxification treatment typically requires individuals to travel to a treatment facility daily on a regular basis for detoxification treatment sessions. Detoxification by itself does not constitute a complete substance abuse treatment, but rather is typically an essential first step in treatment.

[1] *Treatment Improvement Protocol 45: Detoxification and Substance Abuse Treatment*, Substance Abuse and Mental Health Services Administration, 2013, pp. 4 < " http://store.samhsa.gov/shin/content//SMA13-4131/SMA13-4131.pdf > accessed May 26, 2015; *2015 Behavioral Health Program Descriptions*, Commission on Accreditation of Rehabilitation Facilities (CARF International), 2015 < http://www.carf.org/programdescriptions/bh/ > accessed May 26, 2015; and "Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends," Substance Abuse and Mental Health Services Administration (SAMHSA), 2011, < https://store.samhsa.gov/shin/content/SMA09-4443/SMA09-4443.pdf > accessed May 26, 2015.

[2] No consistent set of standards exists for outpatient service intensity levels. Instead, the length of service and other features for a particular definition depend on standards established by a specific credentialing or utilization review entity. For example, under Maryland's Medicaid program partial hospitalization services refer to intensive, nonresidential psychiatric treatment for any part of a 24 hour day for a minimum of four consecutive hours per day in a community setting (see COMAR 10.21.02.01). By comparison, the MHCC's Annual Hospital Services Report states that Partial Hospitalization and Intensive Outpatient Programs "may be a structured, ongoing program that the patient typically attends two to five times a week for two to five hours per day providing clinical behavioral health services."

2. Outpatient Mental Health Services

As noted on page 86, the SAMHSA Behavioral Health Treatment Facility Locator provides detailed data on a variety of behavioral health facilities in Montgomery County, including outpatient facilities. The SAMHSA Locator lists 19 licensed or accredited facilities in Montgomery County that provide outpatient mental health services (some of these facilities are also listed separately as providing outpatient substance abuse services and are also included in Table 42 on page 91). Although OLO found that the list produced by the SAMHSA Locator is not an exhaustive list and that certain facilities known to OLO are not included (such as DHHS facilities), the data offer useful information on the nature of the services provided by many outpatient facilities in the county. Table 40 summarizes data from the facilities' survey responses, including age groups and special populations served and available payment options. Data are not available on the treatment-intensity levels offered (whether a facility offers regular outpatient treatment, intensive outpatient treatment, and/or partial hospitalization).[3] The data show that:

- Almost all facilities offering outpatient mental health services reported serving adults and young adults, while a little over half reported serving children;
- More than half of facilities reported offering Spanish language services;
- The majority of facilities offer special services for adults with serious mental illness and individuals with co-occurring mental and substance abuse disorders, while few offer services for seniors and older adults or for children with serious emotional disturbance;
- All facilities reported accepting Medicaid for payment, and a majority reported accepting Medicare or private insurance; and
- Fewer than a quarter of facilities reported offering payment assistance or a sliding fee scale for individuals paying out of pocket for the cost of care.

[3] It is important to note that the Locator does not distinguish between the outpatient, residential or inpatient services provided by the same facility when listing facility characteristics. The Locator lists characteristics of facilities that reported providing mental health services, but those characteristics may not necessarily pertain specifically to the outpatient services provided by that facility. Three of the 19 facilities also reported providing inpatient services, and four reported providing residential services.

Table 40. Licensed or Accredited Outpatient Mental Health Facilities in Montgomery County, 2015

Self-Reported Available Services	# of Facilities
Age Groups Served	
Children/adolescents	11
Young adults	16
Adults	17
Language Services Available	
Spanish	12
Other languages	6
Services for the hearing-impaired	5
Special Programs or Groups	
Adults with serious mental illness (SMI)	11
Co-occurring mental and substance abuse disorders	10
Clients referred from the court/judicial system	5
Children with serious emotional disturbance (SED)	4
Seniors or older adults	2
Payment Options/Insurance Accepted	
Medicaid	19
Medicare	13
Private health insurance	12
Payment assistance or sliding fee scale	4
Total # of Listed Facilities in Montgomery County	**19**

Source: SAMHSA Behavioral Health Treatment Services Locator, accessed May 2015

The SAMHSA Locator does not provide information on facility capacity. Data from the Maryland Health Care Commission (MHCC) provides information on program capacity of outpatient mental health services provided by hospitals, specifically partial hospitalization, also known as day treatment, and intensive outpatient programs. Table 41 displays information about programs and available treatment slots in Montgomery County from MHCC's Annual Hospital Report. Of note:

- Statewide, 23 acute care general hospitals and five freestanding private psychiatric hospitals offer day treatment programs.
- In June 2013, there were 535 slots for day treatment programs in the 23 acute care hospitals and 250 slots in the five private psychiatric special hospitals for a combined capacity of 785 statewide slots.
- Three Montgomery County acute care hospitals and one Montgomery County private psychiatric hospital accounted for 18% of the statewide total with a total of 138 slots.

Table 41. Partial Hospitalization/Intensive Outpatient Programs in Montgomery County Hospitals

Facility	Maximum number of slots available	Average # of Patients	Occupancy*
Acute Care General Hospitals			
MedStar Montgomery Medical Center	25	23	92%
Suburban Hospital	28	20	71%
Washington Adventist	45	19	42%
Private Psychiatric Hospitals			
Adventist Behavioral Health - Rockville	40	28	70%
Montgomery County Subtotal	**138**		
Statewide Total	**785**		

Source: MHCC, Annual Hospital Report 2014. Effective July 1, 2013, p. 3

* Based on four day average for acute care general hospitals and on average daily census for psychiatric special hospitals

3. Outpatient Substance Abuse Services

24 facilities are listed in the SAMHSA Locator as providing outpatient substance abuse services (some of these facilities also listed separately as providing outpatient mental health services and are also included in Table 40 on page 89). As with outpatient mental health services, the SAMHSA Locator does not provide an exhaustive list of all facilities in the county, and certain facilities including DHHS programs are not included. Table X summarizes survey response data from the Locator. Of note:

- Almost all listed facilities in the County reported providing general outpatient treatment, while only one facility reported providing outpatient detoxification;
- All facilities reported serving adults and young adults, while just under a third of facilities reported serving children or adolescents;
- Less than half of facilities reported providing non-English language services;
- More than half of facilities reported offering special services for individuals with co-occurring mental and substance use disorders, while less than a third reported providing special services for seniors;
- Three quarters of facilities reported accepting Medicaid, while Medicare and private insurance were less commonly accepted; and
- Just under half of facilities reported providing payment assistance or a sliding fee scale for individuals paying out of pocket for services.

Table 42. Licensed or Accredited Outpatient Substance Abuse Facilities in Montgomery County, 2015

Self-Reported Services Available	# of Facilities
Service Category	
General Outpatient Treatment	23
Intensive Outpatient Treatment	10
Outpatient Day Treatment or Partial Hospitalization	3
Outpatient Detoxification	1
Outpatient Medication-Assisted Treatment for Opioid Addiction	5
Age Groups Served	
Children/adolescents	7
Young adults	24
Adults	24
Language Services Available	
Spanish	9
Other languages	3
Services for the hearing-impaired	5
Special Programs or Groups	
Persons with co-occurring mental and substance abuse disorders	15
Clients referred from the court/judicial system	10
Seniors or older adults	7
Adolescents	6
Payment Options/Insurance Accepted	
Medicaid (Payment/Insurance Accepted)	18
Medicare (Payment/Insurance Accepted)	9
Private health insurance (Payment/Insurance Accepted)	13
Payment Assistance or Sliding Fee Scale	11
Total # of Listed Facilities in Montgomery County	**24**

Source: SAMHSA Behavioral Health Treatment Services Locator, accessed May 2015

4. DHHS' Outpatient Programs and Referrals to Public Behavioral Health Services

DHHS manages two outpatient mental health programs that serve individuals with serious mental illness who are not eligible for services through the Public Behavioral Health System (PBHS). As the County's Core Service Agency, DHHS also makes referrals for individuals who are eligible for specialty mental health services (including outpatient services) through the Public Behavioral Health System.

- **The Adult Behavioral Health Program (ABHP)** provides intensive outpatient services to adult residents of Montgomery County, who have co-occurring substance and mental health disorders. Priority is given to serving Montgomery County residents who have been discharged from a psychiatric hospitalization, released from incarceration, or who are homeless. Immigration status is not a barrier to receiving services. Medicaid and Medicare clients are accepted as well as those who are uninsured; private insurance is not accepted. A sliding scale fee is assessed for those clients who are not insured. Services include site-based services beginning with an assessment and diagnostic evaluation, then offering group and individual treatment as well as (as needed) psycho-tropic medication evaluation and medication monitoring, family support and office-based case management

decisions. Eligibility is limited to Montgomery County residents, but being undocumented is not a barrier to receiving services. This program has the capacity to provide services in Spanish, Vietnamese, and English. Other Limited English Proficiency clients are welcome as well as those with specialized cultural and language needs. Peer support is available upon request. In FY 2014, this program served 350 clients with severe and persistent mental illness.

- The **Children's Outpatient Behavioral Health Services Program** aims to provide child-focus, family driven and culturally competent mental health and care coordination services. One part of the program provides psychiatric assessments and therapeutic treatments for children and adolescents with serious emotional impairments; another part works to plan mental health and care coordination services; and a third part provides screening, treatment, case management and other community services for children involved with juvenile justice services. At one time, the waitlist for the children's program had grown due to a lack of Spanish speaking therapists; however, DHHS' 2014 annual report states that this problem has been resolved, and data show the waitlist has been reduced.

Table 43 displays 4.5 years of select program activity data for DHHS' outpatient programs and referral services. The data shows that the children's program does not currently have a waitlist issue. It also shows a sharp increase in referrals to the Public Behavioral Health System, which is the statewide fee-for-service system that provides behavioral health services to Medicaid enrollees and certain uninsured individuals with behavioral health diagnoses.

Table 43. County and PBHS Outpatient Behavioral Health Services, FY11 to FY15 Year to Date

Indicator	FY11	FY12	FY13	FY14	FY15 YTD
Annual adult referrals for outpatient services	NA	NA	105	40	31
Monthly average of children waitlisted	39	56	60	39	1
Annual referrals to the PBHS	1,326	1,311	2,355	2,127	929

Source: DHHS Monthly Activity Reports, FY11 to FY15

B. Residential Facilities

Residential facilities are live-in facilities for patients or clients who are not able to live independently because of their condition. They receive treatment appropriate to their particular needs in a less restrictive environment than an inpatient facility. The characteristics of these facilities vary depending on the population served and the intensity of the treatment required. The State of Maryland establishes licensing requirements for certain residential facilities. This section combines facility information from the SAMHSA Locator with bed capacity data for licensed facilities from the County and the State.

The categories of residential facilities for individuals with mental health disorders are described below:

- **Residential treatment centers (RTCs)** provide treatment services under the direction of a qualified psychiatrist and overnight accommodations for emotionally disturbed children or adolescents.[4]
- **Residential rehabilitation programs (RRPs)** provide services in a home-like environment that support the recovery of individuals with mental health disorders, including services to enable the

[4] COMAR 10.07.04

individual to develop daily living skills needed for independent functioning and services to promote the individual's ability to engage and participate in appropriate community activities.[5]

The categories of residential facilities for individuals with substance use disorders are listed below:

- **Residential treatment programs** include low-, medium- and high-intensity residential substance abuse treatment programs that provide clinically-managed assessment, counseling, drug and alcohol education, vocational assistance services and medication monitoring as well as referrals to additional services.[6]
- **Residential detoxification programs** provide clinically-managed residential detoxification services to patients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support.

This section combines facility information from the SAMHSA Locator with bed capacity data from the County and the State where available.

1. Residential mental health treatment facilities

The SAMHSA Locator lists 11 facilities that reported providing residential mental health treatment services. Table 44 provides data on the services that the listed facilities reported providing. It is important to note that five of the facilities listed also reported providing outpatient services, and that the Locator does not distinguish between the specific characteristics (such as age groups served) of outpatient, residential or inpatient services provided by the same facility. Table 44 lists characteristics of facilities that reported providing residential services, but those characteristics may not necessarily pertain specifically to the residential services provided by the facility.

[5] COMAR 10.21.22
[6] COMAR 10.47.02.08

Table 44. Licensed or Accredited Residential Mental Health Facilities in Montgomery County, 2015

Self-Reported Services Offered	# of Facilities
Age Groups Served	
Children/adolescents	4
Young Adults	7
Adults	8
Language Services Available	
Spanish	6
Other Languages	1
Services for the hearing-impaired	3
Special Programs or Groups	
Persons with co-occurring mental and substance abuse disorders	4
Children with serious emotional disturbance (SED)	4
Adults with serious mental illness (SMI)	4
Clients referred from the court/judicial system	2
Seniors or older adults	2
Payment Options/Insurance Accepted	
Medicaid	10
Medicare	6
Private health insurance	8
Payment assistance or sliding fee scale	1
Total # of Listed Facilities in Montgomery County	**11**

Source: SAMHSA Behavioral Health Treatment Services Locator, accessed May 2015

Bed Capacity of Residential Treatment Centers – Children and Youth. Under Maryland law, a residential treatment center (RTC) provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness. The children require a self-contained therapeutic, educational, and recreational program in a residential program in a residential setting. The length of stay at an RTC is generally 30 days or more.

According to the Maryland Coalition for Children with Mental Health Needs, admission to a residential treatment center depends on a child meeting medical necessity criteria. Alternatively, a child may be referred through the Department of Juvenile Justice or the Department of Social Services. The Maryland Coalition reports as many as 50% of RTC admissions are DJJ referrals.[7]

Table X shows information about the 11 facilities licensed by DHMH's Office of Healthcare Quality. Together these facilities have a licensed capacity of 697 beds. Two facilities in Montgomery County, Adventist Healthcare Behavioral Health and Wellness (88 beds) and the John L. Gildner Regional Institute for Children (80 beds), account for 24 % of the statewide bed capacity.

[7] http://www.mdcoalition.org/resources/childrens-mental-health/155-residential-treatment-centers

Table 45. Statewide Inventory and Bed Capacity of Licensed Residential Treatment Centers

Jurisdiction	Facility Name	Bed Capacity	Population Served	Statewide Share of Beds
Montgomery County	**Adventist Healthcare Behavioral Health and Wellness**	**88**	**Co-ed, ages 11-18***	**24%**
	John L. Gildner Regional Institute for Children	**80**	Co-ed; ages 13-18	
Anne Arundel	Adventist Behavioral Health at Anne Arundel	30	Co-ed, ages 13-17	4%
Baltimore City	Woodbourne Center	48	Boys, ages 12-18*	7%
Baltimore County	Regional Institute for Children and Adolescents (RICA)	45	Co-ed, ages 12-18	50%
	Berkeley & Eleanor Mann Residential Treatment Center	68	Co-ed, ages 12-18	
	Chesapeake Treatment Center – New Directions	29	Males, ages 16-20**	
	Good Shepherd Services	105	Co-ed, ages 13-21***	
	Saint Vincent's Villa	95	Co-ed, ages 5-13	
Dorchester County	AHC Behavioral Health and Wellness Services -- Eastern Shore	59	Males, ages 12-17 and trans. youth 17-20****	8%
Frederick County	The Jefferson School	50	Co-ed, ages 12-17*	7%
Statewide Totals		**697**		**100%**

*Special populations served: sexually aggressive youth. IQ criteria: 65 or 70 and up; **Special population served: sexually aggressive youth with approval of DJS gatekeeper; ***Special population served: dual diagnosis, substance abusers, children with developmental disabilities; ****Substance abuse programs for children who have dual diagnosis.
Source: http://www.mdcoalition.org/resources/childrens-mental-health/155-residential-treatment-centers and Office of Healthcare Quality database.

Bed Capacity of Residential Rehabilitation Programs (RRP). State-licensed residential rehabilitation programs serve individuals who have severe and persistent mental illness with rehabilitation services in a residence that is owned by or leased to an approved provider. RRPs provide extensive support in a structured living environment. A "general" level of care RRP must provide a minimum of 13 face-to-face services in the residence monthly, while an "intensive" level of care RRP must provide a minimum of 19 face-to-face services in the residence monthly and onsite staff 7 days per week.[8]

As the County's Core Service Agency, DHHS contracts with providers to place individuals in residential rehabilitation programs. In FY14, DHHS managed an inventory of 382 residential rehabilitation beds, of which 215 provided a "general" level of care and 167 provided an "intensive" level of care.[9] Table 46 displays placements and average waiting list size for DHHS' residential rehabilitation program. Program

[8] *Report of the Outpatient Services Programs Stakeholder Workgroup,* Maryland Department of Health and Mental Hygiene, December 2014.
[9] The Value Options Provider Manual differentiates residential rehabilitation programs from other housing programs by stating that RRP are not for participants who are able to live in housing of their choice with flexible supports. Section 6.13 Mental Health Residential Rehabilitation Services.

placements have remained steady except for a dip in FY12. The average monthly waitlist has declined since FY12; however, the size still reflects an overall lack of program capacity.

Table 46. DHHS' Residential Rehabilitation Program (RRP) Activity Data, FY11 to FY15 Year to Date

Indicator	FY11	FY12	FY13	FY14	FY15 YTD
Annual number of individuals placed in a RRP	74	53	82	88	39
Average number of individuals per month waitlisted for an RRP placement	147	172	113	70	80

Source: DHHS Monthly Activity Reports, FY11 to FY15

2. Residential programs for substance abuse

The SAMHSA Locator lists four facilities that reported providing residential mental health treatment services: Avery House, Avery Road Combined Care, Avery Road Treatment Center, and Lawrence Court Halfway House. Avery Road Combined Care also provides outpatient services. Table 47 provides data on characteristics of these facilities based on the facilities' survey responses. Of note:

- Three of the four facilities reported providing long-term residential services (more than 30 days), while one facility (the Avery Road Treatment Center) reported providing short-term residential services (30 days or fewer) and detoxification services.
- All four facilities serve adults and young adults, and no facilities serve children or adolescents.
- Only one facility provides Spanish-language services and services for the hearing-impaired, and no facilities reported providing other language services.
- None of the listed facilities reported accepting Medicare and only one reported accepting private insurance, while two reported accepting Medicaid.
- No facilities reported offering payment assistance or a sliding fee scale.

Table 47. Licensed or Accredited Residential Substance Abuse Facilities in Montgomery County, 2015

Self-Reported Services Offered	# of Facilities
Service Category	
Short-term residential*	1
Long-term residential*	3
Residential Detoxification	1
Age Groups Served	
Children/adolescents	0
Young adults	4
Adults	4
Language Services Available	
Spanish	1
Other languages	0
Services for the hearing-impaired	1
Special Programs or Groups	
Persons with co-occurring mental and substance abuse disorders	3
Adolescents	0
Clients referred from the court/judicial system	0
Seniors or older adults	0
Payment Options/Insurance Accepted	
Medicaid	2
Medicare	0
Private health insurance	1
Payment assistance or Sliding Fee Scale	0
Total # of Listed Facilities in Montgomery County	**4**

Source: SAMHSA Behavioral Health Treatment Services Locator, accessed May 2015
* Short-term residential stands for 30 days or fewer of treatment, while long-term residential stands for more than 30 days of treatment.

C. Inpatient Hospital Services and Settings

The Commission on Accreditation of Rehabilitation Facilities (CARF) establishes the following standards for inpatient programs:

> Inpatient treatment programs provide coordinated and integrated services in freestanding or hospital settings. Inpatient treatment programs include a comprehensive, biopsychosocial approach to service delivery. There are daily therapeutic activities in which the persons served participate. Inpatient treatment is provided 24 hours a day, 7 days a week. The goal of inpatient treatment is to provide a protective environment that includes medical stabilization, support, treatment for psychiatric and/or addictive disorders, and supervision. Such programs operate in designated space that allows for an appropriate medical treatment environment.[10]

[10] http://www.carf.org/programdescriptions/bh/

Inpatient hospital psychiatric services are provided in two types of facilities, as defined in the N-MHSS:

- **An inpatient psychiatric unit of an acute care general hospital** is defined as a licensed general hospital (public or private) that provides inpatient mental health services in at least one separate psychiatric living unit. This unit must have specifically allocated staff and space (beds) for the treatment of persons with mental illness. The unit may be located in the hospital itself or in a separate building, either adjacent or more remote, that is owned by the hospital.
- **A private or state-operated psychiatric hospital** is a facility licensed and operated as a **private** psychiatric hospital licensed by the state or as a **state/public** psychiatric hospital that primarily provides 24-hour inpatient care to persons with mental illness.

Inpatient hospital services for substance use disorder treatment can be provided within acute care general hospitals or freestanding detoxification centers. The N-SSATS distinguishes between the following two types of inpatient services:

- **Inpatient substance abuse treatment** provides 24-hour nursing care with physician availability or daily physician care and counseling services in an inpatient setting.
- **Inpatient detoxification** offers 24-hour medically-supervised detoxification services, which are interventions aimed at managing acute intoxication and withdrawal, in an inpatient setting. Detoxification denotes a clearing of toxins from the body of the patient while minimizing physical harm, and is not by itself a complete substance abuse treatment but rather an essential first step.

Maryland's inventory of inpatient psychiatric beds consists of 714 designated beds in acute care general hospitals, 497 staffed beds in freestanding psychiatric hospitals and 990 staffed beds in state hospitals. Additionally, four hospitals in the County are listed in the SAMHSA Behavioral Health Treatment Services Locator as providing inpatient services for substance use disorders, but specific information on the number of beds available for these services is unavailable. The rest of this section looks at each of these elements.

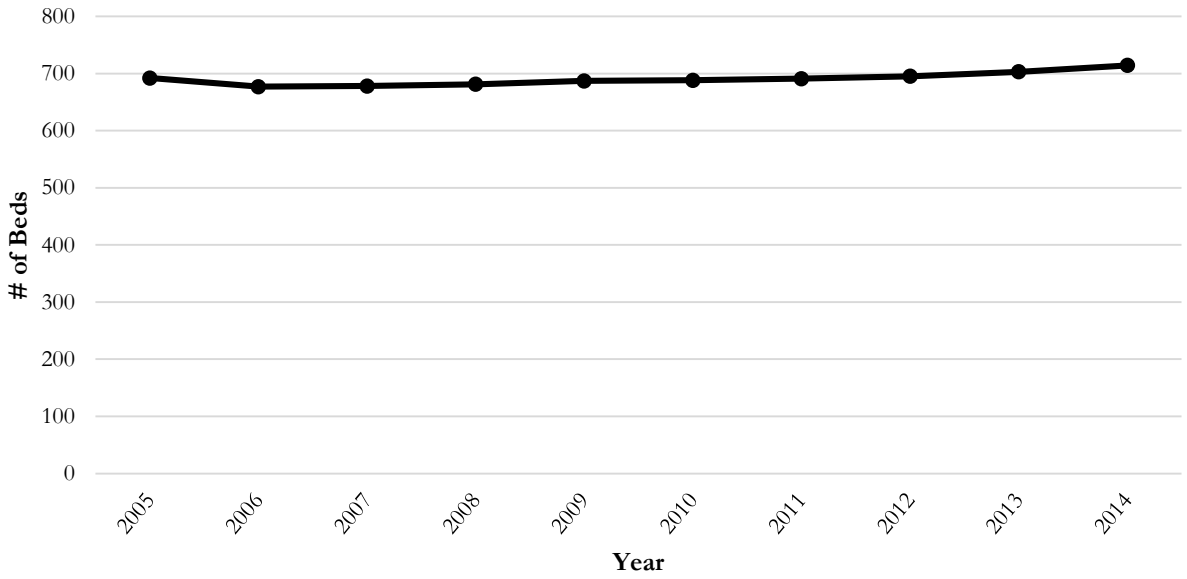
1. Licensed Psychiatric Beds in Acute Care General Hospitals[11]

The Maryland Health Care Commission and the Health Services Cost Review Commission track and regulate acute psychiatric bed capacity as part of licensed bed capacity for acute care hospitals generally. The State's licensing approach uses a baseline 12 month average daily census of acute care patients for each hospital established each year as of March 31. This number is multiplied by 140% to establish the total acute care bed capacity for the coming fiscal year. This calculation assumes that an average annual bed occupancy rate of 71.4% is an appropriate operational benchmark for an acute care hospital. Acute care psychiatric beds are licensed as part of this process.

Ten-Year Statewide Trend. Chart 2 displays data on the trend in the number of licensed psychiatric beds in acute care general hospitals in Maryland between FY2005 to FY2014. While the total number of statewide licensed hospital beds decreased slightly by about 1% during the ten-year period, the number of licensed psychiatric beds increased slightly from 692 beds to 714 (an increase of 22 beds or 3%).

[11] Data in this section are up to date as of FY14, and therefore do not include beds at Holy Cross Germantown Hospital, which opened in October of 2014.

Chart 2. Licensed Psychiatric Beds in Acute Care General Hospitals in Maryland, FY2005-FY2014



Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

County Supply of Psychiatric Beds in Acute Care General Hospitals. County hospitals account for 12% (89 of 714) of acute psychiatric beds in Maryland. County beds are distributed across the three County hospitals that have inpatient psychiatric units: MedStar Montgomery Medical Center (25 beds); Suburban (24 beds) and Washington Adventist (40 beds).

Table 48 displays details about the County's inpatient psychiatric bed inventory by ages and patient types served. All three County hospitals provide acute adult psychiatric beds. Suburban is the only County hospital that also has acute adolescent and acute geriatric beds. None of the hospitals have acute child beds: however, as noted below, these beds are available in a freestanding psychiatric hospital. Washington Adventist is the only acute care general County hospital that accepts involuntary patients.

Table 48. Ages and Patients Served by the County's General Acute Care Hospital Psychiatric Units

Hospital	# of Beds	Adult	Child	Adolescent	Geriatric	Accepts Involuntary Patients
MedStar Montgomery Medical Center	25	✓				No
Suburban Hospital	24	✓		✓	✓	No
Washington Adventist Hospital	40	✓				Yes
Statewide total # of hospitals with this service	**-**	**28**	**2**	**3**	**10**	**23**

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

Occupancy Rates for Inpatient Psychiatric Beds in Acute Care Hospitals. MHCC's annual report provides occupancy rate data for inpatient psychiatric beds in acute care general hospitals. The staffed bed occupancy is calculated by dividing the number of patient days by 365 and dividing this result by the number

of staffed beds. Table 49 summarizes this data for the three County psychiatric hospital inpatient units and for the other four regions in the state. The table shows that in 2012:

- The statewide use of inpatient psychiatric beds in general acute care hospitals totaled 200,766 patient days; County hospitals accounted for just over 10% of this total (21,802 patient days);
- At 68%, the staffed bed occupancy rate for the County's three hospitals was just below the state planning benchmark for all general acute care bed types (71.4%);
- Occupancy rates for other regions ranged from 58% for Southern Maryland to 84% for Western Maryland and the Eastern Shore and 85% for Central Maryland.
- Among the County hospitals, occupancy rates ranged from 58% for MedStar Montgomery Medical Center to 77% for Suburban Hospital.

Table 49. Statewide Licensed Bed Capacity in Psychiatric Units of General Acute Care Hospitals

Hospital/Region	Licensed Beds Designated Psychiatric	Physical Bed Capacity	Staffed Beds	Patient Days	Total
Montgomery County					
MedStar Mont Medical Center	25	33	25	5,282	58%
Suburban Hospital	24	24	24	6713	77%
Washington Adventist	40	40	39	9,807	69%
Montgomery County Subtotals	**89**	**97**	**88**	**21,802**	**68%**
Western Maryland	58	58	56	17,069	84%
Southern Maryland	90	109	98	20,925	58%
Central Maryland	444	441	422	131,141	85%
Eastern Shore	33	43	32	9,829	84%
Statewide Totals	**714**	**748**	**696**	**200,766**	**79%**

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

2. Freestanding Psychiatric Hospitals

Maryland's inventory of freestanding psychiatric hospitals consists of five private hospitals and five state hospitals. These facilities are categorized and licensed separately from general acute care hospitals as special hospitals.[12] This section provides data on the location, capacity and occupancy rates for these facilities.

Private Freestanding Psychiatric Hospitals. Maryland's five private freestanding psychiatric hospitals have a licensed capacity of 601 beds and a staffed capacity of 497 beds. Table 50 displays details about the statewide distribution of these beds and their service characteristics. The data shows that the County's one freestanding psychiatric hospital, Adventist Behavioral Health, accounts for 18% of the state's licensed

[12] Special hospitals have an organized medical staff of physicians with inpatient beds and medical services for patients with specific medical conditions. They may be located on the campus of an acute general hospital or operate as units within an acute general hospital; however, they are separately licensed. The four types of special hospitals include: psychiatric hospitals (discussed above); Medical Rehabilitation Services; Pediatric and Chronic Care hospitals.

capacity and 21% of the state's staffed bed capacity. Adventist accepts involuntary patients and it provides acute child inpatient psychiatric beds, a bed type that was not available at any of the three general acute care inpatient psychiatric units.

Table 50. Statewide Private Psychiatric Hospital Licensed Bed Types and Capacity, June 2013

Region	# hospitals	Licensed Capacity	Staffed Beds	Acute Adult	Acute Child	Acute Adolescent	Acute Geriatric	Invol. Patients?
Montgomery	**1**	**107**	**106**	✓	✓	✓		✓
Western Maryland	1	65	43	✓	✓	✓		✓
Central Maryland	2	414	333	✓	✓	✓	✓	✓
Eastern Maryland	1	15	15		✓	✓		
Statewide Totals	**5**	**601**	**497**					

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

Table 51 shows occupancy rate data for the five freestanding psychiatric hospitals. Both Adventist Behavioral Health and Sheppard Pratt report combined data. The available data shows that the statewide service volume for freestanding hospitals was about 80% of that of the general acute care hospitals. (160,492 versus 200,766 patient days). Freestanding hospitals operate at higher occupancy levels than Montgomery County's general acute care hospitals, with rates ranging from 87% for Sheppard Pratt hospitals in Baltimore and Howard counties to 99% for Brook Lane Health Service in the Western Maryland region.

Table 51. Statewide Private Psychiatric Special Hospital Occupancy Rates, CY2012

Region	Hospital	Licensed Beds	Physical Bed Capacity	Staffed Beds	Patient Days CY2012	Staffed Bed Occupancy CY2012
Montgomery	**Adventist Behavioral Health –Rockville**	**107**	**107**	**106**	39,434	89%
Eastern Shore	Adventist Behavioral Health – Eastern Shore	15	15	15		
Western Maryland	Brook Lane Health Service	65	43	43	15,538	99%
Baltimore County	Sheppard Pratt Hospital	322	322	255	105,520	87%
Howard County	Sheppard Pratt at Ellicott	92	92	78		
Statewide totals		**601**	**579**	**497**	**160,492**	

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

State Operated Psychiatric Special Hospitals. Historically, inpatient psychiatric services were largely a state responsibility and state hospitals were the primary source of either acute or long term continuing care beds. With the closing of state hospitals due to de-institutionalization and/or economic reasons, this supply of state beds was drastically reduced.[13] Maryland has five state-operated psychiatric hospitals which provide both acute and continuing care psychiatric beds. None are located in Montgomery County. Table 52

[13]"In 1970, only 5 percent of psychiatric unit beds were located in general hospital psychiatric units; by 2002, 30% of beds were located in general hospital psychiatric units, according to data collected by the Substance Abuse and Mental Health Services Administration (SAMHSA). Today, largely as a result of deinstitutionalization and the closure of public psychiatric hospitals, community hospitals are the primary source of inpatient psychiatric treatment in the United States on the basis of number of admissions." Cited in Mark T, Stranges E, Levit K. *Using Healthcare Cost and Utilization Project State Inpatient Database and Medicare Cost Reports Data to Determine the Number of Psychiatric Discharges from Psychiatric Units of Community Hospitals*. Online September 7, 2010, U.S. Agency for Healthcare Research and Quality (AHRQ). Available: http://www.hcup-us.ahrq.gov/reports.jsp

displays data from the Annual Hospital Report about these facilities and their use. In FY2013, the statewide occupancy rate was 95%.

Table 52. Psychiatric Beds at State Psychiatric Hospitals: Maryland 2014

Region	Hospital	Licensed Beds	Budgeted Beds	Capacity		Staffed		Patient Days FY2013	Staffed Bed Occupancy FY2013
				Acute Care	Cont. Care	Acute Care	Cont. Care		
Allegany County	Thomas B. Finan Center	88	66	66	22	44	22	24,255	101%
Baltimore County	Spring Grove Hosp. Center	639	366	148	335	109	266	129,099	94%
Carroll County	Springfield Hosp. Center	522	235	98	151	98	151	82,269	91%
Howard County	Clifton T. Perkins Hosp. Center	298	238	19	251	19	221	88,692	101%
Dorchester County	Eastern Shore Hosp. Center	60	60	64	0	60	0	20,093	92%
Statewide totals		**1,607**	**965**	**395**	**759**	**330**	**660**	**344,606**	**95%**

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

3. Inpatient Substance Abuse Treatment and Detoxification Facilities

In contrast to psychiatric beds, the MHCC does not regulate the supply of substance abuse treatment hospital beds separately from other hospital beds and does not publish specific data on this category of beds.[14] The SAMHSA Behavioral Health Treatment Services Locator lists four hospitals that reported providing inpatient substance abuse services in Montgomery County, displayed in Table 53. The table shows that all four hospitals reported serving adults and young adults, while two reported serving children. All four facilities reported providing detoxification services, while three reported providing inpatient substance abuse treatment. Across the state, 20 facilities that responded to the 2013 N-SSATS reported providing inpatient substance abuse services.

[14] COMAR 10.24.14.07

Table 53. Inpatient Substance Abuse Treatment and Detoxification Facilities in Montgomery County

Facility	Location	Age Groups Served			Inpatient Treatment	Inpatient Detoxification
		Children	Young Adults	Adults		
Adventist Behavioral Health	Rockville	✓	✓	✓	✓	✓
MedStar Montgomery Med. Center	Olney	✓	✓	✓		✓
Suburban Hospital	Bethesda		✓	✓	✓	✓
Hatfield Clinical Research Center (NIH)*	Bethesda		✓*	✓*	✓*	✓*
Statewide # of facilities	**20 (total)**				**16**	**20**

Sources: SAMHSA Behavioral Health Treatment Services Locator, Accessed May 2015 and 2013 N-SSATS
* The Hatfield Clinical Research Center at the National Institutes of Health exclusively provides services that are part of clinical research studies.

D. Crisis Services

Behavioral health crisis services are designed to provide on-site evaluation, triage and stabilization services for individuals in crisis, to avoid or reduce unnecessary hospital emergency department admissions and to connect or re-connect individuals to a source of ongoing supports once they are stabilized. The service array for a comprehensive psychiatric crisis program typically includes:

- A **crisis hotline** staffed by people trained to deal with individuals in crisis.
- A **walk-in crisis center or urgent care facility** serves people without an appointment. A specialty center staffed with licensed mental health workers provides support, evaluations and referrals.
- A **mobile crisis team** which is a group of trained mental health personnel who are available to respond to the scene where an individual is experiencing a mental health crisis.
- **Residential crisis beds** which are holding beds where individuals in crisis can be evaluated, triaged and stabilized. Their availability is limited to short timeframes usually of 72 hours or less with flexibility to extend stays as needed.
- A **crisis intervention team** provides crisis intervention services to individuals in the community or to individuals within specific facilities.

1. Montgomery County Government's Crisis Service Programs

DHHS provides four different crisis intervention services. The program's array of services includes two crisis hotlines; a walk-in crisis center, two mobile crisis teams; and residential crisis services.[15] The program operates out of the Montgomery County Crisis Center on Piccard Drive; however, but can deploy staff to on-site locations in the community, such as hospital emergency departments. Additionally, MCPD's Crisis Intervention Team, described in page 43, is a group of officers who are trained to respond appropriately to psychiatric and other crises in the community.

[15] The residential crisis service consists of six triage and evaluation beds that are used to stabilize individuals, prevent hospitalizations and provide linkages to services.

All services are provided 24 hours a day, seven days a week to assist with emergencies or psychiatric crisis. These crisis services function as after hours and weekend backup services for times an individual's primary service providers are not available. The Crisis Center also works closely with MCPS to serve at-risk students. The FY15 approved program budget is $4.5M. Table 54 displays 4.5 years of monthly average phone and walk in contacts plus critical incidents. The data show a slight drop in phone contacts and a recent spike in critical incidents.

Table 54. Crisis Center Activity Data, FY11 to FY15 Year to Date

Indicator	FY11	FY12	FY13	FY14	FY15 YTD
Telephone contacts per month	3,841	3,552	3,700	3,453	3,323
Walk in contacts per month	295	332	340	357	317
Critical incidents per month	2.5	2.2	1.8	2.4	4.7

Source: DHHS Monthly Activity Reports

To place Montgomery County's crisis services in context, Table 55 presents details about crisis programs for seven Maryland jurisdictions based on information from a recently completed DHMH workgroup report. The data show all jurisdictions provide a hotline and a mobile crisis team and six jurisdictions provide crisis beds and emergency psychological services.

Table 55. Crisis Programs and Services Administered by Select Maryland Core Service Agencies

Jurisdiction	24/7 hotline	Mobile Crisis Team	Crisis Beds	Emer. Psych. Services	Urgent Care Center	Crisis Intervention Team
Montgomery County	✓	✓	✓	✓	✓	✓
Anne Arundel	✓	✓	✓	✓	✓	
Baltimore City	✓	✓	✓	✓		✓
Baltimore County	✓	✓	✓	✓	✓	
Frederick County	✓	✓	✓			
Howard County	✓	✓	✓	✓		
Prince George's	✓	✓	✓	✓		✓

Source: Appendix 5, *Report of the Outpatient Services Programs Stakeholder Workgroup*, Maryland Department of Health and Mental Hygiene, December 2014 Workgroup Report

2. Privately Provided Crisis Services in Montgomery County

Some privately operated mental health facilities in Montgomery County provide crisis intervention teams or psychiatric emergency walk in services in addition to the publicly provided services listed above.

- **Crisis teams** affiliated with private mental health facilities are teams of professionals tasked with handling acute mental health issues. The SAMHSA behavioral health facility locator identifies five Montgomery County facilities that reported a crisis team among their array of services. Of 165 facilities in Maryland responding to the 2010 N-MHSS, 49 (29.7%) provided a crisis team within the facility only; 14 (8.5%) provided a crisis team offsite only; 18 (10.9%) provided a crisis team within the facility and offsite and 83 (50.3%) did not provide a crisis team.

- **Psychiatric emergency walk-in services**. According to the N-MHSS, psychiatric emergency walk-in services have specifically trained staff to provide psychiatric care, such as crisis intervention, in emergency situations on a walk-in basis. They enable individuals, family members and friends to cope with the emergency while helping individuals function as a member of the community to the greatest extent possible.[16] An online search of the SAMHSA facility locator yielded seven unique Montgomery County facilities in Table 56 that reported providing walk-in services for psychiatric emergencies. However, DHHS staff report that non-hospital facilities typically refer individuals in crisis to the Montgomery County Crisis Center.

Table 56. Privately Provided Psychiatric Walk-In Services in Montgomery County

Facility Name	Area/City	Age Groups Served			Languages
		Children	Young Adults	Adults	
Behavioral Healthcare of MD	Takoma Park	✓	✓	✓	
Cornerstone	Bethesda		✓	✓	Spanish, Korean
Cornerstone	Rockville		✓	✓	Spanish, Russian
Cornerstone	Silver Spring		✓	✓	Spanish, Korean, Arabic, French, Portuguese
Medstar Mont. Med Center Addiction and MH Center	Olney	✓	✓	✓	
Suburban Hosp. Beh. Health	Bethesda		✓	✓	
Vesta	Silver Spring	✓	✓	✓	Spanish

Source: SAMHSA Facility Locator. https://findtreatment.samhsa.gov/locator Accessed 3/16/15

E. Behavioral Health Services Provided by Other Health-Related Institutions

In addition to the specialty mental health facilities and settings described in the previous sections, other community health care providers deliver services that incorporate care for individuals with mental health issues. This section provides information about the availability of these facilities and services in the County. It looks specifically at hospital emergency departments and Montgomery Cares, which is a group of community-based health care providers that offer basic health care to uninsured adults.

1. Hospital Emergency Departments

Hospital emergency departments are open round the clock to provide medical assistance, including access to psychiatric stabilization for individuals in crisis who are unable to obtain services through other means. The capacity of hospital emergency departments is regulated by the State. Because of the statewide hospital payment structure including charity care, emergency departments cannot turn away individuals for service.

Statewide capacity. Table 57 displays the distribution of emergency treatment capacity by health planning area from MHCC's Annual Hospital Report. The data show Montgomery County's supply of 256 spaces accounts for 12% of statewide capacity; and Montgomery County (25.18) and the Southern region (25.58)

[16] https://info.nmhss.org/Definitions/index.asp. Accessed 3/16/2015

have the lowest rates of treatment spaces per 100,000 people, well below the statewide rate of 35.44 spaces per 100,000 people.

Table 57. Emergency Department/Freestanding Facility Treatment Capacity, FY2014

Hospital/Region[17]	Total Treatment Spaces	Monitored Spaces	Non-Monitored Spaces	Non-Treatment Spaces	2013 Population	Spaces/ 100,000 People
Montgomery County						
Holy Cross	61	35	26	8		
MedStar Mont Medical Ctr	41	32	9	3		
Shady Grove Adventist Hosp.	21	9	12	2		
Suburban Hospital	43	29	14	3		
Washington Adventist	26	15	11	0		
Mont. County Subtotal	**256**	**151**	**105**	**16**	**1,016,677**	**25.18**
Western Maryland	185	109	76	10	494,407	37.42
Southern Maryland	318	218	100	22	1,243,062	25.58
Central Maryland	1,144	897	247	99	2,722,221	42.02
Eastern Shore	198	139	59	11	452,447	43.76
Statewide Totals	**2,101**	**1,514**	**587**	**158**	**5,928,814**	**35.44**

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2014.

County Hospital Emergency Department Visits Related to Behavioral Health. Both Montgomery County and the State of Maryland track and report multiple health process and outcome indicators as part of a statewide population health planning effort. Table 58 displays current County indicators for behavioral health related emergency department visits. The data show:

- Mental health conditions account for about 2.5 times as many visits as substance use disorders;
- County indicators for both visit types are better than their respective state targets; and
- Statewide, the County has the lowest rate of emergency department visits for substance abuse disorders and the second lowest rate for mental health conditions.

Despite the County's positive performance from a statewide perspective, its rates of emergency department visits for substance abuse disorders and mental health conditions have both increased since 2010. Substance use disorder visits increased from 518 visits per 100,000 people in 2010 to 583 visits in 2013, an increase of 12 percentage points. Mental health condition visits increased from 1,102 per 100,000 people in 2010 to 1,524 in 2013, an increase of 38 percentage points.

[17] The Western region includes Allegany, Frederick, Garrett and Washington counties. The Southern region includes Calvert, Charles, Prince George's and St. Mary's counties. The Central region includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford and Howard counties. The Eastern Short region includes Caroline, Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico and Worcester counties.

Table 58. Montgomery County Behavioral Health Emergency Department Visits per 100,000 People, 2013

Indicator	Visits per 100,000	Time Period	Statewide Rank	Better or Worse than State Target	Trend
Emergency Department Visits per 100,000 people for Substance Abuse Disorders	582.8	2013	#1	Better	**Getting worse.** Rate was 466.1 ED visits per 100,000 in 2010, 518.0 in 2011 and 559.2 in 2012.
Emergency Department Visits per 100,000 people related to Mental Health Conditions	1,524.2	2013	#2	Better	**Getting worse.** Rate was 1,102 ED visits per 100,000 in 2010.

Source: OLO and DHMH SHIP http://dhmh.maryland.gov/ship/SitePages/Home.aspx

2. Community Health Centers and the Montgomery Cares Behavioral Health Program

Community health centers can be a common source of behavioral health treatments. Responses to SAMHSA's National Survey on Drug Use and Health suggest that roughly 7% of patients who are treated for a behavioral health issue receive services in an outpatient medical clinic, including a community health center.[18]

The Primary Care Coalition (PCC) and DHHS jointly support the Montgomery Cares Behavioral Health Program. Montgomery Cares is a group of independent community health centers that offer basic health care to uninsured adults in Montgomery County. The Behavioral Health Program uses interdisciplinary teams of care managers and primary care providers supported by consulting psychiatrists and family support workers. The program maintains a partnership with the Georgetown University Department of Psychiatry. In FY14, the program served 1,447 patients, or 11.2% of all patients. The most common diagnoses among those with a behavioral health diagnosis (1,378) were depression (47%) and anxiety (44%).

PCC's evidence based program is a collaborative care model that provides universal screening to identify behavioral health treatment needs. The screening targets depression, anxiety and substance use disorders, following up with treatment and referrals for other services as needed. PCC reports that its approach leverages the fact that many adults with mental health issues prefer to seek treatment in primary care settings. The model also responds to the tremendous lack of access to psychiatry at all levels by supporting primary care providers who can prescribe medications, making cost effective use of psychiatrists and deploying care managers to monitor patients and step up treatment as needed.

In April 2014, two more clinics were added to the program, bringing the total participation to six clinics and 12 sites. Besides the PCC program, four other Montgomery Cares' clinics use a similar model to offer integrated behavioral health services. PCC estimates that the combined coverage of these programs reaches nearly 95% of the uninsured patients who access Montgomery Cares' clinics for primary care services.

[18] Community Health Centers are a nonprofit public or private entity that delivers health care services to a target population group with special characteristics. In Maryland, DHMH's definition of community health centers includes Federally Qualified Health Centers, Maryland Qualified Health Centers (MQHCs), public facilities, non-profit facilities, and private facilities. DHMH further defines a MQHC as a non-profit, comprehensive health practice facility designated by DHMH as Medicaid facilities that are eligible to receive enhanced Medicaid reimbursement for their services to Medicaid patients.

F. Summary

This chapter compiles data from a variety of sources on behavioral health outpatient, residential, and inpatient treatment facilities in Montgomery County, as shown on Table 59. The table lists bed space or treatment slot capacity where it was available, but in many cases only data on the numbers of facilities were available.

Table 59. Montgomery County Behavioral Health Treatment Facilities Data Summary

Setting	Available Data Points
Outpatient	• 19 mental health facilities • 24 substance abuse facilities • 138 slots in hospital-based intensive outpatient or partial hospitalization programs
Residential	• 11 mental health facilities • 4 substance abuse facilities • 168 beds in two residential treatment centers for children and adolescents • 382 residential rehabilitation beds for serious mental illness
Inpatient	• 89 inpatient psychiatric beds in three general hospitals • 106 staffed beds in one private psychiatric hospital • Four general hospitals providing inpatient substance abuse detoxification or treatment
Crisis	• DHHS 24-hour crisis services include two crisis hotlines, a walk-in crisis center, two mobile crisis teams and residential crisis services • The MCPD's Crisis Intervention Team responds to crises in the community
Other health institutions	• Five general hospitals have a combined total of 256 treatment spaces in emergency departments, which treat individuals experiencing behavioral health crises. • The Montgomery Cares Behavioral Health Program provides behavioral health services delivered by primary care physicians to uninsured adults in six clinics at 12 sites.

Although the data in this chapter cannot serve to fully quantify the capacity of existing behavioral health treatment providers in Montgomery County, it along with the previous chapter on the County's behavioral health workforce offers key data points about the availability of behavioral health services in the County.

Chapter X. Interview Feedback and Reports on Gaps in Behavioral Health Services

Data on behavioral health and behavioral health services offer a foundation for understanding behavioral health issues in Montgomery County, but they do not provide a complete picture. In particular, available data do not provide sufficient information to quantify the exact need for specific types of services or to fully quantify the capacity of existing services. Additionally, available data do not provide full information on the numerous barriers that many individuals face in accessing services, including financial, transportation, and health-related barriers.

To respond to the Council's request to examine gaps in the provision of behavioral health services, OLO conducted key stakeholder interviews with representatives from the County Government, Montgomery County Public Schools, and community organizations to seek feedback. OLO supplemented these views with other sources of information on service gaps from reports about behavioral health services in the County. This chapter summarizes the gaps identified from interviews and reports.

A. Interview feedback on gaps

Stakeholders interviewed by OLO described a variety of gaps in the provision of behavioral health services in Montgomery County. In many instances, multiple stakeholders who interact with the behavioral health system in different ways, including service providers, service consumers, and government program managers, described similar gaps. Many stakeholders also noted that the services available in Montgomery County are extensive relative to other jurisdictions, but that the need is also extensive. The paragraphs below summarize the gaps that stakeholders described to OLO.

Unmet behavioral health service needs for adults and children with serious and persistent mental illness/serious emotional disturbances and co-occurring disorders. Stakeholders note that reductions in the number of beds available in State psychiatric hospitals in recent decades and restrictions on Medicaid funding for inpatient psychiatric care for adults contribute to a gap in services for individuals with severe behavioral health disorders. Stakeholders state that a need exists for more services designed to support this population living in community and their access to community-based behavioral health and other necessary services. The specific service needs stakeholders mention in this category include case management, Assertive Community Treatment, Health Homes, Wraparound, and care management systems.

Unmet housing needs for individuals with serious behavioral health disorders. Multiple types of housing in the community exist for individuals with behavioral health disorders, including intensive and general residential rehabilitation programs (RRP), supportive housing, and group homes. Stakeholders report that availability is limited at all levels, as evidenced by waiting lists for RRP beds (see page 96). Stakeholders note that budget constraints at the State level, high housing costs in Montgomery County and the stigma associated with behavioral health disorders create barriers to providing housing for this population.

Inadequate crisis intervention resources and need for better coordination with hospitals. The County's Crisis Center, Mobile Crisis Team, and the MCPD Crisis Intervention Team along with hospital emergency departments provide services for individuals experiencing psychiatric crises. Stakeholders report that these existing options are inadequate or inappropriate for addressing the needs of individuals in crisis, and police must often detain individuals in crisis due to a lack of appropriate alternatives to incarceration. Additionally, the Crisis Center has experienced steady increases each year in the numbers of MCPS students requiring services, creating an additional strain on existing resources. Finally, stakeholders identify a need for better coordination between hospitals and community providers to ensure that individuals in crisis receive correct

medications in the hospital and connect effectively to appropriate follow-up care to prevent readmission to the hospital.

Lack of beds and lack of coordination with State and the judicial system for serving individuals with behavioral health disorders involved in the criminal justice system. MCPD, DOCR and DHHS collaborate extensively to address the needs of justice-involved individuals with behavioral health disorders. Stakeholders report that this population is not well served by certain elements of this system. For example, as noted above, staff report that many individuals with behavioral health disorders are incarcerated due to a lack of appropriate alternatives, and that incarceration can lead to worsening of their condition. Additionally, staff report that inmates certified to be a danger to themselves or others are typically not able to be transferred to the State's forensic psychiatric hospital within the 12 hours required by State law due to a lack of available beds, which are often filled instead by individuals declared to be incompetent to stand trial.[1] Finally, many stakeholders consider that the lack of a mental health court in Montgomery County represents a missed opportunity to provide an alternative to incarceration and motivate adherence to treatment among offenders suffering from mental illness.

Need for more specialized services and coordination for individuals with other health/disability needs in addition to behavioral health needs. A large portion of individuals with behavioral health disorders suffer from co-occurring mental health and substance abuse disorders. Additionally, many individuals experience other health or developmental issues in addition to behavioral health disorders. In many cases, barriers exist to receiving care for both (or multiple) issues. Stakeholders report that more providers are developing the capacity to address co-occurring mental health and substance abuse, but this remains a major area of need. In other cases appropriate services are extremely limited. For example, DHHS staff report that residential rehabilitation programs and substance abuse programs lack home health aides or other service supports to address seniors' age-related issues, and that assisted living facilities lack resources to adequately address seniors' behavioral health-related issues. Similarly, stakeholders report that individuals with autism who also have mental health disorders struggle to obtain care from psychiatrists. Additionally, individuals with serious behavioral health disorders often face barriers in obtaining care for physical health issues.

Significant financial barriers to access to care for individuals with low incomes who are not eligible for Medicaid. Several stakeholders pointed out that while the Medicaid program offers a relatively comprehensive set of behavioral health benefits for individuals and families with low incomes, many individuals with low incomes are not eligible for Medicaid, including undocumented immigrants, seniors with Medicare, and individuals who receive disability benefits through Social Security. Availability of public funding for behavioral health services for this population is limited. Significantly, even individuals with Medicare or private insurance, including those receiving subsidies through the Affordable Care Act, are often required to pay significant out-of-pocket costs to access behavioral health services, and often find that their plan does not cover the services they need and/or that providers do not accept their insurance.

Lack of behavioral health providers, especially psychiatrists, who accept reimbursement through insurance, and lack of bilingual providers. Stakeholders report that many behavioral health providers, particularly psychiatrists and child psychiatrists, do not accept reimbursement through private or public insurance, thereby requiring patients to pay for the full cost of care out of pocket. Additionally, psychiatrist costs are often prohibitively high for many community-based programs to provide these services to their clients. Finally, numerous stakeholders reported difficulties in recruiting bilingual behavioral health professionals, who are needed to serve individuals with limited English proficiency.

[1] Staff report that many of these individuals are held under court order in the State hospitals pending a hearing date.

Need for better access to updated information about community-based providers in the County. OLO received feedback that individuals and organizations often encounter difficulties in finding information on the vast array of community-based providers in the County. While several online databases exist, these are often out of date or lack key information that could help consumers and referring organizations navigate existing resources, for example age or insurance status requirements.

Other needs identified by stakeholders. Stakeholders also identified the following areas where specific gaps in services or providers exist:

- Early intervention to decrease the length of time between an individual's initial symptoms to the time they seek treatment, particularly among adolescents and young adults;
- Additional support services for individuals with serious behavioral health disorders living in the community including transportation and legal services;
- More resources for substance abuse prevention in schools;
- Trauma-trained providers for child welfare cases where there is a continuing pattern of abuse;
- Treatment for sex offenders;
- Outreach to veterans regarding existing services;
- Services to address hoarding;
- Support for seniors with adult children with behavioral health issues; and
- Outreach and support for unaccompanied minors who have experienced trauma while maintaining services for existing population.

B. Additional information on gaps in behavioral health services in Montgomery County

OLO reviewed reports regarding behavioral health services in Montgomery County that identified gaps in services. This section describes each report and the gaps it identified.

Montgomery County Core Service Agency Fiscal Year 2014 Annual Report. As noted on page 22, the Maryland Public Behavioral Health System (PBHS) encompasses a system of county and multi-county authorities called Core Service Agencies (CSAs) responsible for planning, managing and monitoring publicly funded mental health services at the local level. In Montgomery County, the CSA is situated in the Behavioral Health and Crisis Services Area of the Department of Health and Human Services. The County's CSA produces an annual report describing the County's accomplishments in behavioral health, data on expenditures and persons served through the Public Behavioral Health System (PBHS), and service needs. The Fiscal Year 2014 report identifies service needs in the following areas:

- Providers offering both mental health and substance abuse treatment for individuals with co-occurring disorders;
- Residential rehabilitation program capacity, including specialized programs for seniors with age-related somatic care needs and for adults with somatic care needs;
- Housing for special populations including sex offenders, individuals with criminal backgrounds, undocumented individuals, individuals with developmental disabilities, and individuals with additional significant health problems;
- Case management for individuals who present in emergency departments;
- Need to develop cultural and linguistic competencies among the behavioral health workforce;

- Mental health professionals with experience working with individuals with severe and persistent mental illness and with co-occurring substance abuse disorders, as well as mental health professionals with supervisory experience;
- Need to divert more individuals with mental health needs who have committed low-level offenses from incarceration to community-based care; and
- More income-blind wraparound services, which provide intensive care planning and management for families with children and adolescents with serious emotional disorders.

HealthyMontgomery Behavioral Health Action Plan Report, **2014**. The Behavioral Health Action Planning Work Group is a component of HealthyMontgomery, the community health improvement process for Montgomery County that aims to identify and describe disparities in health status among the County's communities and populations, identify unmet health needs, develop and implement action plans to meet those needs, and evaluate the effectiveness of the strategies implemented. In 2014, the Work Group released its action plan report, which defined three primary Local Health Issue Areas as well as additional gaps in behavioral health, described below.

Local Health Issue Areas

1. There is a need for consumers, families, referral agencies and behavioral health providers to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms and how to access services;
2. There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care; and
3. There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.

Additional gaps

- Shortage of behavioral health specialists (particularly psychiatrists) and bi-lingual behavioral health service providers;
- Lack of funding for services that address cultural barriers to seeking behavioral health care;
- Need for more integration of behavioral health and primary care and of mental health and substance abuse services;
- Inadequate data collection stemming from lack of system integration and financing; and
- Financing inadequacies, including inadequate reimbursement rates from third-party insurers, co-payment requirements for Medicare enrollees and lack of acknowledgment of effect of no-show rates for Public Behavioral Health System providers.

Montgomery County Master Facilities Confinement Study, 2014. The County commissioned the Master Facilities Confinement Study, which is an extensive review of criminal justice in the County and was released in January of 2014, to establish future bedspace requirements for the County's correctional facilities and pre-release center. This study included feedback regarding mental health needs and services related to the criminal justice population, including:

- Need for more consistent approach in the Emergency Communications Center for classifying incidents as "true mental illness" when dispatching police to a scene;

- Need for better data collection on police responses to mental health-related incidents, including data on response times, frequency of interactions between police and mentally ill, and the number of jail diversions;
- Lack of resources in the community for diverting individuals with behavioral health issues from incarceration and for addressing needs of mentally ill individuals returning to the community from the jail, including lack of residential beds, lack of community providers prepared to accept referrals from the criminal justice system, and lack of appropriate housing options;
- Limited availability of inpatient treatment within the State system;
- Lack of formal mental health screening for individuals who have been detained by police but are released by District Court Commissioner on personal recognizance;
- Limited bed capacity in the Montgomery County Correctional Facility's Crisis Intervention Unit, which provides special housing for mentally ill inmates and lack of "step-down" stabilization unit for inmates who require an intermediate level of care; and
- Need for more services for mentally ill individuals within Pre-Release and Re-entry Services, which currently has limited capacity to address needs of individuals with serious mental illness.

Statewide Report about Caregivers' Use of Psychiatric Emergency Programs. In 2011, the Maryland Coalition of Families for Children's Mental Health (MCF) conducted seven focus groups across the state as part of a CMS grant awarded to DHMH to assess crisis response services for youth with serious behavioral health disorders. MCF issued a report, *Listening and Learning from Families: Crisis Services and the Experiences of Families Caring for Children and Youth with Mental Health Needs* ("The MCF Report") in December 2013.[2]

Table 60, excerpted from the report, summarizes information about families' awareness and use of crisis services. It suggests a lack of awareness about crisis services other than the police or emergency departments and mixed views about the helpfulness of the services families used. MCF offers four conclusions: 1) that families want alternatives to the emergency department; 2) that law enforcement officers are the front line of the crisis; 3) that families with Limited English Proficiency face additional challenges and fewer options; and 4) that Maryland's mental health crisis system is underfunded and lacking in services.

[2] Focus group participants were caregivers of youth under 22 with serious complex mental health disorders who had used crisis services in the past two years. There were a total of 48 focus group participants, including a focus group for seven Spanish speaking participants held in Montgomery County. Just over 81% of the children were taking medications (an average of 4.4 medications each); 69% were male; and 50% were ages 14 to 17. Caregivers completed a lengthy survey in addition to their focus group participation. The authors' caution that these results reflect services across the state, which vary widely; and that the reasons families' decide to engage crisis services vary widely as well.

Table 60. Statewide Responses to Family Survey on Crisis Services Type of Crisis Services

Service	# of Families Responding	Do You Know if This Service is Available in Your Community?	Have You Ever Used This Service for Your Child?	Was it Helpful?
Crisis Hotlines/ Online Resources	43	13	11	6
Police	39	39	28	16
Mobile Crisis Team	41	19	16	5
Emergency Department	39	39	33	13
Mental Health Urgent Care	47	12	8	4
Emergency Respite	47	9	3	0
ED Diversion	45	16	15	10
Care Coordination and Stabilization	43	13	9	8

Source: Maryland Coalition of Families for Children's Mental Health (MCF) December 2013

Chapter XI. Findings

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as, "a state of mental/emotional being and/or choices and actions that affect wellness."[1] Behavioral health problems include mental health disorders and substance use disorders. A mental health disorder is a condition in which alterations in thinking, mood or behavior occur that may cause distress and impair functioning. A substance use disorder is the dependence on or abuse of alcohol or illicit drugs.

The Council requested this Office of Legislative Oversight (OLO) study to examine the interplay of public and private resources as they are directed towards behavioral health services in Montgomery County and, in particular, identify where service gaps exist in Montgomery County.

To this end, OLO used multiple approaches to examine the need for and availability of behavioral health services in Montgomery County. These approaches included estimating the numbers of Montgomery County residents with behavioral health disorders and examining how health coverage status impacts access to behavioral health services. OLO also reviewed the provision of behavioral health services for the criminal justice-involved population as well as prevention, referral, and recovery support services. Finally, OLO analyzed data on the behavioral health workforce and behavioral health facilities in Montgomery County, and conducted interviews with numerous stakeholders with knowledge of behavioral health services in Montgomery County.

These findings are divided into five topic areas:

- County estimates of population with behavioral health disorders
- Behavioral health financing in the United States
- Access by health insurance coverage
- Services for the criminal justice-involved population
- Prevention, referral and recovery support services
- Data on the behavioral health workforce and behavioral health facilities

[1] "What Is Behavioral Health," Substance Abuse and Mental Health Services Administration (SAMHSA) website, < http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/1 > accessed 3/9/2015

PREVALENCE OF BEHAVIORAL HEALTH DISORDERS

Finding #1: Assuming that prevalence rates of mental illness in Montgomery County are similar to national rates, approximately 144,000 adults in the County experienced mental illness in the past year, including 33,000 with mental illness that was seriously disabling. An additional 9,000 youth aged 12-17 experienced a major depressive episode in the past year.

Data from the 2013 National Survey on Drug Use and Health (NSDUH) indicate that approximately 18.5% of adults in the United States experienced mental illness in the past year and 4.2% experienced seriously disabling mental illness. Limited data are available on overall mental illness prevalence rates among children, but NSDUH data show that about 11% of youth aged 12-17 experienced a major depressive episode in the past year. OLO applied these national prevalence rates to the county population to estimate how many county residents experienced mental illness in the past year, shown on the table below.

County Mental Illness Estimates by Level of Functional Impairment, 2013

Characteristic for Mental Health Concern	Census Population Estimate	NSDUH Prevalence Rates	Subgroup Estimate
Adults Aged 18+	777,159		
Any Mental Illness		**18.5%**	**143,774**
Severity Level of Impairment			
Mildly Disabling		9.4%	73,053
Moderately Disabling		4.8%	37,304
Seriously Disabling		4.2%	32,641
Characteristic for Mental Health Concern	**Census Population Estimate**	**NSDUH Prevalence Rates**	**Subgroup Estimate**
Youth Ages 12-17	80,921		
Share of Youth With Major Depressive Episode		**10.7%**	**8,659**
Without Severe Impairment		3.0%	2,428
With Severe Impairment		7.7%	6,231

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

Finding #2: Assuming that prevalence rates of substance use disorders in Montgomery County are similar to national rates, approximately 70,000 youth and adults in the County experienced a substance use disorder in the past year, including 25,000 adults who had a co-occurring mental health disorder. An additional 4,000 youth aged 12-17 experienced a disorder.

Substance use disorders include both substance abuse and substance dependence. Substance dependence has symptoms including drug or alcohol tolerance and withdrawal and is considered to be more severe than substance abuse, which refers to a pattern of substance use that leads to recurrent life problems such as failure to fulfill work obligations or legal problems.

Data from 2013 National Survey on Drug Use and Health show that 8.2% of youth and adults aged 12 and over experienced past-year substance use disorders. Disorders were significantly more prevalent among the 18-25 year old age group, among which 17.3% experienced a past-year disorder, than among youth or older

adults. Additionally, 17.5% of adults with mental illness also experienced substance use disorders. As with mental illness, OLO applied national prevalence rates to the county population to estimate how many county residents experienced substance use disorders in the past year, shown on the table below.

Table X. Estimates of County Population Experiencing Substance Use Disorders in the Past Year, 2013

Type of Substance Use Disorder	Census Population Estimate	NSDUH Prevalence rate	Subgroup Estimate
Population aged 12+	857,262		
Any substance use disorder		**8.2%**	**70,363**
Illicit drug dependence or abuse		2.6%	22,310
Alcohol dependence or abuse		6.6%	56,633
Age group (any substance use disorder)	**Census Population Estimate**	**NSDUH Prevalence Rate**	**Subgroup Estimates***
12-17	80,921	5.2%	4,345
18-25	92,635	17.3%	16,546
26 or older	684,524	7.0%	49,472
Substance use disorders by presence of mental illness among adults	**Subgroup Population Estimates**	**Illicit Drug or Alcohol Dependence Rates**	**Substance Use Disorder Prevalent Population Estimates**
No Mental Illness in Past Year	633,385	6.5%	41,170
Any Mental Illness in Past Year	**143,773**	**17.5%**	**25,160**
Serious Mental Illness in Past Year	32,641	23.1%	7,540

Source: OLO based on ACS 2013 1 year estimates and NSDUH 2013 national estimates.

HEALTH INSURANCE COVERAGE AND ACCESS TO BEHAVIORAL HEALTH SERVICES

Finding #3: Funding for behavioral health services in the United States, and by extension Montgomery County, relies on a complex patchwork of public and private sources.

Individuals in the United States access behavioral health services through a variety of avenues, including public health coverage such as Medicare or Medicaid, private health insurance coverage, paying for services out of pocket, or accessing other public services that are grant-funded. The third-party insurer or government entity that pays for services is often referred to as the "payer". The major types of payers for behavioral health services in the United States are described below:

- **Medicare** is a nationwide federally administered health insurance program for individuals aged 65 and older, persons with disabilities, and individuals with end stage renal disease or Lou Gehrig's Disease.
- **Medicaid** provides medical assistance for low-income populations and is operated by the states in partnership with the federal government.
- **Private health insurance coverage** includes employer-based plans and individual plans purchased directly from an insurer or through a health exchange established by the Affordable Care Act.

- **State Mental Health Authorities** historically administered centralized public funding for mental health services, and now form part of a complex system that also includes Medicaid, Medicare and federal grant funding.
- **Other federal:** this category includes a block grant program that supplements state-financed programs as well as additional federal programs that finance support services.

Finding #4: Nationally, public funding from federal, state and local governments combined accounted for 61% of behavioral health funding in 2009. Private sources are likely to account for a larger share of spending in Montgomery County, given income levels and private insurance coverage rates.

The table below summarizes private and public behavioral health funding in the United States in 2009, the latest year for which data are available. The table shows that:

- Public sources accounted for the majority of funding for behavioral health services, and among these Medicaid, which includes both federal and state funding, is the largest source, followed by other state and local funding;
- Out of pocket spending, which refers to direct spending by individuals on behavioral health services, accounted for nearly $19 billion or 11% of the total spending on behavioral health services; and
- Medicare experienced significant growth in behavioral health spending between 2004 and 2009.

2009 Behavioral Health Spending in the United States ($ millions)

Source	Spending	% Share	Annualized growth since 2004
Private sources	**$66,584**	**39%**	**5%**
Private insurance	42,562	25%	5%
Out of pocket	18,791	11%	4%
Other private	5,231	3%	6%
Public sources	**$105,136**	**61%**	**5%**
Medicare insurance	20,544	12%	21%
Medicaid insurance	44,227	26%	3%
Federal dollars	29,171	17%	6%
State matching dollars	15,056	9%	0%
Other federal grants	10,492	6%	3%
Other State and Local	29,873	17%	2%
Total	**$171,720**	**100%**	**5%**

Source: SAMHSA Spending Estimates

Finding #5: In 2013, nearly 77%% of Montgomery County residents had private health insurance coverage, 23% had public coverage, and 11% were uninsured.

The table below displays 2013 American Community Survey (ACS) data on the numbers and percentages of non-institutionalized Montgomery County residents holding different types of health insurance coverage, as well as the corresponding percentages for the civilian non-institutionalized population of the United States. The data show that Montgomery County has a significantly higher rate of private insurance coverage (77%) compared with the national rate (65%) and that a smaller share of the County population (23%) has public coverage compared with the corresponding national share (32%).

Health Insurance Coverage Status of Non-Institutionalized Montgomery County Residents

Health Coverage Type	Montgomery County		United States
	#	%*	%*
Private health insurance	**774,807**	**77%**	**65%**
Employment-based health insurance	668,071	66%	54%
Direct-purchase health insurance	114,306	11%	12%
TRICARE/military health coverage	32,564	3%	3%
Public coverage	**231,644**	**23%**	**32%**
Medicare coverage	130,798	13%	16%
Medicaid/means-tested public coverage	113,823	11%	18%
Department of Veterans Affairs (VA) Health Care	9,487	1%	2%
Uninsured	**111,515**	**11%**	**15%**

*Percentages add up to more than 100% because an individual can hold more one type of health insurance coverage.

It is important to note that these data, which precede the implementation of important elements of the Affordable Care Act (ACA), do not include individuals who became newly eligible for Medicaid as a result of the ACA or previously uninsured individuals who signed up for a private insurance plan on the Maryland Health Exchange for 2014 or 2015. National data suggest that the number of uninsured dropped by 25% in 2014,[2] and Medicaid data show that the number of Medicaid-eligible individuals in Montgomery County increased by 29% in 2014, when the Medicaid expansion took effect.

Finding #6: Medicare and Medicaid, the two major public health insurance programs available to County residents, cover a broad range of behavioral health services. However, financial barriers to access in Medicare and gaps in behavioral health service coverage in both programs exist.

As noted above, Medicare provides health insurance coverage for individuals aged 65 and older, individuals with disabilities, and individuals with end stage renal disease or Lou Gehrig's Disease, while Medicaid provides medical assistance for low-income populations. The table on the following page provides a side-by-side summary of the major behavioral health services covered by each program. Of note:

[2] Sanger-Katz, M.,"Is the Affordable Care Act Working: Has the percentage of uninsured people been reduced?" New York Times, October 26, 2014, < http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=0#uninsured > accessed May 26, 2015.

- Medicare enrollees must pay for significant portions of the cost of services through coinsurance, which requires enrollees to pay for 20-40% of costs, deductibles, as well as premiums (not shown on the table) that must be paid to receive coverage for non-hospital care and prescription drugs;
- Maryland's Medicaid program typically does not require enrollees to contribute to the cost of care with the exception of nominal copays required for prescription drugs;
- Medicare does not cover certain outpatient behavioral health services covered by Medicaid, including opioid addiction treatment that uses medications such as methadone, mobile treatment, and psychiatric rehabilitation; and
- Medicaid provides limited coverage for inpatient and residential care for adults because federal law prohibits states from using Medicaid funds to cover inpatient care in psychiatric hospitals or mental health and addictions residential treatment facilities.

Comparison of Medicare and Medicaid Covered Behavioral Health Services

Medicare	Medicaid
Outpatient services	
Outpatient psychotherapy subject to a $147 deductible 20-40% coinsurance, and Structured Assessment and Brief Intervention (SBIRT) therapies for drug abuse or dependency.	**Outpatient** mental health and substance abuse services, including treatment with medications such as methadone used to treat opioid addiction and mobile treatment provided by a multidisciplinary treatment team in a variety of community settings.
Outpatient detoxification, 20% coinsurance required.	**Outpatient detoxification.**
Partial hospitalization, which provides therapeutically intensive and structured clinical services and is subject to a $147 deductible and additional coinsurance.	**Partial hospitalization** as well as **psychiatric rehabilitation programs** aimed at improving or restoring independent living and social skills.
Inpatient and residential care	
Inpatient hospitalization in a general or psychiatric hospital for a psychiatric condition for a maximum of 90 days per spell of illness with a deductible of $1,260 and a per-day coinsurance payment of $315 days 61-90, in addition to a 20% coinsurance for physician and treatment services while hospitalized.	**Inpatient hospitalization in general hospitals**. Federal law prohibits states from using Medicaid funds to cover inpatient care in psychiatric hospitals or mental health and addictions residential treatment facilities for individuals aged 22-64.
Inpatient detoxification in a general or psychiatric hospital with a deductible of $1,260 and copay of $315 per day for days 61-90, in addition to 20% coinsurance for physician and treatment services while hospitalized.	**Residential treatment services for individuals under the age of 21** with emotional disturbances or substance use disorders as well as family support and other services for children with serious emotional disturbances residing in a home or community-based setting.
Other	
Care coordination through a Patient-Centered Medical Home.	**Care coordination** services for individuals with serious mental illness or individuals also enrolled in opioid treatment programs.
Prescription drugs for individuals who pay premiums for prescription drug coverage.	**Prescription drugs** for mental health and substance use disorders with a $1-$3 copay.

Finding #7: Of the approximately 775,000 County residents who held private health insurance plans in 2013, about half held plans subject to laws and regulations that require coverage of specific behavioral health services.

Federal and State law establish rules regarding the type of coverage that private health insurance must provide, including behavioral health benefits. However, different rules apply to the different types of private plans, and only some plans are required to cover behavioral health services. Whether a specific rule applies depends on whether a plan is:

- An **individual** plan purchased directly from an insurer, a **small group** plan (for employers with between 2 and 50 employees) or a **large group** plan (for employers with over 50 employees);
- **Fully-insured** or **self-insured**: a fully-insured plan is purchased on the commercial insurance market by individuals or employers, whereas a self-insured plan is established and funded directly by an employer.
- **Grandfathered** or **new**: a plan is considered "grandfathered" under provisions of the Affordable Care Act if it was in place as of March 2010 and has not been substantially changed.

OLO examined whether the different categories of private health insurance plans are subject to either a **parity mandate** or a **substantive benefit mandate** and estimated of the numbers of County residents holding each type of plan. A parity mandate does not require health plans to provide behavioral health benefits, but prohibits health plans, if they do provide behavioral health benefits, from making these benefits more restrictive than medical or surgical benefits. In contrast, a substantive benefit mandate requires health plans to provide specific behavioral health benefits. OLO estimates that about 424,500 County residents, or over half of those with private coverage, have plans that are subject to substantive benefit mandates, while 333,900 hold plans subject only to a parity mandate. An additional 16,000 residents are covered by private plans that are not subject to any mandates regarding behavioral health coverage.

SERVICES FOR THE CRIMINAL JUSTICE-INVOLVED POPULATION

Finding #8: State and County agencies provide a broad range of services aimed at addressing the needs of justice-involved individuals with behavioral health disorders at different stages of the justice process. However, stakeholders report that there is a lack of sufficient alternatives to incarceration for this population.

Montgomery County residents can receive behavioral health services as a result of being involved in the criminal or juvenile justice systems. Inmates in prisons and jails have a constitutional right to adequate health care, including behavioral health care,[3] and evidence indicates that a significant proportion of justice-involved individuals suffer from behavioral health disorders. The table below describes behavioral health interventions provided by State and County agencies at each stage of the criminal justice process.

Services for Justice-Involved Individuals with Behavioral Health Disorders

Stage	Services
1. Law enforcement	The Police's Crisis Intervention Team and the Department of Health and Human Services' (DHHS) Mobile Crisis Team and Juvenile Justice Services address the needs of individuals in crisis in the community and seek alternatives to arresting individuals with behavioral health disorders where appropriate.
2. Initial detention and court hearings	After an individual has been arrested, DHHS, the Department of Correction and Rehabilitation (DOCR) and the Maryland Department of Juvenile Services (DJS) provide screenings and assessments of behavioral health disorders, provide treatment, divert individuals from incarceration where appropriate, and refer to community treatment.
3. Jails, prisons and courts	DOCR, DHHS, the Maryland Department of Public Safety and Correctional Services (DPSCS), and DJS provide behavioral health assessment and treatment services to individuals in their custody. Additionally, the Montgomery County Circuit Court Adult Drug Court Program provides an alternative to formal prosecution for criminal defendants who complete a drug or alcohol abuse treatment program in the community.
4. Reentry to the community	DOCR, DHHS, DPSCS and DJS provide services aimed at planning for and preparing individuals in their custody for reentry to the community, including linking them to behavioral providers in the community.
5. Parole, probation and community supports	After an individual has been released from the custody of DOCR, DPSCS or DJS, in some cases staff continue to monitor the individual and ensure that they receive the behavioral health services they need. However, DOCR and DHHS staff report that resources available for this purpose are limited.

Despite these interventions, stakeholders report concerns that too many individuals with behavioral health disorders are incarcerated due to a lack of appropriate alternatives, that State psychiatric hospitals do not have sufficient bed space to serve individuals certified to be a danger to themselves or others, and that the lack of a mental health court in Montgomery County represents a missed opportunity to provide an alternative to incarceration and motivate adherence to treatment among offenders suffering from mental illness. Efforts are underway to establish a mental health court in the Montgomery County Circuit Court by 2016.

[3] Cohen F, Dvoskin J, "Inmates with mental disorders: a guide to law and practice," *Mental and Physical Disability Law Reporter* 16:339–346, 1996.

PREVENTION, REFERRAL AND RECOVERY SUPPORT SERVICES

Finding #9: MCPS, the County Government and various community organizations provide behavioral health promotion and prevention activities and referral services that are targeted at specific populations, primarily among school-age children and youth. Further study would be required to determine the quality and adequacy of services.

SAMHSA identifies behavioral health promotion and prevention as two key elements of the continuum of care for behavioral health. Services in these categories are typically provided free of charge and are supported with a combination of state, local and private foundation funding. Therefore, access does not depend on an individual's health coverage status.

Promotion and prevention are closely related and the terms are often used interchangeably, but can be distinguished in that promotion activities are aimed at strengthening determinants of mental wellness such as social-emotional competence and strengthening an individual's ability to cope with adversity, while prevention focuses on averting behavioral health problems, particularly substance use disorders. Additionally, many services in these categories provide referrals to behavioral health treatment where appropriate. The table below lists promotion, prevention and referral services, most of which are targeted at children and youth.

Behavioral Health Promotion, Prevention and Referral Services in Montgomery County

Agency or Organization	Services
Montgomery County Public Schools	Mental health and substance use components of the School Health Curriculum, Student Services which includes school psychologists, counselors and pupil personnel workers, and partnerships with the Mental Health Association, Identity, Inc., and the County's Crisis Center
Department of Health and Human Services	School Health Services, Linkages to Learning in high-poverty elementary and middle schools and Regional Youth Services Centers, Positive Youth Development Initiative, and Child Welfare Services
Montgomery College	Monthly wellness newsletter, substance abuse prevention education events, and the Behavioral Intervention Team
Organizations in the community	Montgomery County Alliance to Prevent Substance Abuse (Many Voices for Smart Choices), Dare to Be You Program operated by Family Services, Identity, Inc.'s Latino Wellness Program, Mental Health Association's H.O.P.E.S. program, Washington Youth Foundation's behavioral health outreach and education, Brave and Bold coalition on underage substance abuse, Community of Concern parent substance abuse prevention efforts
Online behavioral health treatment referral databases	infoMontgomery, Maryland Community Services Locator, Maryland Certified Treatment Locator, SAMHSA Behavioral Health Treatment Services Locator, and Network of Care

Further study is required to assess the quality and adequacy of the County's behavioral health promotion and prevention activities. With regards to referral services, OLO received feedback that individuals and organizations often encounter difficulties in finding information on the vast array of community-based providers in the County. While several online databases exist, these are often out of date or lack key information that could help consumers and referring organizations navigate existing resources, for example age or insurance status requirements.

Finding #10: A variety of community organizations and groups in Montgomery County offer support for individuals in recovery from behavioral health disorders. Further study would be required to determine whether services are effective or adequate.

Recovery is the process of ameliorating the negative impacts of behavioral health disorders, including not only the direct effects of the disorder on the individual through compliance with long-term treatment and after care but also indirect effects such as discrimination and poverty. Individuals who are not behavioral health professionals, including peers who have also experienced similar disorders as well as friends and family, can support an individual's recovery.

In Montgomery County, individuals receiving treatment for and/or recovering from behavioral health disorders can participate in a variety of community groups or centers that offer self-help or mutual support networks to assist individuals in managing their lives and to support recovery, as summarized in the table below. Many of these groups target adults, though some provide specific services for children and youth.

Behavioral Health Recovery Support Services in Montgomery County

Organization/Group	Description
Mental Health	
Wellness and Recovery Centers	Two centers funded by the County provide peer-run recovery activities for adults with mental health disorders.
National Alliance for the Mentally Ill (NAMI)	The Montgomery County chapter of NAMI provides peer-run classes and support groups for individuals with mental illness and their families.
The Federation of Families for Children's Mental Health	The Federation provides family and youth peer-to-peer support, education, advocacy, leadership opportunities, and information and referral services for youth and young adults with emotional, behavioral and/or mental health challenges.
Depression and Bipolar Support Alliance (DBSA)	The DBSA is a national organization that aims to support individuals suffering from depression and bipolar disorder with two support groups that meet regularly in Montgomery County.
Substance Use	
Recovery Partners Montgomery (RPM)	RPM receives State funding to promote "recovery-oriented systems of care," which are services and relationships that support long-term recovery from addiction, such as community activities, employment support and training for peer recovery specialists.
Support Groups (various)	Numerous mutual-aid recovery support groups for individuals with addictive, compulsive or other behavioral problems and their families, meet in the county on a weekly basis, including twelve-step groups like Alcoholic Anonymous and SMART Recovery groups which offer an alternative to the twelve-step approach.

DATA ON BEHAVIORAL HEALTH WORKFORCE AND FACILITIES

Finding #11: Workforce data show a shortage of psychiatrists in the County but a sufficient workforce of other mental health professionals. At the same time, stakeholder feedback suggests that many individuals face financial and language barriers in accessing care from behavioral health professionals, particularly psychiatrists.

Based on methods developed in a set of studies commissioned by the Health Resources and Services Administration (HRSA), OLO estimates that the County has a need for 27 psychiatrists per 100,000 population and 62 mental health professionals of all types per 100,000 population. The data in the table below show that the County has 21 full-time equivalent psychiatrists per 100,000 population, indicating a shortage of psychiatrists in the County. More broadly, the County has 313 licensed mental health professionals per 100,000 population (full-time equivalent data are not available for all occupations), indicating that the County does not have a shortage in this area.

Comparison Between Estimated Need for Mental Health Professionals and Number of Existing Licensed Professionals in Montgomery County

	Psychiatrists	Any Mental Health Professional
Estimated Need for Professionals Per 100,000 Population*	27	62
Licensed Professionals Per 100,000 Population	33	313
Estimated FTEs per 100,000 Population	21	NA*

* Data on full-time equivalents for professionals other than psychiatrists were not available

It is important to note that these data do not include information on whether providers accept public or private health insurance or on the language skills of providers. Stakeholders report that many behavioral health providers, particularly psychiatrists and child psychiatrists, do not accept reimbursement through private or public insurance, thereby requiring patients to pay for the full cost of care out of pocket. Additionally, psychiatrist costs are often prohibitively high for many community-based programs to provide these services to their clients. Finally, numerous stakeholders reported difficulties in recruiting bilingual behavioral health professionals, who are needed to serve individuals with limited English proficiency.

Finding #12: Behavioral health treatment facilities in Montgomery County include specialized behavioral health outpatient, residential, inpatient and crisis facilities as well as hospital emergency departments and Montgomery Cares clinics. However, existing facilities do not meet the needs of all residents who require behavioral health services.

Individuals can receive a variety of different types of outpatient, residential and inpatient care in behavioral health treatment facilities. OLO compiled data from various sources to provide an inventory of behavioral health facilities in Montgomery County, as summarized in the table below. The table lists bed space or treatment slot capacity where it was available, but in many cases only data on the numbers of facilities were available.

Montgomery County Behavioral Health Treatment Facilities Data Summary

Setting	Available Data Points
Outpatient	• 19 mental health facilities • 24 substance abuse facilities • 138 slots in hospital-based intensive outpatient or partial hospitalization programs
Residential	• 11 mental health facilities • 4 substance abuse facilities • 168 beds in two residential treatment centers for children and adolescents • 382 residential rehabilitation beds for serious mental illness
Inpatient	• 89 inpatient psychiatric beds in three general hospitals • 106 staffed beds in one private psychiatric hospital • Four general hospitals providing inpatient substance abuse detoxification or treatment
Crisis	• DHHS 24-hour crisis services include two crisis hotlines, a walk-in crisis center, two mobile crisis teams and residential crisis services • The MCPD's Crisis Intervention Team responds to crises in the community
Other health institutions	• Five general hospitals have a combined total of 256 treatment spaces in emergency departments, which treat individuals experiencing behavioral health crises • The Montgomery Cares Behavioral Health Program provides behavioral health services delivered by primary care physicians to uninsured adults in six clinics at 12 sited

Finding #13: Individuals with low-incomes who are not eligible for Medicaid have limited payment options at many behavioral health treatment facilities in the County.

Survey data show that Medicaid was the most commonly accepted form of payment at both mental health and substance abuse outpatient treatment facilities in the County, with most facilities accepting this form of payment. Fewer facilities reported accepting Medicare, private insurance or offering payment assistance or a sliding fee scale, as shown on the table below.

Payment Options or Insurance Accepted at Outpatient Behavioral Health Facilities in Montgomery County

Payment/Insurance Category	Mental Health Facilities	Substance Abuse Facilities
Medicaid	19	18
Medicare	13	9
Private health insurance	12	13
Payment assistance/sliding fee scale	4	11
Total # of Listed Facilities	**19**	**24**

These data are consistent with feedback from stakeholders, who reported that low-income individuals who are not eligible for Medicaid, including undocumented immigrants and certain elderly individuals and individuals with disabilities, are often unable to access services. Significantly, even individuals with Medicare or private insurance are frequently required to pay significant out-of-pocket costs to access behavioral health services, and find that their plan does not cover the services they need and/or that providers do not accept their insurance.

Finding #14: Limited capacity of inpatient facilities and special housing impacts individuals with serious behavioral health disorders. Stakeholders report that a need exists for more services designed to support this population living in the community.

Multiple stakeholders reported that limited bed capacity in State psychiatric hospitals and limited availability of special housing such as residential rehabilitation programs, supportive housing and group homes contribute to a gap in services for individuals with serious behavioral health disorders. For example, the table below displays placements and average waiting list size for DHHS' residential rehabilitation program, which includes 382 beds across the County. Program placements have remained steady except for a dip in FY12. The average monthly waitlist has declined since FY12; however, the size still reflects an overall lack of program capacity.

DHHS' Residential Rehabilitation Program (RRP) Activity Data, FY11 to FY15 Year to Date

Indicator	FY11	FY12	FY13	FY14	FY15 YTD
Annual number of individuals placed in a RRP	74	53	82	88	39
Average number of individuals per month waitlisted for an RRP placement	147	172	113	70	80

Source: DHHS Monthly Activity Reports, FY11 to FY15

Stakeholders state that a need exists for more services designed to support this population living in the community and their access to community-based behavioral health and other necessary services. The specific service needs stakeholders mention in this category include case management, Assertive Community Treatment, Health Homes, Wraparound, and care management systems.

Finding #15: Hospital emergency departments and DHHS's numerous crisis services play a key role in serving individuals experiencing behavioral health crises. However, stakeholders report that existing services do not meet the growing need and that better coordination is needed between hospitals and community providers.

DHHS's array of crisis services includes two crisis hotlines, a walk-in crisis center, two mobile crisis teams, and residential crisis services. MCPD's Crisis Intervention Team is a group of officers who are trained to respond appropriately to psychiatric and other crises in the community. These services are provided 24 hours a day, seven days a week to assist with emergencies or psychiatric crisis. Additionally, hospital emergency departments in five county hospitals are open round the clock to provide medical assistance, including access to

psychiatric stabilization for individuals in crisis. In 2013, County hospitals received 583 visits per 100,000 population for substance use disorders and 1,524 visits per 100,000 population for mental health conditions.

However, stakeholders report that these existing options are inadequate or inappropriate for addressing the needs of individuals in crisis, and police must often detain individuals in crisis due to a lack of appropriate alternatives to incarceration. Additionally, the Crisis Center has experienced steady increases each year in the numbers of MCPS students requiring services, creating an additional strain on existing resources. Finally, stakeholders identify a need for better coordination between hospitals and community providers to ensure that individuals in crisis receive correct medications in the hospital and connect effectively to appropriate follow-up care to prevent readmission to the hospital.

Finding #16: Existing facilities and providers do not always effectively serve individuals with other health/disability needs in addition to behavioral health needs.

A large portion of individuals with behavioral health disorders suffer from co-occurring mental health and substance abuse disorders. Additionally, many individuals experience other health or developmental issues in addition to behavioral health disorders.

In many cases, individuals face barriers to accessing appropriate care. Stakeholders report that more providers are developing the capacity to address co-occurring mental health and substance use disorders, but this remains a major area of need. Additionally, DHHS staff report that residential rehabilitation programs and substance abuse programs lack home health aides or other service supports to address seniors' age-related issues, and that assisted living facilities lack resources to adequately address seniors' behavioral health-related issues. Similarly, stakeholders report that individuals with autism who also have mental health disorders struggle to obtain care from psychiatrists. Finally, individuals with serious behavioral health disorders often face barriers in obtaining care for physical health issues.

The table below displays survey data that shows that more than half of both mental health and substance abuse outpatient facilities in the County reported providing special programs for individuals with co-occurring mental health and substance abuse disorders, but only 2 mental health facilities and 7 substance abuse facilities reported providing special programs for seniors.

Special Programs at Outpatient Behavioral Health Facilities in Montgomery County

Special Programs or Groups	Mental Health Facilities	Substance Abuse Facilities
Co-occurring mental and substance abuse disorders	10	15
Seniors or older adults	2	7
Total # of Listed Facilities	**19**	**24**

CHAPTER XII. Agency Comments on Final Draft

The Office of Legislative Oversight circulated a final draft of this report to the Chief Administrative Officer for Montgomery County. OLO appreciates the time taken by County Government representatives to review the draft and provide comments. OLO's final report incorporates technical corrections and comments provided by County Government staff. The written comments received from the CAO are included in their entirety, beginning on the following page.

OFFICE OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

July 23, 2015

TO: Chris Cihlar, Director, Office of Legislative Oversight

FROM: Timothy L. Firestine, Chief Administrative Officer

SUBJECT: OLO Draft Report 2015-13: Behavioral Health in Montgomery County

I am in receipt of your draft report No. 2015-13, providing a description and an evaluation of the of the behavioral health system in Montgomery County. Your assessment of this program has been thorough, thoughtful, and balanced.

The fact that the report looks at our entire continuum of services -- from wellness and promotion through treatment and recovery -- is especially commendable for two reasons:

- It underscores the broader national and state context in which our system operates and clarifies some forces that make providing behavioral health services and supports so difficult.

- It raises the challenges we face and points to the gaps in our system.

In response to the report's findings, we offer the following comments. Please note that our comments will focus on some of the critical issues the report raises, the implications for future planning and our suggested next steps.

The report provides ample data on the following critical issues:

1. The prevalence of mental illness and substance abuse disorders in the County is significant across all communities -- affluent and less affluent, all races, colors, and creeds. In addition to the data contained in the report, recent data from the State and from the Centers of Disease Control on Opiate overdose deaths underscore this reality.

2. Mental health problems begin in childhood and if left unaddressed intensify into adulthood. It is clear that any efforts to improve the overall mental health of county residents must address the needs of children, youth and their families.

3. Funding for behavioral health has become increasingly fragmented and restrictive -- with a complex array of funding sources and accompanying mandates. While funding exists from many sources, this can sometimes have the effect of limiting coordination and integration of services to those most in need

4. Montgomery County government has historically supported the behavioral health treatment system, helping to close gaps and creating new services as needed. Although health care reform is helping to address the needs of more County residents, the County will continue to face the challenge of serving a large number of uninsured residents.

5. The joint efforts of the County's Police, Health and Human Services, and Correction and Rehabilitation Departments are helping to prevent arrests, to reduce recidivism due to unaddressed behavioral health problems, to provide mental health and addiction treatment services for those who are incarcerated, and to support the reentry into the community of those whose incarceration is ending. We are proud of the work done through these efforts and know that it will continue to find creative ways to divert residents away from jail and into behavioral health services.

6. The county does indeed offer a broad spectrum of services and supports in behavioral health, the most notable being "deep end" treatment services. Both public and private providers combine to address much of the need; but gaps such as housing, care coordination, case management exist. The waitlists for admissions to residential programs and to see psychiatrists are prime examples of capacity problems. These concerns will continue to be a focus of attention as we work with the State, the provider community, and stakeholders in building a stronger system.

7. At the other end of the continuum, our efforts to promote behavioral health or to prevent behavioral health problems are small, fragmented, and the impact is unclear. This is an area that needs additional work to build a more coherent approach to promoting the overall behavioral health of the county's residents.

The report's data on workforce needs additional study:

While the absolute number of professionals in the county appears to be adequate, numerous factors still limit workforce capacity in both the public and private service sectors. Among the most important of these factors are:

- Cultural and linguistic competence.
- Out-of-pocket costs in the form of premiums and deductibles.
- Providers' enrollment in health care panels or willingness to accept Medicaid or Medicare.

Clearly, we need a deeper examination of these and other barriers to identify and address the gaps in workforce that both providers and consumers report.

Our Suggested Next Steps

The OLO team has accomplished a major step in describing the behavioral health system in the county and its many challenges. Through no fault of the OLO team, the report only hints at future directions for behavioral health in the County. We suggest the use of the report as the point of departure for a deeper examination of the county system and the development of a comprehensive plan for meeting current and future needs of county residents.

Again, I thank the Office of Legislative Oversight for its work on this report. If you have questions or need additional information, please contact Uma Ahluwalia at 240-777-1198 or uma.ahluwalia@montgomerycountymd.gov.

TLF:rc

cc: Uma Ahluwalia, Director, Department of Health and Human Services
Fariba Kassiri, Assistant Chief Administrative Officer

LIST OF APPENDICES

APPENDIX A

Summary of Federal Medicaid Rules

Federal Medicaid and CHIP eligibility rules. Federal law requires state Medicaid programs to cover – or make eligible – certain population groups and allows states to cover certain additional groups. The table below summarizes these eligibility rules. There is no specific eligibility category for individuals with behavioral health needs, and individuals that use behavioral health services may belong to any group. Many of the criteria are based on whether a person's annual family income is below a certain percentage of the Federal Poverty Level (FPL). In 2015, the FPL for a family of four is $24,250. Additionally, for most individuals, family income is calculated as "Modified Adjusted Gross Income," or "MAGI," which is generally a household's adjusted gross income from a federal tax return plus any tax-exempt income, such as Social Security Income, that the household receives.[1]

Federal Medicaid and CHIP Coverage Groups

Group	Mandatory	Optional
Children	• Infants born to women eligible for Medicaid • Children younger than 6 years old whose families earn up to 133% of the FPL • Children aged 6-18 whose families earn up to 100% of the FPL • Certain children who receive adoption assistance or are in foster care	• Certain children under age 6 whose families earn more than 133% of the FPL* • Certain children aged 6-18 years whose families earn more than 100% of the FPL*
Adults	• Parents or caretaker relatives of dependent children with incomes at about 41% of the FPL (based on historical criteria for welfare/cash assistance) • Pregnant women whose family income is up to 133% of the FPL • Individuals receiving Supplemental Security Income (SSI), which is a public assistance program designed to help aged, blind, and disabled people with little or no income • Elderly and disabled individuals with limited incomes and resources who also qualify for Medicare ("Medicare-Medicaid enrollees" or "dually eligible individuals") • Former foster care children through age 25 who were enrolled in Medicaid when they aged out of foster care	• Non-elderly, non-pregnant adults with incomes at or below 138% of the FPL (originally mandatory in the Affordable Care Act, but now effectively optional as a result of a Supreme Court decision) • Certain low-income parents who do not qualify under the mandatory group based on historical criteria for welfare/cash assistance • Certain pregnant women with incomes higher than 133% of the FPL • Individuals that are elderly and disabled with incomes below 100% of the FPL • Nursing home residents with low incomes • Certain targeted population groups that receive home and community-based services as part of a State's Medicaid program • Certain individuals who are working disabled • Individuals considered to be "medically needy", meaning those with higher incomes or wealth who have excessive medical bills

Source: Substance Abuse and Mental Health Services Administration. *Medicaid Handbook: Interface with Behavioral Health Services*. HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013, pp. 2-11 to 2-16
*Federal law gives states broad discretion in determining eligibility for their Children's Health Insurance Programs (CHIP), which covers children under the age of 19. 19 states, including Maryland, cover children whose families earn up to 300% of the FPL or more.

[1] "Modified Adjusted Gross Income (MAGI)," HealthCare.Gov website, < https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/ > accessed 2/20/2015; and "MAGI: Medicaid and CHIP's New Eligibility Standards," fact sheet, Center for Medicaid and CHIP Services, U.S. Department of Health and Human Services, September 30, 2013, < http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf > accessed 2/2/2015

As indicated on the table above, the Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all non-elderly, non-pregnant adults with incomes at or below 138% of the Federal Poverty Level. Although federal law indicates that it is mandatory for states to cover this population, the Supreme Court ruled in 2012 that requiring states to cover this group to avoid losing all federal Medicaid funding is unconstitutional. Therefore, it is currently optional for states to expand eligibility to this group of adults.[2]

Federal Medicaid behavioral health services rules. Federal law also specifies categories of services that states are required to cover ("mandatory") and additional categories of services that states may cover ("optional") through their Medicaid programs. No service category includes only behavioral health services, and behavioral health services fall under multiple categories. Moreover, the same types of behavioral health services may be classified under different service categories in different states. The following service categories typically include behavioral health services: [3]

- *Inpatient hospital* services are mandatory to cover and include inpatient psychiatric services in psychiatric units of general hospitals. Inpatient psychiatric services provided in psychiatric hospitals, or "institutions for mental diseases" (IMD), for individuals aged between 22 and 64 *cannot be covered* unless the IMD has 16 beds or fewer – this age restrictions are known as the "IMD exclusion". States have used waivers to bypass the IMD exclusion in specific cases. Inpatient services in IMDs for under age 22 or those aged 65 and older are optional to cover.
- *Outpatient hospital* (mandatory), *Federally Qualified Health Center* (mandatory) and *clinic* (optional) are three service categories that are differentiated based on the provider types, but can include similar behavioral health services such as individual and group therapy, family counseling, intensive outpatient treatment such as day treatment, and medication management.
- *Physician* services are mandatory to cover and include services provided by a psychiatrist or physician specialized in addictions; states can limit the number of visits in a given time period.
- *Prescription drugs* are optional to cover and include drugs used to treat behavioral health conditions.
- *Other licensed practitioner* services are optional and include services provided by psychologists or clinical social workers.
- *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* is a required, comprehensive set of medical services for Medicaid-eligible children and adolescents, including evaluation and treatment of behavioral health problems; EPSDT includes any treatment deemed medically necessary.
- *Other diagnostic, screening, preventive and rehabilitative care* is an optional service category, known as the "rehab option", often used by states to cover recovery-oriented behavioral health services such as therapy, skills training in areas such as independent living and employability skills, recovery support and relapse prevention training. Additionally, intensive services such as partial hospitalization or Assertive Community Treatment, which is a team treatment approach for individuals with serious and persistent mental illness, may be covered under this category. Case management can be a component of services in this category.
- *Targeted case management* services are optional to cover and are restricted to specific eligibility groups (defined by disease or geographic location) selected by states. Case management helps individuals access services including medical care and other community supports, and can coordinate care provided by a team of providers.

[2] *Medicaid Handbook: Interface with Behavioral Health Services*, pp. 7-5 to 7-13
[3] Ibid., pp. 3-1 to 3-14

- *Section 1915(i)* is a category of optional home and community based services (HCBS) that can be used by states to cover services for individuals with behavioral health disorders. HCBS services can include case management, home health aide services, adult day health care, habilitation (services to improve daily living skills), respite care (short-term relief for family caregivers), day treatment, partial hospitalization, psychosocial rehabilitation, and supported employment to help individuals with behavioral health disorders find meaningful jobs.
- *Health homes* is a new, optional category of Medicaid services established by the Patient Protection and Affordable Care Act (ACA). Health homes aim to coordinate care for targeted individuals with chronic conditions, including individuals with serious and persistent mental health conditions, by designating specific providers or teams of providers to act as patients' "health homes". Health home services include care coordination, comprehensive care management, transitional care and follow-up, health promotion, patient and family support, and referral to community social services.[4]

Medicaid financing. The federal government's share of spending on a state's Medicaid program, known as the federal medical assistance percentage (FMAP), varies by state based on criteria including per capita income, and can be adjusted for fluctuations in the economy. The average FMAP for all states is currently 57%. The current FMAP for Maryland is 50%, meaning that, in general, the federal government pays for 50% of costs.

However, the FMAP is different for certain types of costs. For example, the FMAP for enrollees newly eligible as a result of the Affordable Care Act is 100 percent from 2014 to 2016, and will decrease to 90% by 2020. Similarly, the FMAP for health home services, which is a new, optional category of Medicaid service created by the ACA, is 90% for the first two years that a state provides the service. Additionally, the federal government matches state CHIP spending at a rate that is 15 percentage points higher than for Medicaid (the FMAP for CHIP in Maryland is 65%).[5]

Options for structuring state Medicaid programs. Federal law allows states to structure their Medicaid programs in different ways with respect to how beneficiaries can access services and how states pay for services. In particular, states can choose a "fee-for-service" structure, a "managed care" structure, or a combination of the two.

Fee-for-service has historically been the standard framework for states' Medicaid programs. Under fee-for-service, providers (such as physicians and hospitals) deliver services to eligible individuals and then bill states for those services. Eligible individuals can typically obtain care from any provider of their choice, as long as the provider accepts Medicaid reimbursement. Fee-for-service structures have been criticized for creating a financial incentive for providers to deliver a higher quantity of services without regard to quality and for failing to adequately coordinate care for individuals with complex health issues.

More recently, many states have implemented managed care frameworks for all or parts of their Medicaid programs. Under managed care, a state will typically contract with an organization, usually referred to as a "managed care organization" (MCO), to provide services to Medicaid enrollees through a defined network of

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[4] "Health Homes," Medicaid.gov, Centers for Medicare & Medicaid Services, < http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html > accessed 11/18/14.

[5] Ibid., pp. 2-21 to 2-23 and "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP," Kaiser Commission on Medicaid and the Uninsured, September 2012, < http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf >, accessed 11/14/2014; and Centers for Medicare & Medicaid Services, Letter to State Medicaid Directors and State Health Officials Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010, p. 4 < http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf > accessed 12/11/2014.

providers. Managed care structures allow states to transfer risk to MCOs, and the degree of risk that is transferred can vary. In a "full-risk" contract, the state pays the MCO a set fee per enrollee per month, known as a "capitation" payment, and the MCO provides all benefits to enrollees. The MCO must pay for services even if the cost of enrollees' use of services exceeds capitation payments, and can keep or reinvest unused funds if enrollees use fewer services.

To ensure that their Medicaid programs effectively meet the needs of individuals with behavioral health needs, many states with managed care frameworks provide behavioral health services through separate structures, often referred to as "carve-outs," from those used for other medical services. For example, a state with a managed care structure for other medical services may choose to provide behavioral health services through a fee-for-service structure, as is done in Maryland. Alternatively, a state can contract with a specialty MCO that only provides behavioral health services and to which risk can be allocated differently compared with the MCO or MCOs that provide other medical services.[6]

[6]*Medicaid Handbook: Interface with Behavioral Health Services*, pp. 5-1 to 5-4, and "Managed Care, Medicaid and Mental Health Resource Guide," National Alliance on Mental Illness, 2011, < http://www.nami.org/Template.cfm?Section=About_the_Issue&Template=/ContentManagement/ContentDisplay.cfm&ContentID=119135 > accessed 11/14/14.

APPENDIX B

Summary of Maryland Behavioral Health Integration Process

In 2011, the Maryland General Assembly requested that, "the Department of Health and Mental Hygiene (DHMH) convene a workgroup of interested parties to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues,"[1] noting concerns that differences between systems of care for mental illness and substance use disorders result in inefficient delivery of services for these individuals. In that year, DHMH began a three-phase process to develop a model for an integrated behavioral health service delivery and financing system in collaboration with stakeholders including providers, individuals with behavioral health needs, and advocates.

During the first phase of the process in 2011, a consultant conducted structured interviews with stakeholders and produced a report assessing the strengths and weaknesses of the existing system of care for behavioral health in Maryland and options for the future. The report's five conclusions about system weaknesses were: (1) benefit design and management are poorly aligned; (2) purchasing and financing are fragmented; (3) care management is not coordinated; (4) performance and risk are lacking; and (5) integrated care needs improvement. The consultant proposed two alternative models for behavioral health integration to coincide with the implementation of the Affordable Care Act in 2014, described in the table below as models 1 and 2.

Proposed models for behavioral health integration in Maryland

Model	Type	Description
1	Protected Carve-In	Medicaid-financed behavioral health benefits would be managed by the Managed Care Organizations (MCO) that also manage other Medicaid benefits, thereby integrating behavioral health into the Medicaid managed care system.
2	Risk-Based Carve-Out	The State would establish a contract or contracts with one or more Behavioral Health Organizations (BHOs) to manage behavioral health benefits, with insurance and/or performance risk borne by the BHO or BHOs (adopted).
3	Risk-Based Population Carve-Out	Behavioral health benefits would be "carved-in" to the Medicaid managed care system as in Model 1, but a separate contracted entity would manage Medicaid benefits for individuals with serious behavioral health disorders.

During the second phase of the process, DHMH held a series of public meetings and a comment period. A DHMH steering committee produced a report that assessed the integration models proposed by the consultant and examined a third model (model 3 in the table above). Based on its assessment, the steering committee report recommended, and the Secretary of Health and Mental Hygiene accepted the recommendation, to implement the second model, the "risk-based carve-out". The recommendation specifically called for contracting with a single Administrative Services Organization (ASO) to manage behavioral health benefits and allocating "significant and meaningful" performance risk to the ASO and providers. In addition, the Secretary decided to merge the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration into the Behavioral Health Administration (BHA).

During the third phase, DHMH held additional public meetings to obtain feedback on specific issues related to the behavioral health integration model, including financial incentives, quality measures and data sharing. The new ASO contract took effect in January, 2015.[2]

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[1] *Joint Chairmen's Report: Report on the State Operating Budget (HB 70) and the State Capital Budget (HB 71) and Related Recommendations*, 2011 Session, Maryland General Assembly, p. 68.

[2] *Report on Behavioral Health Integrated Service Delivery and Financing System Implementation*, Maryland Department of Health and Mental Hygiene, January 30, 2014, < https://mmcp.dhmh.maryland.gov/Documents/behavioralhealthJCRfinal12-13.pdf > accessed 7/1/2015; and *An Integration Model for Medicaid-Financed Behavioral Health Services*, Recommendation delivered to Secretary Sharfstein, October 1, 2012, < http://dhmh.maryland.gov/bhd/Documents/BHI_Report2012_FINAL.pdf > accessed 7/1/2015

APPENDIX C

Maryland Medicaid Health Homes Program

Health homes are a Medicaid service provided through the PBHS that offers care coordination and care management services to eligible individuals with severe behavioral health disorders. The Maryland Health Homes program was launched in 2013 and benefits from federal incentives established by the ACA.

Maryland's program targets Medicaid populations who either have a serious mental illness or have an opiod substance use disorder as well as risk for chronic conditions due to tobacco, alcohol or other non-opiod substance use. To be eligible, an individual must be enrolled in a DHMH approved psychiatric rehabilitation program (PRP), mobile treatment service (MTS) or an opioid treatment program accredited as a health home provider. In exchange for a monthly per capita fee, a provider must provide each enrollee with a dedicated care manager and two services per month from one of the following six service categories: comprehensive care management; care coordination; health promotion; comprehensive transitional care; individual and family support services; and referral to community and social support services.

Last October, a report prepared by the Hilltop Institute ("The Hilltop Report") provided data for first year of the Health Homes Program.[1] In its first year, the Health Home program had a peak enrollment of 4,252 individuals. Individuals with a mental health diagnosis accounted for 92% to 98% of participants each month; those with a substance use disorder accounted for 24% of monthly participants. Obesity, present in 75% to 79% of monthly participants, was the most common secondary chronic condition. A key anticipated outcome of health home programs is reduced hospitalizations and emergency department use as a result of shifting participants toward integrated and comprehensive care.

The Hilltop Report provides descriptive data on inpatient hospital admissions and emergency department visits of health home participants. With respect to hospitalizations, during year one, 77.5% of participants had no inpatient hospital admissions. 13.4% of participants had one inpatient hospital admission and 9% had two or more. 10.8% of hospitalized participants had at least one potentially avoidable hospitalization. About half of all participants (52.7%) had at least one emergency department (ED) visit, and 22% of all participants had three or more emergency department visits. The report estimates that 40% of all ED visits could have been avoided with timely primary care while 21.8% were not avoidable. Mental health diagnoses accounted for 20.5% of all ED visits, compared to 0.5% that were drug related. The Hilltop Report does not provide conclusions regarding the effectiveness of the health homes program compared with regular Medicaid because sufficient data are not yet available.

[1] http://dhmh.maryland.gov/bhd/Documents/Health%20Homes_Annual%20Report%2010-31-2014.pdf