HHS Committee #1
October 8, 2015
Worksession

MEMORANDUM

October 6, 2015

TO: Government Operations & Fiscal Policy Committee

FROM: Natalia Carrizosa, Legislative Analyst
Sue Richards, Senior Legislative Analyst
Office of Legislative Oversight

SUBJECT: **Office of Legislative Oversight Report 2015-13 *Behavioral Health in Montgomery County***

The Council released Office of Legislative Oversight (OLO) Report 2015-13: *Behavioral Health in Montgomery County* on July 28, 2015. The report responds to the Council's request for a report that examines the public and private resources directed toward behavioral health in the County. The Executive Summary for Report 2015-13 appears on ©1-4 and is followed by responses from the Chief Administrative Officer (©5-7) and the Co-Chairs of the Healthy Montgomery Behavioral Health Task Force (©8-14).

The purpose of this worksession is for the Health and Human Services Committee to consider the findings of Report 2015-13. At the worksession, OLO will present an overview of the report. The following representatives of the County Government, Montgomery County Public Schools, and the behavioral health community will be available at the worksession to provide comments and answer questions:

Department/Agency/Organization	Representative
Department of Correction and Rehabilitation	Gale Starkey, Acting Warden
Department of Correction and Rehabilitation	Anthony Sturgess, Medical Director
Department of Correction and Rehabilitation	Dr. Lauren Campbell, Mental Health Services Program Administrator
Department of Health and Human Services	Dr. Raymond Crowel, Chief, Behavioral Health and Crisis Services
Healthy Montgomery Behavioral Health Task Force	Kevin Young, Co-Chair
Mental Health Association of Montgomery County	Scot Marken, CEO
Montgomery County Public Schools	Chrisandra Richardson, Associate Superintendent for Special Education and Student Services
Montgomery County Public Schools	Debra Berner, Director, Department of Student Services

The remainder of this packet summarizes OLO's findings.

SUMMARY FINDINGS

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 stakeholders with knowledge of behavioral health services in Montgomery County. This section summarizes the findings of the report:

- 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. 70,000 youth and adults experienced a substance use disorder in the past year, including 25,000 adults with a co-occurring mental health disorder.
- In 2013, nearly 77%% of Montgomery County residents had private health insurance coverage, 23% had public coverage, and 11% were uninsured (percentages add up to more than 100% because some individuals hold more than one type of coverage). Recently released data from the 2014 American Community Survey data show that the percentage of uninsured decreased to approximately 10%.
- 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.
- Of the approximately 775,000 County residents who held private health insurance plans in 2013, about half held plans subject to rules that require coverage of specific behavioral health services.
- 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 a lack of sufficient alternatives to incarceration for this population.
- MCPS, the County Government and various community organizations provide behavioral health promotion and prevention activities that are targeted at specific populations, primarily among school-age children and youth. Additionally, a variety of community organizations and groups in Montgomery County offer support for individuals in recovery from behavioral health disorders.
- 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 professionals, particularly psychiatrists.
- Individuals with low-incomes who are not eligible for Medicaid have limited payment options at many behavioral health treatment facilities in the County.
- 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.
- 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.
- Existing facilities and providers do not always effectively serve individuals with other health and disability needs in addition to behavioral health needs.

LIST OF ATTACHMENTS

Item	Begins at:
Executive Summary of OLO Report 2015-13 – *Behavioral Health in Montgomery County,* July 28, 2015	©1
Memorandum from Timothy Firestine, Chief Administrative Officer, July 23, 2015	©5
Response from Kevin Young, Co-chair of the Healthy Montgomery Behavioral Health Task Force, July 23, 2015	©8
Response from Thom Harr, Co-chair of the Healthy Montgomery Behavioral Health Task Force, July 23, 2015	©10

Behavioral Health in Montgomery County

OLO Report 2015-13 July 28, 2015

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.

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: for 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

Adventist HealthCare
Behavioral Health & Wellness Services

July 23, 2015

Dear Mr. Crowel,

Per your request, I am providing my initial response to the Office of Legislative Oversight (OLO) report.

I would like to thank Montgomery County Councilmember George Leventhal for authorizing the OLO report. Natalia Carrizosa and Sue Richards have conducted a thorough study, and like any good study, they have identified additional questions we need to address. The study creates a great framework for further dialog and in-depth research on their identified findings.

In general, the OLO report offers a great overview of the complex behavioral health system in Montgomery County. It accurately describes the fundamental information that makes up this system, however, it lacks the depth behind the statistics. There is tremendous value in understanding the detail regarding the characteristics of Montgomery County and the realities of behavioral healthcare for the diverse population of the County. The scope of the report does mention addressing the collaboration within those identified resources and the gaps of those resources. More time is needed for the OLO to further assess and describe their findings so that it captures the political limitations and opportunities, existing and potential collaborations, and potential expansion of resources to ensure adequate behavioral health services that meet the need of a large disparate population.

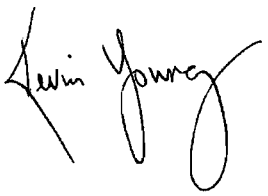
The findings also create the foundation for further discussion and collaborative planning between private and public providers. Leveraging the current work the Healthy Montgomery Behavioral Health Task Force is doing and augmenting the stakeholders involved, the Task Force can broaden its scope to support the Behavioral Health Division of the Department of Health and Human Services. Based on the current findings, some of the opportunities to collaborate might include joint recruitment of bilingual professionals and additional psychiatrist as well as identifying the gaps in access to service and creative ways to fill those gaps. We can also explore the development of a mental health court to ensure that those individuals who are arrested for minor crimes that appear to be attributed to a mental health or substance abuse problem receive treatment rather than being directed to our correctional system.

There is a need to focus further on how behavioral services in Montgomery County are funded. There is also a need to collaborate to support the amendment to the Health Choice 1115 demonstration that would allow for Medicaid payments for services in Institutions For Mental Disease (IMD) exclusion waiver. If the IMD waiver goes away it further limits access to less costly acute care for adult psychiatric

patients between the ages of 21 to 65. Medicaid currently will not cover this service provided outside of a general hospital with psychiatric services.

In summary, the initial findings in this report are valuable in helping to identify the behavioral health needs in Montgomery County. As more data is gathered, I look forward to participating in additional discussions about implementing a plan to address the gaps in care and expand access to behavioral health services.

Sincerely,



Kevin Young, FACHE
President, Adventist HealthCare Behavioral Health & Wellness Services
Co-chair, Healthy Montgomery Behavioral Health Task Force

Thom Harr's Musings on the OLO report

Summary: We need to develop increased availability and diversity of housing, especially increasing residential rehabilitation; implement a mental health court; train more professionals who are willing to serve in the public system, particularly bi-lingual and bi-cultural persons; implement a care management system for higher end users; develop mental health capacity at critical points in the community (housing and unemployment sites); and do a much better job of addressing trauma in the lives of the people we are assisting.

The Long Version

Wow! The OLO report is a *tour de force* in the quantification and description of the behavioral health service system in general and specifically in Montgomery County. The level of complexity and detail has provided absolute clarity for me on why I have had a low grade head ache since I came into this arena about 28 years ago.

It accurately describes a fairly robust level of resources for which we can all be grateful but, as with any report from the outside looking in, doesn't emphasize quite enough the short comings of the system as perceived by the people working within. However, it did effectively highlight several that are, in my mind, persistent over a long period of time and continuing.

INCIDENCE AND PREVALENCE: The OLO report is extremely thorough and does a great job of quantifying need in our community. I would add one observation that I believe is significant. Studies I have seen in the past indicate that the incidence and prevalence of anxiety and depression disorders in impoverished populations is roughly triple that of the population as a whole. To the extent that one of the most rapidly growing portions of our population is people living in poverty (look at the FARMS rates) we are probably underestimating the need. The PCC behavioral health effort is likely to be the best place to observe this and establish validity of the assertion. They see more people in poverty, more minority patients, and more of the uninsured. I think it would be worth exploring further as the interventions are quite different than for those at the higher end of BH service needs.

HOUSING: The conclusions regarding housing are critical. Stable housing is not only important for the obvious need to provide shelter but it can also mitigate symptoms of mental illness, as does stable employment, and a dependable safety net of services with access to food and health care.

I did not recall seeing much on the State cap on residential rehabilitation services slots that has existed for well over a decade. During this period there have been several increases for specific projects to reduce the census at State hospitals, but little growth to account for the consistent increase in overall population. As the OLO report

demonstrates, the incidence and prevalence of BH disorders is relatively consistent and well known. We have a burgeoning population so demand is up. That was reflected in one or two references to recent spikes in demand.

Certain sub-sets of persons needing housing should be factored in to some quantification of the short fall. For example, at Family Services we have been dealing with people deemed to be "frequent flyers" (n=700) for hospital utilization as determined by the discharge units of the Adventist Hospitals (Holy Cross Hospitals have recently been added). About 66% of the referrals have a behavioral health diagnosis and most a co-occurring somatic medical condition. Nearly all have social-economic factors influencing their health care utilization.

We have observed two major areas of difficulty in providing stability, the lack of housing and the presence of substance abuse disorders. At the same time, many are not eligible for the public mental health system or the housing provided. This represents another range of housing need and the integration of both behavioral health and primary care into the setting. OLO did accurately report the move to integration in these areas and the need for more progress. That won't be particularly successful without more housing units.

CRIMINAL JUSTICE: OLO did a great job of describing the issues here and the services in place. We need to continue working on options including a mental health court (apparently now scheduled for early 2016 though I did not see that in the report), sequential intercept, and the transition from corrections to community.

SEQUENTIAL INTERCEPT IN A BROADER CONTEXT: This concept is not only important for the criminal justice system but for the system as a whole. Simply put, early intervention is more effective and less costly than awaiting the full development of crisis and then intervening. Given that every single resident has both mental health and mental illness in some form ranging from a bad day to a chronic and debilitating illness it is hard not to gear up for the late and obvious stage of BH problems.

At the same time, I think there are some obvious places in the community where there is the intersection of daily life and BH problems. A couple that I see as obvious are work force/unemployment related situations and housing counseling. Persons experiencing loss of employment or threatened with loss of a home have a very direct challenge to their BH. In one brief period during the recent "Great Recession" Family Services had three patients commit suicide in the face of eviction of foreclosure. These were individuals with well-established diagnoses of serious mental illness but for them loss of housing or the fear of it was the last straw.

While this is the high end, the housing counselors on our campus reported may BH related issues. People unable to stop crying, husbands and wives in heated argument with blame for the loss of housing, depression, and anger. The counselors themselves had a high degree of stress as they went from helping people to purchase a home to working almost exclusively with people losing one.

Some distribution of mental health professionals to key areas would have been especially helpful. The OLO report reference mental health first aid a number of times and that too is one of the tools that could be greatly increased to allow for this intervention in other locations as needed.

PROVIDER AVAILABILITY: This is a particularly difficult area to fully understand and quantify. OLO correctly notes throughout that the number of BH professionals reported to work in Montgomery County does not include a distinction between those who accept insurance and those who do not. Also, the report doesn't cover and probably could not cover the many barriers to BH professionals who are willing to accept Medicare and Medicaid clients. These include increased administrative requirements, electronic records, electronic billing, delays in payment, and the challenges involved in serving people with very challenging socio-economic circumstances along with their BH issues. In short, it takes motivated providers to be willing to deal with this sub-set of the population.

Our experience over the years has been that psychiatry for public mental health or services to the poor is in short supply. While I can't provide the research to prove my belief that many doctors and therapists simply opt to take no insurance and focus on patients with financial means, I think the maps showing distribution in the County support my perception of the system. The concentration of doctors in the lower county, Bethesda and Chevy Chase, puts them in relatively expensive territory for offices and residences. It also places them among a population more likely to have financial means. It completely reinforced my oft expressed belief that many psychiatrists, especially child and adolescent psychiatrists, opt for private pay patients as it means a better quality of life for themselves, a patient population that is receiving support from family and community, and a significantly reduced administrative burden in terms of billing, court appearances, pre-authorization, and so forth.

While OLO clearly referenced the shortage of certain language capacities in the system I believe the issue can't be overstated. We are the most diverse County in Maryland and are probably leaders in the country as a whole. Each wave of immigration brings not only language requirements but cultural challenges in the provision of BH services. Our medically driven system's need for diagnostic clarity often serves as a barrier to groups with cultural biases against BH issues. That makes these services hard to fund and to deliver.

There is a corollary to the language issue that I believe is also important and that is the quality of the services provided. As we move services to cultural sub-groups the standards of care are not the same. They are not governed by the more comprehensive standards of a certified outpatient mental health clinic. The shortage of personnel may lead, and I believe does lead, to the provision of services by persons with less experience and training. Moving people up the professional ladder is critical to ultimately providing not just culturally comfortable services but clinically excellent services. I referenced earlier the need to overcome cultural barriers and population specific

organizations are a huge factor but they need to recruit, pay, and supervise the best trained people possible. That may not be well supported by the current system.

One final note on provider availability and preparation! The OLO report addressed the incidence of disease but I don't believe it emphasized the number of people with BH who are victimized, nor did it address the level of trauma in the general population. We live in an era when violence is on the rise. People commit unspeakable acts, others observe those acts or are the victims of those acts; sexual assault and abuse are widespread issues; and, we hear the news about gun violence as if it were no more than part of today's weather report. There is always weather of some sort and it seems there is always violence of some sort as well. Treating those who have experienced severe trauma is a specialty care issue. We need to ensure that we have people trained to handle this in conjunction with mental illness or substance abuse.

THE MISSING PIECE: Everyone who responds will have something a little different to fill in as the answer to this question. I believe it is CARE MANAGEMENT!!! The OLO report references care management but doesn't include a lot of detail. There are places we can go to look for that detail including the federal Administration for Health Research and Quality (AHRQ).

While there are more pieces missing than just care management –housing, mental health court, possibly a "restoration center", work force development – I happen to see this as the best way to make use of what we already have and to incorporate any gap filling additions.

Most of us have been around to hear numerous references to the high cost of US health care and yet less impressive outcomes than other countries. We reference a national system driven by payment for acute care treatment and the belief that we have not placed enough emphasis on outcome. The general belief is that we are now moving in a global way to implement a chronic care model with emphasis on long term outcomes (as one might imagine for the management of chronic diseases like diabetes of COPD).

At the same time, current theory on the "social determinants of health" would suggest that about 80% of health status is not based on medical care but other factors that include opportunity, education, employment, housing, nutrition, nurturing environments, early care including pre-school education and similar components of life. We also know that many people have diminished cognitive function when facing a crisis. In the world of health and human services we would simply say people get overwhelmed by the issues in their lives and find it difficult to access services or take corrective actions that would improve their quality of life.

For some of us fortunate enough to have a doctor or nurse in the family or just well-educated and well informed people among our family and friends we can find support in a crisis. However, in a mobile society including one containing many new residents from other lands, that traditional circle of support doesn't exist. A care manager can become that link that you need.

Also, the complexity of the OLO report alone is enough to suggest how difficult it is to understand and navigate the system, even if it has fairly robust services. In the acute care model, payment for care management has not been available at the level of need. In the evolving model, there is increased interest in supporting this. People absolutely do get lost between providers, fail to follow through, and suffer needlessly. Care management can't solve every problem but it can optimize using what we have and getting people through a crisis and on to stable management of their lives and health.

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