HHS COMMITTEE #5
April 28, 2016

WORKSESSION

MEMORANDUM

April 26, 2016

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Worksession:** FY17 Recommended Operating Budget
Department of Health and Human Services
Behavioral Health and Crisis Services

Those expected for this worksession:
Uma Ahluwalia, Director, Department of Health and Human Services (DHHS)
Dr. Raymond Crowel, Chief, DHHS Behavioral Health and Crisis Services
Patty Stromberg, DHHS Management and Budget
Rachel Silberman, Office of Management and Budget

Behavioral Health and Crisis Services

Excerpts from the County Executive's Recommended Budget for Behavioral Health and Crisis Services are attached at © 1-6.

Behavioral Health and Crisis Services FY17 Budget Overview

For FY17, the Executive is recommending funding of $43,781,449 for Behavioral Health and Crisis Services (BHCS). This is a 2.9% increase from the FY16 approved budget of $42,536,067 for this service area. The following table shows budget trends since FY13.

Behavioral Health and Crisis Services Expenditures in $000's	FY13 Budget	FY14 Budget	FY15 Budget	FY16 Budget	FY17 Rec	Change FY16-17
Behavioral Health Planning and Management	9,019	7,820	7,854	8,087	8,624	6.6%
Access to Behavioral Health	3,303	3,213	3,566	3,648	3,712	1.8%
Treatment Services Administration	2,762	5,591	5,655	5,905	6,521	10.4%
Forensic Services - Adult	1,988	2,062	2,329	2,375	2,201	-7.3%
Outpatient Behavioral Health Services - Adult	3,326	3,127	3,211	3,239	3,309	2.2%
Outpatient Behavioral Health Services - Child	5,573	5,489	5,512	5,582	5,521	-1.1%
Trauma Services	4,782	4,660	4,766	4,960	4,966	0.1%
24-Hour Crisis Center	4,252	3,997	4,505	4,825	5,064	5.0%
Seniors/Persons w Disabilities Mental Health Services	675	763	775	787	787	0.0%
Specialty Behavioral Health Services	2,293	2,139	2,436	2,568	2,513	-2.1%
Service Area Administration	570	586	615	562	564	0.4%
TOTAL	**38,543**	**39,447**	**41,224**	**42,538**	**43,782**	2.9%

Background Information – Testimony/Priorities from the Mental Health Advisory Committee and Victim Services Board

1. **Alcohol & Other Drug Abuse Advisory Council (© 7-12)**
   - Support funding for sober and stable housing options for inmate being released from jail that have gone through treatment programs.
   - Institute alcohol and drug use prevention and awareness programs beginning in elementary school and continuing through the secondary education level.

4. **Mental Health Advisory Committee (MHAC) (© 13-17)**
   - Support full year funding for the children's crisis stabilization team.
   - Increase funding in the base budget to reduce personnel lapse to help the Department meet demand in county clinics and the crisis center.
   - Explore creative ways to increase providers for specific populations in the light of the elimination of State funding.
   - Minimize cuts to non-profit organizations. Replace State funding for Collaboration Council to Support Family Navigation, Pathways to Services, and Youth Service Bureaus.
   - Create a county-wide coordinated system of care for adults.
   - Continue to advocate for more deflection and diversion program along the criminal justice continuum, from a restoration center to a mental health court.

The priorities memo notes that the MHAC is working with DHHS to create a comprehensive strategic plan for behavioral health.

3. **Victim Services Advisory Board (VSAB) (© 18)**
   - Resolve housing issues for domestic violence victims and their families by providing permanent, long-term housing with case management.
   - Make the VSAB an information resource for the public on victim services available in the County. VSAB has fashioned a new public awareness campaign and is working to assemble a directory of services.

CE Recommended Changes by Program

A. 24-Hour Crisis Center

For FY17, the Executive is recommending $5,064,678 for this program that provides telephone, walk-in, mobile crisis outreach, and residential services to people experiencing a situational, emotional, or mental crisis. The Crisis Center provides services 24 hours a day, seven days a week. It works to provide assistance in least-restrictive environment. It also provides services during disasters and community critical incidents.

1. Annualization of Contract for In-Home Stabilization Services (Contract for Mobile Crisis Team for Children and Adolescents) $200,000

The Council added funding for this Crisis Team after discussion with Dr. Crowel about the significant growth in referrals from Montgomery County Public Schools (MCPS) to the Crisis Center and considering the recommendation from the Mental Health Advisory Committee. The program is intended to (1) respond to youth in psychiatric crisis via mobile outreach; and (2) provide in-home and community based intensive follow-up to stabilize youth while preventing unnecessary hospitalizations or risks to safety.

While implementation was delayed, DHHS has provided the following up-date that says the services became operational April 11th:

> The contract for the Child & Adolescent In-Home Stabilization Service was executed with Family Services, Inc., effective January 1, 2016. Since that time, the agency has worked on developing the program and hiring staff. The program has a program director, and has hired a therapist and two in-home stabilizers. The program is now operational and began to accept referrals from the Crisis Center on Monday April 11, 2016. All referrals from DHHS, MCPS, and Police go through the Crisis Center to ensure that the child can be served safely in a non-institutional setting and that the family is willing to engage in the clinical process. There is no requirement for the contract to bill at this time.

The updated School Referral Report is attached at © 19-20. While the total number of referrals went up from FY14 to FY15, last year at this time there had been 815 total referrals while this year's report shows 767 for FY16. However, the number of schools that had referred this time last year was 115 while this year's report shows 136 for FY16. Most referrals are from

middle school. Unfortunately, referrals for "harm to self" have continued to increase from 362 in FY11 to 812 in FY15.

Council staff recommendation: **Approve as recommended by the Executive.**

2. Decrease Cost of Mental Health Association Emergency Preparedness Contract ($20,000)

As a part of the FY16 Savings Plan, the Council approved the elimination of this emergency preparedness program (but shifted some of the funding to the hotline). This reflects the FY16 action.

Council staff recommendation: **Approve as recommended by the Executive.**

3. Multi-program Adjustments
$59,787

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

B. Behavioral Health Planning and Management

For FY17, the Executive is recommending funding of $8,623,640 for this program area that houses services required of DHHS as the State-mandated local mental health authority (Core Service Agency). This program area provides programming for people with serious persistent mental illness and serious emotional illness and the development of the continuum of care that is focused on recovery and allowing people to live in the least restrictive clinically appropriate setting. Special populations include people with co-occurring disorders, homeless people, and people who are on conditional release from incarceration. Contract monitoring for all contracts in this service area are a part of this program.

1. Alcohol and Drug Administration Federal Treatment Grant
$240,000

This funding helps to implement a Local Addictions Authority (that is required by the State and similar to a Core Service Agency for substance abuse and addictive disorders. DHHS provided responses to the following questions.

What specifically will this new funding be used for? Is the new funding in addition to funding in the base? If so, what is the total FY17 funding?

The $240,000 funds two therapist positions to investigate complaints; monitor correction of provider deficiencies related to quality service reviews; problem solve difficult client situations; assist the Behavioral Health Administration (BHA) and Beacon Health Options in placing individuals in need of behavioral health treatment; and, develop a provider network that meets the treatment needs of the community.

This is supplemental funding to the FY16 budget that is expected to continue in FY17. The FY17 award letter includes the same $240,000 for the Local Addictions Authority (LAA).

LAAs are required to submit a plan to the State. What is the status of plan development?

The LAA FY17 plan was submitted to BHA in March 2016.

Council staff recommendation: **Approve as recommended by the Executive.** Council staff suggests the Committee schedule a later discussion to review the information on opiate overdoses and deaths, the Local Addictions Authority Plan, and the work of the Overdose Fatality Review Team. At that session, the HHS Committee could also review the range of treatment programs that are in place and the need for some to have recovery housing/sober housing after treatment.

Update: Local Overdose Fatality Review Team

DHHS has provided the following update on the Local Overdose Fatality Review Team (MCOFRT).

- The MCOFRT held its first meeting with identified and recruited community members and professionals in March 2016.

- The group is tasked with:
  - Promoting cooperation and coordination among agencies involved in investigations of drug overdose deaths or in providing services to surviving family members.
  - Developing an understanding of the causes and incidence of drug overdose deaths in the county.
  - Developing plans for and recommending changes within the agencies represented on the local team to prevent drug overdose deaths.
  - Advising the Department on changes to law, policy, or practice, including the use of devices that are programmed to dispense medications on a schedule or similar technology, to prevent drug overdose deaths.

- Team membership may include the following or his or her designee:
  - County health officer
  - Director of local department of social services

- The state's attorney
- The superintendent of schools
- A state, county, or municipal law enforcement officer
- The director of behavioral health services in the county
- An emergency medical services provider
- A representative of a hospital
- A health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders
- A representative of a local jail or detention center
- A representative from parole, probation, and community corrections
- The secretary of juvenile services.
- A member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer.
- Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.

- The Panel decided to officially begin reviewing fatality reports once the State Chief Medical Examiner releases the next quarterly report within the next 30 days. Once the report is made available the panel will select a number of fatality reports for review. The Current plan is to meet every other month to conduct reviews.

2. Annualization of Shared Outpatient Psychiatrist
$110,000

The Council added $165,000 in expenditures and assumed $99,000 in offsetting revenues in FY15 to begin this initiative to partner with non-profit providers to increase psychiatric capacity. The Executive did not move forward with this item in FY15 and it was expected to begin in January 2016. Director Ahluwalia has previously told the Committee that recruitment has not been successful. DHHS has provided the following update.

After two rounds of solicitations, we were unsuccessful in our efforts to recruit a psychiatrist. In addition to the solicitations, we also sent out an invitation to over 500 area psychiatrists to discuss opportunities within the county. A total of 9 doctors attended the meeting. The primary reason for a lack of interest in this contract is salaries that are no longer competitive in this area. For example, the State Department of Health and Mental Hygiene is offering $310,000 annually for a psychiatrist on the Eastern Shore. Across the country, the rates are now well above $300,000 per year. Our current full time personnel costs (salaries and fringes) for psychiatrists in the county are between $225,000 and $246,000 annually, including benefits.

The following actions are underway to remedy this issue:

- The Office of Human Resources is undertaking a wage review for county employed physicians.

- We are exploring the possibility of hiring Psychiatric Nurse Practitioners, with prescribing privileges. There are growing numbers of Practitioners and they can be contracted at lower rates.
- We are working with members of the Mental Health Advisory Committee to explore alternative means of delivering psychiatric services (e.g., tele-psychiatry).

- Please confirm that total expenditures are $220,000 and that there is still an assumed 40% offset from revenue ($88,000).

  Because there is not a contract for shared outpatient psychiatrist, we are unable to project any revenue collection.

Council staff recommendation: **Council staff suggests that the Committee discuss this funding ($220,000) in the context of the wait list for Spanish speaking mental health services at the Child and Adolescent Clinic. Perhaps it is better to use these resources for a different service, given the difficulty in implementing this proposal and as there will be no off-setting revenue.**

3. Multi-program Adjustments
$186,580

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

Issue: Funding for Family Navigation

The Council has received correspondence asking that a shortfall in State funding for several programs be replaced. One of those programs is the Family Navigation program. The Executive's budget includes $60,000 for this purpose but it does not show as a separate item in the program portion of the document.

Issue: Funding for Implementation of Healthy Montgomery Behavioral Health Task Force Recommendations

Healthy Montgomery has been working to create a coordinated system of care in Montgomery County that includes enhanced information for the public and providers and protocols to facilitate the transfer of clients from institutional settings (hospitals, jails, schools, etc.) to community-based behavioral health services. The March 2016 summary of these

recommendations is attached at © 21-27. Last year, the Committee discussed the plan, which was then still in final development, with Dr. Crowel and Director Ahluwalia.

The first recommendation is to update InfoMontgomery so that it is an accurate, relevant, and updated inventory of behavioral health services that has improved usability and accessibility. Two specific costs associated with implementing this recommendation are additional staff time ($17,500) and licenses for iCarol software ($7,000).

Council staff recommendation: **Place $24,500 on the reconciliation list to update InfoMontgomery as recommended in the Healthy Montgomery BHTF report.**

Issue: Inflationary Adjustment to Residential Treatment Providers

As with the DD Supplement, the County provides a supplement to residential treatment providers for adults with serious mental illness. For FY17, the Executive has not included any increase in the funding for this supplement.

Residential Treatment	FY13	FY14	FY15	FY16	FY17
Community Connections	50,647	52,166	53,731	54,805	54,805
Family Services Inc.	221,441	228,084	234,926	239,624	239,624
Rock Creek Foundation	73,381	75,582	77,849	77,849	77,849
St. Luke's House/Threshold*	321,970	661,250			
St. Luke's House/Threshold*	329,020	-			
Cornerstone			681,088	694,709	694,709
TOTAL	**996,459**	**1,017,082**	**1,047,594**	**1,066,987**	**1,066,987**

*St. Luke's and Threshold services are now provided by Cornerstone Montgomery

Council staff recommendation: **Approve (3) three of 1% each $10,670 for a total of $32,010 on the reconciliation list to provide an increase. This is consistent with the HHS Committee recommendation for an increase to non-profit providers.**

C. Service Area Administration

For FY17, the Executive is recommending $564,069 in this program that includes service wide administration.

1. Multi-program Adjustments
$2,404

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

D. Mental Health Services for Seniors and Persons with Disabilities

For FY17, the Executive is recommending $786,699 for this program that provides outreach mental health services for seniors who cannot or will not access office-based services as well as working with stressed caregivers. The program also provides mental health services to people who are hearing impaired.

1. Multi-program Adjustments
$7

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

E. Treatment Services Administration

For FY17, the Executive is recommending $6,520,615 for this program area that manages the federal and state alcohol and drug assistance grant and Medicaid funded community based programs. The program oversees the addiction continuum of care by private providers.

1. Alcohol and Drug Abuse State Treatment Grant – Avery Road Treatment Center
$213,954 (Grant Fund)
2. Avery Road Treatment Center Operating Contract
$213,954 (General Fund)

Last year, the Committee discussed the funding for Avery Road Treatment Center and was informed that the contract for ARTC services would be going to bid. The Committee agreed that any issue regarding additional funding should be handled through the competitive bidding process.

The Executive's operating budget includes a $427,908 increase for Avery Road ARTC. It is expected that half will be funded by the State. This funding is for operating of the ARTC program. The Council has also reviewed and tentatively approved the public-private partnership part of the new contract for the construction of a new Avery Road Treatment Center. The following table shows the FY16 funding. The Council is being asked to provide additional appropriation so that the new FY17 contract can be executed. The capital and operating contracts are linked. In exchange for contributing to and managing the construction of the new Avery Road Treatment Center the vendor will have a 30-year agreement to operate the program. There are clauses for default or reclaiming the facility but it is expected to be a 30 year agreement. The contract has not yet been executed, but it is expected the award will be complete in the next few weeks. The County will continue to pay for 49 beds at the facility for

placements by the County. The vendor may fill the remaining beds with private-pay clients unless the County chooses to purchase them at the State rate.

	FY16 Amount
County Fund	$1,638,278
BHA Federal Treatment Grant	$645,662
BHA State Treatment Grant	$315,905
ARTC Contract Total	$2,599,845

In addition to Avery Road Treatment Center services, the County also funds Avery Road Combined Care and the Journey's for Women outpatient treatment program. The Journey's program serves uninsured female clients that are alcohol and drug dependent. The following tables show the funding that is in the base budget.

Avery Road Combined Care

	FY16 Amount	FY17 Amount
County Fund	$318,690	$355,442
BHA Federal Treatment Grant	$360,718	$694,696
BHA State Treatment Grant	$370,730	
Total	$1,050,138	$1,050,138
No. of Beds	15	15

Journey's for Women

	FY16 Amount	FY17 Amount
County Fund	$200,000	$200,000

Council staff recommendation: **Approve as recommended by the Executive.** As noted earlier Council staff is suggesting an after budget session to discuss a range of opiate abuse issues including current programs.

3. Multi-program Adjustments
$188,191

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

F. Access to Behavioral Health Services

For FY17 the Executive is recommending funding of $3,711,501 for this program that provides access to behavioral health services, assessment, and diagnostic evaluation. The program also provides immediate (but brief) case management, therapy, and medication services to people being discharged from a hospital or jail until they can be linked into the community outpatient system. Urine monitoring and laboratory services are also provided through this program.

1. Multi-program Adjustments
$63,800

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

G. Forensic Services - Adult

For FY17, the Executive is recommending $2,201,365 for this program that provides the Clinical Assessment and Triage Services Team (CATS) and Jail Addiction Service (JAS) program. The programs include assessments and, for those booked into the jail, discharge planning, and coordination with community-based services.

1. Multi-program Adjustments
$45,769

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

Issue: Mental Health Court

The Public Safety and Health and Human Services Committee were briefed during the development of the plan for implementation of a Mental Health Court in Montgomery County. The report of the Mental Health Court Planning and Implementation Task Force was sent to the Honorable John Debelius III, Administrative Judge of the Montgomery County Circuit Court on January 19, 2016. The Court has applied to the Office of Problem-Solving Court for approval to implement this effort.

Council staff has confirmed with the Office of Management and Budget that the Executive will forward a supplemental appropriation to fund this effort when it is approved by the Court.

H. Outpatient Behavioral Health Services – Adult

For FY17, the Executive is recommending $3,309,369 for this program area that provides comprehensive outpatient treatment and intensive outpatient treatment for adult residents of the County. The program also houses the Adult Behavioral Health program that provides a comprehensive range of services to County residents with high need and who are in multiple systems but may not be eligible for care through the public mental health system.

1. Annualization of Adult Behavioral Health Enhancements $112,500

In FY15, the Council approved $225,000 to enhance adult behavioral health services after discussion with Dr. Crowel about high-profile crimes where the offender had a history of mental illness, concern about suicides in the County, surveys highlighting the percentage of the population that need mental health services and the wait time of 2 to 8 weeks to access services. Dr. Crowel noted that the Department has been creative in trying to meet needs, working to integrate mental health with primary care and substance abuse, and starting a second Assertive Community Action Team. The start was delayed in FY16 and this funding annualizes the FY16 level back to the original FY15 funding. DHHS has provided the following update on how these funds will be spent and the expected outcomes.

> Overall, the goal is to better integrate primary care and behavioral health services for persons with Serious and Persistent Mental Illness (SPMI). For example, Montgomery Cares clients who are found to have mental health issues more complex or severe than can be managed in a health clinic can be referred to the Adult Behavioral Health Program (ABHP) for treatment.
>
> A bilingual registered nurse (Primary Care Coalition of Montgomery County contract) has been at the Adult Behavioral Health Program (ABHP) since January 2016. She is actively involved with the program and has been seeing individual clients, as well as assisting the psychiatric staff at ABHP. The nurse's activities are targeted specifically but not exclusively to low income Spanish and French speaking clients, as many of these clients do not have adequate health care or have had multiple disruptions in access to primary health care. As such, many of these clients experience chronic health conditions such as diabetes, hypertension and obesity related to poor diet and lack of nutritional knowledge.
>
> The expected outcome from the addition of this position includes:
>
> - increased screening and referral for primary health care conditions such as diabetes, hypertension and obesity with referral to and coordination with primary healthcare providers;
> - an eventual decrease in the long term negative health effects of untreated conditions such as hypertension, diabetes and obesity with a resulting decrease in loss of work, disability and healthcare costs;

- increased ability of clients to make meaningful, informed choices about managing their health via health education on the relationship between diet, physical activity and health status;
- increased efficiency and productivity of the psychiatric staff as the community health nurse can assume duties such as contacting pharmacies; reviewing lab work; managing medication orders and the inventory of medical supplies;
- administration of long term injectable medication and follow up; and,
- creation of specific health metrics for a community health nurse in a community mental health center serving a low income immigrant client population.

A Spanish speaking therapist (Cornerstone Montgomery Inc. contract.) was added to ABHP in early April 2016 to increase the capacity of this program to serve low income, uninsured or undocumented Spanish speaking clients with severe and persistent mental health problems such as bipolar disorder, schizophrenia, major depression and PTSD. The therapist has started seeing clients and is taking on many of the new Spanish speaking referrals from the Access Team.

The expected outcome from the addition of this position includes:

- increased capacity to serve Spanish speakers with severe and persistent mental health problems;
- increased capacity of ABHP to provide in depth service as needed to vulnerable clients who are not able to utilize alternate community resources as a result of their immigration status;
- increase in community, family and employment functioning of the low income Spanish speaking client population;
- better coordination with available community resources with decreased caseloads; and,
- creation of a Spanish language co-occurring group to serve male clients who have both mental health and substance abuse issues.

Council staff recommendation: **Approve as recommended by the Executive.**

2. Multi-program Adjustments
($41,904)

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

I. Outpatient Behavioral Health Services – Child

For FY16, the Executive is recommending $5,553,116 for this program that provides or supports comprehensive mental health treatment and care coordination services to children, youth, and their families. The program has three teams: the Child and Adolescent Outpatient Mental Health Services Team, the Home-based Treatment Team (supports Child Welfare Services), and the System of Care Development and Management Team. This program area also houses Juvenile Justice Services and SASCA.

1. Overdose Misuse Prevention Program
$45,000

This funding will be used for a community awareness campaign to combat opioid use. DHHS has provided the following information.

The budget funds the Montgomery County Collaboration Council for Children Youth & Families contract to provide substance abuse prevention education, outreach, and activities to reduce opioid related overdoses in Montgomery County. The grant is not restricted to youth and children. It also has the flexibility to target people across the lifespan. The Strategic Prevention Framework (SPF) process actually takes into account targeting certain age groups based on selected strategies. This process begins with a community needs assessment, capacity building, strategic planning, implementation, and evaluation. The ability to move forward in this process is contingent on approval from BHA.

Council staff recommendation: **Approve as recommended by the Executive.**

2. Multi-program Adjustments
($106,306)

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

Issue: Child and Adolescent Clinic Wait List and Psychiatric Resources

The Committee has had an ongoing interest in the wait list for the Child and Adolescent Clinic. The wait list has declined from 60 in FY13 to 14 for FY15. However, the first 7 months of FY16 show an average of 33, with a high of 51 in December 2015. A majority of those on the wait list from January –March (© 34) needed services in Spanish; however, in November 2015 the majority needed services in English. There is one vacant Therapist position which is in the process of being filled.

As noted earlier, there is $220,000 in the budget associated with the shared-psychiatrist idea. The Committee may want to discuss with DHHS whether, since a psychiatrist is not likely to be hired, whether a part of the funding might be shifted to an additional Therapist for this clinic. The Committee has previously discussed the service needs of Children Fleeing Violence which may send more clients to these services.

J. Trauma Services Program

For FY17, the Executive is recommending $4,965,546 for this program that provides integrated clinical services to domestic violence victims and offenders, sexual assault victims, and victims of general crime. Services are provided at the Family Justice Center and at Piccard Drive.

Performance Measures

The Committee may want to discuss these performance measures with the Department as they show an expectation that outcomes can return to the FY14 level by FY18.

	Actual FY14	Actual FY15	FY16 Est	FY17 Target	FY18 Target
Percentage of child victims of sexual assault and general crime that show a decrease in symptoms after treatment*	90	73	83	83	83
Percentage of clients receiving therapy that demonstrate improvement on a domestic violence rating scale	85	89	80	80	80

*as measured by the child's reaction to Traumatic Events Scale clinical scales

1. Multi-program Adjustments
$5,196

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

K. Specialty Behavioral Health Services

For FY17, the Executive is recommending $2,513,173 for this program that includes the Adult Drug Court, Medication Assistance Treatment program. The Medication Assisted Treatment program serves people who are opiate dependent, uninsured, and have not succeeded with other treatment.

1. Multi-program Adjustments
($54,543)

Multi-program Adjustments account for compensation changes, annualizations and other items impacting more than one program.

Council staff recommendation: **Approve as recommended by the Executive.**

Behavioral Health and Crisis Services

FUNCTION

The mission of Behavioral Health and Crisis Services (BHCS) is to promote the behavioral health and well-being of Montgomery County residents. BHCS works to foster the development and to ensure access to a comprehensive system of effective services and support for children, youth and families, adults, and seniors in crisis or with behavioral health needs. BHCS is committed to ensuring culturally and linguistically competent care and the use of evidence based or best practices along a continuum of care. BHCS works with the State's public mental health and substance abuse system, other HHS service areas, County agencies and the community to provide strength-based and integrated services to persons in need.

Program Contacts

Contact Raymond L. Crowel of the HHS - Behavioral Health and Crisis Services at 240.777.1058 or Rachel Silberman of the Office of Management and Budget at 240.777.2786 for more information regarding this department's operating budget.

Program Descriptions

24-Hour Crisis Center

This program provides telephone, walk-in, mobile crisis outreach, and crisis residential services to persons experiencing situational, emotional, or mental health crises. The Crisis Center provides all services, twenty-four hours/day seven days/week. Much of the work of the Crisis Center focuses on providing the least restrictive community-based service appropriate to the client's situation. Many of the services provided are alternatives to more traditional mental health services. Psychiatric crisis resources are used to prevent hospitalizations and suicides. Disaster mental health services include crisis management and consultation for disasters and community crises. The Crisis Center coordinates the mental health response during disasters and community critical incidents. During the off-hours (after 5:00 p.m., weekends, and holidays), crisis back-up services are provided for various health and human services needs when the clients' primary service providers are not available.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of students identified by schools to be at risk that are stabilized utilizing community resources without hospital intervention	95	95	95	95	95

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**4,824,891**	**36.90**
Increase Cost: Annualization of Contract for Intensive In-Home Stabilization Services	200,000	0.00
Decrease Cost: Mental Health Association Emergency Preparedness Contract	(20,000)	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	59,787	0.00
FY17 Recommended	**5,064,678**	**36.90**

Behavioral Health Planning and Management

As the State mandated local mental health authority, this program is responsible for the planning, management, and monitoring of Public Behavioral Health Services for children with serious, social, emotional and behavioral health challenges, and adults with a serious and persistent mental illness. The functions include developing and managing a full range of treatment and rehabilitation services including services for persons with co-occurring mental illness and substance abuse disorders, homeless persons, and persons who have been incarcerated

and/or are on conditional release. Services include the ongoing development of a resiliency and recovery oriented continuum of services that provide for consumer choice and empowerment. This program now manages all service area contracts.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY1
Percent of children served by the continuum of behavioral health services that demonstrate higher degree of social connectedness and emotional wellness as demonstrated by positive outcomes in housing, quality of life, legal encounter, and employment/education	95.8	95.2	96.0	96.0	96.0
Percent of adults served by the continuum of behavioral health services that demonstrate higher degree of social connectedness and emotional wellness as demonstrated by positive outcomes in housing, quality of life, legal encounter, and employment/education	77.4	77.8	77.0	77.0	77.0

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**8,087,060**	**15.50**
Add: Alcohol and Drug Abuse Administration Federal Treatment Grant (200A773)	240,000	2.00
Increase Cost: Annualization of Shared Outpatient Psychiatrist Contract	110,000	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	186,580	0.00
FY17 Recommended	**8,623,640**	**17.50**

Service Area Administration

This program provides leadership, oversight, and guidance for the administration of Behavioral Health and Crisis Services.

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**561,665**	**3.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	2,404	0.00
FY17 Recommended	**564,069**	**3.50**

Mental Health Services: Seniors & Persons with Disabilities

This program provides outreach mental health services for seniors who cannot or will not access office-based services as well as persons experiencing caregiver stress. It provides Prevention and Early Intervention services for seniors by providing drop in groups at senior centers; psycho education; consultation to assisted living providers, Housing Opportunities Commission resident counselors, senior center directors; and mental health training to providers of services for seniors. This program also provides mental health services to persons who are deaf or hearing impaired.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of surveyed homebound seniors reporting an improvement in their quality of life as measured by Mental Health Statistics Improvement Program Consumer Survey Scale	78	94	86	86	86

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**786,692**	**2.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	7	(1.00)
FY17 Recommended	**786,699**	**1.00**

Treatment Services Administration

Provides overall management of the Federal and State Behavioral Health Administration grant and Medicaid funded community based programs, and oversees operations of the addiction continuum of private providers.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of decrease in substance abuse for patients completing treatment (Level 1 Outpatient Treatment) [1]	73.7	83.0	75.0	75.0	75.0

[1] *Percent decrease in substance abuse goal is set at 75% by the State of Maryland.*

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**5,904,516**	**3.00**
Increase Cost: Alcohol and Drug Abuse State Treatment Grant - Avery Road Treatment Center	213,954	0.00
Increase Cost: Avery Road Treatment Center Operating Contract	213,954	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	188,191	0.00
FY17 Recommended	**6,520,615**	**3.00**

Access to Behavioral Health Services

This program area includes Access to Behavioral Health Services, Community Case Management Services, and Urine Monitoring Program. The Access to Behavioral Health Services program provides information and referral, screenings and assessments for uninsured and low-income consumers with mental health and/or substance abuse problems to connect them to the appropriate community services. To provide effective engagement in needed services, program staff also provide short-term case management and psychiatric services to vulnerable clients such as those recently discharged from a psychiatric hospital or jail until they can be linked to a community outpatient mental health program. The program offers services at a central office and collocated with HHS income supports offices and the Department of Correction and Rehabilitation Pre-trial Services. Community Case Management Services provides intensive social work services to individuals with serious mental illness to ensure effective engagement in needed services and sufficient community supports to reduce negative outcomes and foster the wellness and recovery of the consumer. The Federal/State Projects for Assistance in Transition from Homelessness (PATH) in this unit particularly targets the re-entry needs of mentally-ill individuals in the criminal justice system. The Urine Monitoring Program serves clients referred by the courts, social service agencies, or behavioral health providers, and others required to submit to breathalyzer and urine surveillance or who require or request such screening and testing to support recovery from substance abuse.

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**3,647,701**	**32.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	63,800	1.00
FY17 Recommended	**3,711,501**	**33.00**

Forensic Services - Adult

Adult Forensic Services is composed of two programs: Clinical Assessment and Transition Services (CATS); and Jail Addiction Services (JAS). CATS has two components: (1) assessment and post-booking diversion services within 24 hours of booking to inmates with behavioral health issues upon entry into the Montgomery County Detention Center; and (2) discharge planning for inmates who are being released from the Correctional Facilities by assessing inmates' behavioral health needs and coordinating access to services in the community. JAS is an intensive jail-based residential addiction treatment program for inmates who suffer from substance related disorders at the Montgomery County Correctional Facility.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of successful Jail Addiction Services clients that were not reincarcerated in the Montgomery County Correctional Facility within the next fiscal year following program completion	76	79	78	78	78

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**2,374,603**	**19.00**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	(173,238)	0.00

FY17 Recommended Changes	Expenditures	FTEs
FY17 Recommended	**2,201,365**	**19.00**

Outpatient Behavioral Health Services - Adult

Adult Outpatient Behavioral Health Services provides comprehensive addiction, mental health outpatient, and intensive outpatient services to adult residents of Montgomery County who have co-occurring substance and mental health disorders. Priority is given to serving vulnerable persons including intravenous drug users; women who are pregnant or have young children; and those who lack health insurance, are homeless, or medically compromised. Many program participants are also involved with the criminal justice system or have chronic medical conditions such as diabetes or HIV/AIDS. The Adult Behavioral Health program accepts referrals from Access to Behavioral Health Services and Avery Road Treatment Center. Services include a comprehensive range of substance abuse and mental health programs including assessment and diagnostic evaluation, group and individual treatment, psychotropic medication evaluation and medication monitoring, family support and case management services. Services are individualized with the adult being a partner in all treatment decisions. Service capacity includes treatment for adults with Limited English Proficiency and those with specialized cultural and language needs. Peer-led and other Recovery Support Services are offered at each site.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of clients showing improvement in functioning and decreased symptoms - based on the symptoms list	76	82	82	82	82
Percentage of clients that completed treatment plan upon discharge (% is based on discharged clients)	52	38	48	48	48

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**3,238,773**	**19.50**
Increase Cost: Annualization of Adult Behavioral Health Enhancement	112,500	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	(41,904)	0.75
FY17 Recommended	**3,309,369**	**20.25**

Outpatient Behavioral Health Services - Child

Child Outpatient Behavioral Health Services offers comprehensive substance use prevention, mental health treatment, and care coordination services for Montgomery County youth and their families, including for the most vulnerable. Services are individualized, child focused, family driven, culturally and linguistically appropriate and accessible via office, school, and community based settings. Child Outpatient Behavioral Health Services strives to serve the behavioral health needs of youth and families along a continuum of care from prevention to treatment. There are two outpatient behavioral health clinics that provide assessment, psychiatric treatment, and individual and family therapy for children and adolescents with emotional and behavioral issues. The Home Based Treatment Team provides mobile treatment specifically for children and families involved with Child Welfare Services. There are also programs dedicated to serving youth and families involved with the Department of Juvenile Services (Violence Prevention Initiative), and to preventing substance use and promoting healthy behaviors and lifestyles (Prevention Program). In addition, the Screening and Assessment Services for Children and Adolescents (SASCA) program provides substance use and mental health screening and referral, and collaborates with the State Attorney's Office and the Montgomery County Police Department to provide youth with an alternative to involvement with Department of Juvenile Services.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of offenders under age 18 that are diverted to substance abuse education or mental health treatment programs who do not re-enter the correction system within 12 months of being assessed compliant with requirements [1]	92	94*	88	88	88
Percentage of clients that meet their treatment goals at the time of discharge	65	69	72	72	72

[1] ** This measure is by definition a 12-month follow-up of clients, so actual FY15 data reports recidivism rate for clients who completed substance abuse education and /or behavioral health treatment programs in FY14.*

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**5,582,100**	**28.25**

FY17 Recommended Changes	Expenditures	FTEs
Add: Overdose Misuse Prevention Program (2002444)	45,000	0.00
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	(106,306)	0.00
FY17 Recommended	**5,520,794**	**28.25**

Trauma Services

Trauma Services is comprised of two programs: The Abused Persons Program (APP) for partner violence and The Victim Assistance and Sexual Assault Program (VASAP) for sexual assaults and general/violent crimes. Trauma Services provides comprehensive, individualized and culturally appropriate clinical and victim assistance services to domestic violence victims and offenders, sexual assault victims, and victims of general crime of all ages. All victims may be assessed and receive short term counseling and psychiatric care, as well as a variety of specialty services geared to their particular need. Programming for domestic violence, sexual violence and human trafficking victims also includes information and referral, lethality assessments, crisis intervention, safety planning, and placement in emergency shelter. Services are provided on-site at the Family Justice Center, at 1301 Piccard Drive and at 8818 Georgia Avenue. Programs for victims of sexual assault include outreach twenty-four hours a day, seven days a week through volunteer support to rape and sexual assault victims at hospitals and police stations, where they provide information, referrals, crisis intervention and linkage to counseling.

Program Performance Measures	Actual FY14	Actual FY15	Estimated FY16	Target FY17	Target FY18
Percentage of adult victims of sexual assault and general crime that show a decrease in symptoms after treatment (as measured by Post-Traumatic Stress Disorder Checklist - Civilian clinical scales)	82	83	82	82	82
Percentage of child victims of sexual assault and general crime that show a decrease in symptoms after treatment (as measured by the Child's Reaction to Traumatic Events Scale clinical scales) [1]	90	73	83	83	83
Percentage of clients receiving therapy that demonstrate improvement on a domestic violence rating scale	85	89	80	80	80

[1] *According to clinical observations, in FY15 the program served a number of child/teen crime victims with very complex needs, which resulted in a decline in the overall program performance. The cases include unaccompanied minors with a complex history of trauma as well as teens who were victimized more than once in the same year.*

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**4,960,350**	**29.55**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	5,196	0.00
FY17 Recommended	**4,965,546**	**29.55**

Specialty Behavioral Health Services

Specialty Behavioral Health Services is comprised of the Adult Drug Court Program and the Medication Assisted Treatment Program (MAT). The Adult Drug Court program is a collaborative effort between the Department of Health and Human Services, Circuit Court, Office of the Public Defender, State Attorney's Office, Department of Corrections and Rehabilitation, Adult Probation and Parole, Montgomery County Police Department, and the Montgomery County Sheriff's Office. It provides intensive treatment services to chronic substance abusing offenders who are before Circuit Court for violation of probation and /or new criminal offenses. The MAT program serves adult residents of Montgomery County, who are diagnosed with substance use disorders. Individuals served in MAT are opiate dependent, uninsured, and have not been able to succeed in other venues of treatment. The MAT program is a comprehensive opioid treatment program and provides medical management with methadone maintenance therapy, and psychiatric services including medication for those with co-occurring mental health disorders. Treatment includes individual, group, family therapy, drug testing, case management, crisis services, discharge planning, and pharmacotherapy.

FY17 Recommended Changes	Expenditures	FTEs
FY16 Approved	**2,567,716**	**21.50**
Multi-program adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting multiple programs.	(54,543)	0.00

FY17 Recommended Changes	Expenditures	FTEs
FY17 Recommended	**2,513,173**	**21.50**

Program Summary

Program Name	FY16 APPR Expenditures	FTEs	FY17 REC Expenditures	FTEs
24-Hour Crisis Center	4,824,891	36.90	5,064,678	36.90
Behavioral Health Planning and Management	8,087,060	15.50	8,623,640	17.50
Mental Health Services: Seniors & Persons with Disabilities	786,692	2.00	786,699	1.00
Service Area Administration	561,665	3.50	564,069	3.50
Treatment Services Administration	5,904,516	3.00	6,520,615	3.00
Access to Behavioral Health Services	3,647,701	32.00	3,711,501	33.00
Forensic Services - Adult	2,374,603	19.00	2,201,365	19.00
Outpatient Behavioral Health Services - Adult	3,238,773	19.50	3,309,369	20.25
Outpatient Behavioral Health Services - Child	5,582,100	28.25	5,520,794	28.25
Trauma Services	4,960,350	29.55	4,965,546	29.55
Specialty Behavioral Health Services	2,567,716	21.50	2,513,173	21.50
Total	**42,536,067**	**210.70**	**43,781,449**	**213.45**

Executive Summary

During the 2014-2015 year the Alcohol and Other Drug advisory Council advanced in its mission to provide guidance to the County Executive and County Council in identifying prevention, treatment and recovery needs and reviewing the County's efforts in addressing those needs. This section of the annual report summarizes the activities and accomplishments of the past year and outlines priorities for the next year.

AODAAC Activities and Accomplishments 2014-2015

- Convened a meeting with Department of Liquor Control staff to gain knowledge on alcohol distribution and regulations in the County;
- Convened a meeting with Chair of the Alcohol Beverages Advisory Board to learn more about the impact privatization would have on public health and public safety;
- Hosted The Therapeutic Value of Music, which was uplifting winter event where multiple genres of music were played and wellness in the recovery process was discussed;
- Provided ongoing support for the County's plan to enter into a public private partnership for the development of a new ARTC;
- Toured the Montgomery County Correctional Facility to meet with Jail Addiction Service Staff and inmates enrolled in the program to discuss program and client needs;
- Reviewed opioid overdose data in the County on a regular basis with MCPD representative;
- Support of two Drug Take Back (DTB) events:
  Fall of 2014– on September 27, 2014, 1,008 pounds of prescription medication were collected around the County;

  Spring 2015– on May 2, 2015 530 pounds of prescription medication were collected at multiple locations throughout the County;
- Participation in the first Recovery Walk in the County on September 13, 2014 in recognition National Recovery Month;
- Examined data in the County to determine the full impact of substance abuse on County residents as well as the cost;
- Sent Prevention Opportunity letter to County Executive and County Council requesting support with better substance abuse related data collection;
- Convened a presentation with Montgomery College Education Coordinators to discuss their MC Project Aware program and how to engage students in their online alcohol assessment tool;
- Convened a presentation by Child and Adolescent Services to become more aware of the program and gaps in service;
- Convened a meeting with MC Police Department Alcohol Initiatives Section to learn more about their unit, enforcement and compliance checks;
- Representation on the Behavioral Health Task Force with the goal of creating an integrated behavioral system;
- Hosted an Annual Spring Forum with the Mental Health Advisory Committee, titled Finding Your Voice in Recovery;

AODAAC Activities and Accomplishments Continued

- Participated in The Community-Wide Homeless Provider Meeting;
- Convened a presentation and about Avery Road Combined Care to become more knowledgeable about services offered at that facility;
- Convened a presentation with representatives from the Maryland Office of the Attorney General and the MC State's Attorney's Office to learn about Maryland's response to the Heroin epidemic;
- Attended the local Summit held by the Governor's Emergency Task Force.

Pending Legislation Reviews

- Reviewed and discussed AODAAC's position on alcohol and drug related bills pending in the 2014 General Assembly:
- Reported that a bill passed that outlawed powered alcohol;
- Submitted an opinion to HHS regarding SB212 Driving Under the Influence—Ignition Interlock System Program, which would mandate SB212 the use of an interlock system for any individual after a first- time conviction of driving under the influence of alcohol. This bill did not pass.

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AODAAC Priorities for 2015-2016

- Evaluate and improve substance abuse prevention programs aimed at youth in the County and those who care for youth;
- Advocate for funding that supports sober housing programs for individuals being released from the detention center;
- Advocate for diversion programs for offenders with mental health and substance abuse diagnoses;
- Collaboration with the Mental Health Advisory Committee on the Annual Forum;
- Review and submit opinions on bills in the Maryland General Assembly that relate to drug and alcohol policy;
- Continued support of the County's Overdose Response Program.

Alcohol & Other Drug Abuse Advisory Council

Date: October 7, 2015

To: County Council Health and Human Services Committee

From: The Alcohol and Other Drug Abuse Advisory Council

Re: AODAAC 2015-2016 Priorities

The Alcohol and Other Drug Abuse Advisory Council wishes to submit the following two priorities for the upcoming year. Our representative looks forward to attending the HHS Committee work session on October 15th and will elaborate further on these two priorities.

In December 2014, the AODAAC held its monthly meeting at the Montgomery County Correctional Facility (MCCF) in Clarksburg, Maryland. The purpose of the meeting was to tour the facility and meet with staff and inmates enrolled in the Jail Addiction Service (JAS) program. We learned that inmates volunteered to participate in JAS, which is a structured addiction treatment program where they receive at least nine treatment hours per week. Both male and female inmates expressed obstacles upon release included finding secure and supportive housing. Without sober and stable housing options many have difficulty maintaining sobriety and being compliant with release or probation conditions. It is AODAAC's priority to advocate for adequate funding that includes supportive, therapeutic housing programs that assists those being released from incarceration. AODAAC is also supportive of the County's efforts to identify and create diversion/treatment programs at multiple intercepts in the criminal justice process for offenders with mental health and substance abuse diagnoses.

The second and a consistent priority for the AODAAC is the institution of alcohol and drug use prevention and awareness programs beginning in elementary school and continuing through the secondary education level. Since the loss of funding for Safe and Drug Free Schools there has been no consistent programming in Montgomery County schools that promotes drug and alcohol abuse prevention and awareness. In the light of the recent double fatal crash in the Wootton Community and the significant rise in the heroin overdose rate in the County, we feel that it is detrimental that the County and MCPS invest funding in a standardized, evidence based program that targets youth and their parents and focuses on the potential health and life consequences of drug and alcohol abuse. The AODAAC believes it is imperative that parents are equipped with prevention techniques, as well as knowledge of the dangers of underage drinking and drug use, the consequences of allowing underage drinking in their homes and know the warning signs of usage and where to receive help.

ALCOHOL AND OTHER DRUG ABUSE ADVISORY COUNCIL

Honorable Nancy Floreen
President, Montgomery County Council
100 Maryland Avenue
Rockville, Maryland 20850

April 14, 2016

Dear Council President Floreen:

We, the Alcohol and Other Drug Abuse Advisory Council, respectfully suggest a study to fill policy gaps and lead to more effective **prevention** of opiate abuse in the County.

Legally prescribed opioids are useful for pain management, of course. Sadly, there is growing recognition that they also pave two on-ramps of society's narcotic abuse highway. The prescription opioid backdrop is alarming. The CDC reports that opioid prescription volumes have quadrupled since 1999 with no comparable increase in the occurrence of pain they are designed to treat. One on-ramp is that legally prescribed opioids lead to unintended newly-addicted individuals. Then, legally prescribed pills in circulation are diverted to youth parties and school bathrooms and a black market fueling yet more addicted individuals. Pill mills, rogue prescription writers and aggressive opioid shoppers all contribute to, but do not explain, the extent of the legal prescription opioid phenomenon.

A study published in December in the Annals of Internal Medicine (http://annals.org/article.aspx?articleid=2479117) examined 2,880 non-fatal prescription opioid overdose events over 11 years. It found that over 90% of these overdose victims were legally resupplied with yet more prescription opioids. Over two-thirds of those were provided by the same medical professionals who prescribed the overdose-inducing opioids. This March, the CDC issued revised opioid prescriber guidelines (http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm) to address the issue. There is a medically necessary minimum level of legally prescribed opioids and then there's the level we are at. We believe that learning about how far apart these levels are will help prevent future addiction cases.

We believe Montgomery County would benefit from focused attention on two aspects of this issue currently filled mainly with anecdotal information insufficient to guide policy choices. Otherwise diligent doctors, dentists and other opioid prescribers may simply not know how to avoid worsening the County's substance abuse problems that often begin with the opioid prescriptions they write. Compounding the matter, they may write many opioid prescriptions in an information vacuum regarding patient experience.

Prescriber Education. The Annals study triggered multiple suggestions for improvements in medical school education of new doctors and strong calls for better in-practice opioid prescribers. To what extent is adequate education, especially among in-practice prescribers, taking root? We think these questions are open in Montgomery County:

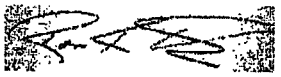
- What are the populations of the various kinds of practitioners who write opioid prescriptions?
- What is the current state of their knowledge and attitudes regarding prescription opioids and the associated best practices?
- How many opioid prescriptions are written and pills put into circulation each month or year?
- What is the population of opioid prescription recipients?
- What education policies and tools, both currently in use or available, exist to educate doctors, dentists and other opioid prescribers and dispensaries in the County? Who establishes or provides them?
- What obstacles can be removed or incentives provided to improve the results?

Adequate Information. Maryland implemented a PDMP (Prescription Drug Monitoring Program) to capture information about opioid prescriptions among other drugs. Our understanding is that Maryland's PDMP is both voluntary and, as a system, hard to use. A second state-wide system, CRISP (Chesapeake Regional Information System for our Patients), allows inter-provider information flow of electronic medical records. CRISP has a feature called the ENS (Event Notification System). It is designed to assertively inform health care providers about patient events including opioid overdoses. Additionally, known reporting gaps persist with the coding of 911 calls when overdose events are involved, further clouding the data.

- What are the populations of PDMP and CRISP users and non-users?
- What are the habits and attitudes among opioid prescribers about using PDMP and CRISP?
- What obstacles block better utilization and what actions and reasonable incentives might help improve results?
- What steps remain to clarify overdose event reporting?

There is now broad agreement that legally prescribed opioids inadvertently fuel downstream addiction. We recommend that the ways this works should be better defined so it can be managed better. A study like what we described broadly could be done, perhaps, by OLO or a qualified consulting firm. The results can **prevent** some of the future cost and tragedy of opioid abuse that started with the best of intentions.

Respectfully,



Roni K. White, Chair

Mental Health Advisory Committee Budget Priorities FY17

1. **Support Full Year Funding for the Children's Crisis Stabilization Team.** We have appreciated the council's advocacy for this program since its inception.

2. **Increase funding in the base budget for the personnel lapse savings.** BHCS has struggled to meet the increased demand in county clinics and in the crisis center, especially for children.

3. **Explore creative ways to increase providers who specialize in specific populations and maintain funding for county wraparound in light of the elimination of state funding for wraparound for children and youth.** The need for bilingual mental health providers in Spanish and child psychiatrists has never been more acute in Montgomery County, especially with the significant amount of immigration from Latin America over the last five years that increased enrollment in MCPS. Estimates are that between 9000-12000 Spanish speaking students enrolled in MCPS over the last five years.

4. **Minimize Cuts to Non-Profit Organizations that Provide Behavioral Health Services and Peer and Family Support. Support the Replacement of the State Funding Shortfall for the Collaboration Council to Support Family Navigation, Pathways to Services, and Youth Services Bureaus Programs ($162,500).** The changes in funding strategies at the state level are making it increasingly difficult for providers to offer these services and supports. The new funding priorities from the Governor's Office on Children are putting programs in jeopardy, which will greatly reduce the safety net traditionally provided for consumers and their families.

5. **Create a County-Wide Coordinated System of Care for Adults.** Create a county-wide coordinated system of care for adults with behavioral health challenges that builds upon and expands beyond efforts of hospitals to coordinate care. The Office of Legislative Oversight (OLO) report cited many behavioral health services that are available in Montgomery County. However, adults with multiple needs cycle through our hospitals and jails often due to poor or no care coordination and because of difficulty accessing needed services. MHAC asks that the county continue to explore and establish a system that would function to coordinate care with adult consumers among all agencies involved, harmonize and integrate efforts among the agency providers, track care and collect data. This county-wide model could be aligned with hospital and non-profit systems, and funding could come from entities and insurance companies that have a vested interest in lowering rates of costly hospital admissions and re-admissions and jail recidivism. The MHAC supports the recommendations made by the Care Coordination Subcommittee of the Healthy Montgomery Task Force.

6. **Continue to Advocate for More Deflection and Diversion Programs Along the Criminal Justice Continuum from a Restoration Center to a Mental Health Court.** MHAC continues to support decriminalization efforts in both the juvenile justice and criminal justice systems. We support the work of the Mental Health Court Planning and Implementation Task Force. The approval process to establish a Mental Health Court for circuit and district courts will most likely be completed before mid-year. Given that BHCS is already understaffed, we recommend additional mid-year funding for

two positions needed to support the court. About $90,000 would fund each position for a full year. We know from Mental Health Courts in other jurisdictions that a robust array of community services must be in place in order to ensure the success of the court. Data from other established Mental Health Courts also has proven that judges, police officers, and community behavioral health providers who establish a stable team experience more positive outcomes. Given that the judges are already familiar with BHCS through the CATS Initiative, and the high turnover rate at private behavioral health provider entities, we strongly encourage funding the 2 positions within BHCS rather than through the private sector.

In Montgomery County, an estimated 22 percent of the inmates at Montgomery County Correctional Facility and Montgomery County Detention Center are men and women with mental health disorders. Rates of those with serious mental health disorders in jails are 3 to 4 times higher than in the general population. Jails spend 2 to 3 times more on adults with mental health disorders due to treatment needs. We will continue to engage in ongoing dialogues with the County Council and the judicial system to support the planning and initiation of a comprehensive plan that addresses the spectrum of criminal involvement so that there is a systemic response, using an effective use of resources, to decriminalize mental health disorders.

7. **Future Recommendation.** The BHCS staff, under the visionary leadership of Dr. Crowel, is creating a comprehensive strategic plan for behavioral health in Montgomery County. As the plan develops it will provide the county with a clearer sense of our needs and a set of recommended priorities for future funding and other support. MHAC is looking forward to working with BHCS/HHS on developing and implementing the plan. As we identify needs, it may be necessary to provide increased funding for our changing community.

Element	Privatization	HHS
Costs	Staffing: - 3.5FTES new positions fully funded by GF - $400,000 OE (office, computers, phones, Mileage etc.) – Additional GF required. $20-25k est.	Staffing: 2.0 new FTES -$260,00 new funding 1.5 FTE's assigned to the MHC – current staff OE – absorbed w/in existing HHS budget
Comments Revenue generation from this work from Targeted Case Management is uncertain and will not cover the costs of the time staff will need to spend in court related issues. Moving one T-II and sharing an OSC from CATS will leave the CATS program stretched in terms of capacity but the Task Force work group agreed that the potential diversion of clients may over time reduce the load on CATS to more manageable levels.		
Experience and Skills	Skills: Private County providers do not currently have the requisite skills/experience: Assessment skills with forensic populations focusing on criminogenic issues and legal issues take many years to fully train for. The same can be said for integrative planning that addresses the needs of PD/SAO and Courts Resource capacity: Current county private providers don't have depth of relationships with the various MH entities that will be serving this population. Private providers do not have established relationships or knowledge of processes with SAO, PD, DOCR, Shelters, Local Hospitals, State Hospital and the Judiciary.	HHS staff has decades of experience in working with Criminal Justice involved clients around Reentry, diversion, court advocacy, sentence mitigation. HHS staff who work in the jails have clearances and training that allow them access to correctional and court facilities. An HHS team will have ready and rapid access to the full array of other HHS services for MHC clients, thanks to the EHR and EICM tools that are in place. HHS has long collaborative relationships with SAO, PD, DOCR, Shelters, Local Hospitals, State Hospital and the Judiciary.
Comments Privatizing would weaken MHC effectiveness for at least several years. The MHC team will need to be in continuous close working relationships with those partners. County behavioral health providers all offer a variety of services. How a private MHC team would make referrals to it's own programs vs. other providers will not foster the kind of multi-agency teaming that is essential for these clients. An HHS staffed MHC does not have this problem.		
Other issues associated with privatizing.	The work involves an intensive level of case management services. Targeted Case Management (TCM) funding and authorization process does not fund many of the assessment or court related activities associated with MHC. Fee for service will never adequately address the intensive case management required There are currently no Private TCM providers in the county.	At present HHS operates the only licensed TCM in the county. Providers have historically been unable to provide the service without losing money. Some small portion of the service may be reimbursable in year two.
Administrative issues	Requires an RFP and contract with a provider – This would delay Start-Up between 6 and 9 months.	HHS can Start-up within three months of receiving new PINS and funding.
Comments: The task force has consistently worked towards a rapid start-up of the program once the Office of Problem Solving Courts gave approval.		

Mental Health Advisory Committee's Top Two Priorities for FY16
Submitted to
The County Council's HHS Committee
Work session on October 15, 2015

The Montgomery County Mental Health Advisory Committee (MHAC), mandated by the State of Maryland, is committed to evaluate and monitor the development of mental health services and to work collaboratively with our community partners to monitor, advise and advocate for a comprehensive mental health system of care for all persons in Montgomery County.

The following are MHAC's two top priorities for FY16.

1) Minimize further budget cuts to Behavioral Health and Crisis Services (BHCS) and advocate for a system of coordinated care with a focus on supports to assist those transitioning into the community from higher levels of service and increasing providers who specialize in specific populations.

    - Budget cuts to BHCS since 2009 have exceeded $3 million resulting in significant reductions to programs and services.
    - The Office of Legislative Oversight July 2015 Report cited many behavioral health services that are available in Montgomery County. However, people with multiple need cycle through our hospitals and jails often due to poor or no care coordination and difficulty accessing needed services.
    - According to the Health Services Cost Review Commission of Maryland, the estimated associated charges of hospital re-admissions within 30 days are 656.90 million.
    - Recidivism is higher for those with mental health disorders often due to charges, such as failure to appear or violation of probation, which could often have been prevented with good care coordination.
    - MHAC will advocate for the county to continue to explore and to establish a system which would function to coordinate care with consumers among all agencies involved, harmonize and integrate efforts among the agency providers, track care, and collect data. The funding for this model could come from general hospitals and insurance companies that have a vested interest in lowering rates of costly hospital admissions and re-admissions. This model has been used with high risk populations that have multiple needs, such as behavioral health challenges, homelessness, somatic needs, and involvement in the criminal justice system.

2) Possible configurations of the system could include two or three care coordinators based at the Core Service Agency, which could be managed by county personnel or bid out the service.

    - Start-up costs to cover two care coordinators, software, and training are estimated to be between $150,000 to $200,000.

(16)

- Our hope is that if the program is established using this model, it could be expanded to accommodate consumers with lower risks as well to create another point of access for several populations.

3) Continue to advocate for more deflection and diversion programs along the criminal justice continuum from a Restoration Center to a Mental Health Court.

- The Mental Health Advisory Committee continues to support decriminalization efforts in both the juvenile justice and criminal justice systems. In Montgomery County, an estimated 22 percent of the inmates at Montgomery County Correctional Facility and Montgomery County Detention Center are men and women with mental health disorders. Nearly 75% of these inmates are likely to have a co-occurring substance abuse disorder.
- Rates of those with serious mental health disorders in jails are 3 to 4 times higher than in the general population. Jails spend 2 to 3 times more on adults with mental health disorders due to treatment needs.
- MHAC is very hopeful about the work of the Mental Health Court Planning and Implementation Task Force. We will continue to engage in ongoing dialogues with the County Council and the judicial system to support the planning and initiation of a comprehensive plan that addresses the spectrum of criminal involvement so that there is a systematic response to the decriminalization of mental health disorders to include an effective use of resources.

Health and Human Services Committee
Work Session on Policy Issues

Date: 10/15/15
B/C/C Victim Services Advisory Board (VSAB)
B/C/C Representatives: Sorell Schwartz

Policy Issue #1: Resolve Housing Issues For Domestic Violence (DV) Victims and Their Families

Permanent (long-term) housing for Domestic Violence (DV) Victims is a critical need, necessary to ensure continuity of safety and life stabilization for this physically and psychologically vulnerable population. DV victims are provided temporary shelter and appropriate wrap-around services at the Betty Ann Krahnke Center (BAK). The prescribed period of residence is 2 to 3 months but because of the unavailability of transitional and long-term housing, at times clients remain at BAK about 6 months. Those unable to transition from BAK to safe conditions are provided temporary hotel housing, which is expensive and wholly inadequate with respect to protection from abusers. Further, DV victims face significant challenges that place them at risk for negative outcomes including: (a) high cost of living in the county, (b) lack of education and vocational skills, and (c) physical/emotional effects of complex trauma. Through the efforts of the VSAB working with County offices, long-term housing program for at least two young female-headed households will be instituted at Fleet Street properties, county-owned property that has been reserved by the county for DV victims and their families transitioning out of BAK. Although it is a positive step to have the two (2) available Fleet Street properties now identified as sites for transitional housing, and they are in the process of being refurbished by the County, this in no way addresses the much larger need for affordable long-term housing for DV victims. VSAB has met with Chuck Short, Special Assistant to the County Executive and members of county housing programs and housing advocacy groups to identify strategies to increase the availability of viable housing stock for DV victims and families in need of long-term housing. Additionally, we need about 100,000 for case management needs for this new initiative.

Policy Issue #2: Position Board as information resource for public on victim services available in the County

The VSAB plays a critical role as a conduit for relaying budgetary and other needs of both County Victims' programs and non-profits to HHS and to the Council and Executive. It has always acted to preserve staffing for direct victim services. This has an immediate and measurable impact on victims. The Board's chief contribution to this effort is the interviews its members conduct annually of County agencies and non-profits that provide such direct victim services. This year the Board provided more in-depth questions to a wider range of service providers in an effort to help assess and document the scope of their services and the populations they serve. The Board is currently working to assemble a directory of services for use by County professionals and the public. The Board has also fashioned a new awareness plan to help raise awareness among policymakers, county organizations and the general public, particularly of the existence of the County's Victim Compensation Fund and its role in helping to compensate victims of crime in our County.

FY 2016 YEAR TO DATE(YTD) SCHOOL REFERRAL REPORT

TOTAL REFERRALS	*FY16 YTD*	*FY 15*	*FY 14*	*FY 13*
	767	1075	1035	771

TOTAL SCHOOLS REFERRING	*FY16*	*FY 15*	*FY 14*	*FY 13*
	136	153	174	202

FY16 - School	*Referred*	*# not referred*
ELEMENTARY	***68***	***59***
MIDDLE	***38***	***0***
HIGH SCHOOL	***25***	***0***
PRIVATE	***5***	***N/A***

	FY16 YTD		*FY15*	
TYPE OF REFERRAL	*# STUDENTS*	*%*	*# STUDENTS*	*%*
ELEMENTARY	172	22.72%	224	20.93%
MIDDLE SCHOOL	341	44.45%	462	42.97%
HIGH SCHOOL	241	31.42	350	32.55%
EDISON TECH CENTER	2	.26%	1	0.09%
ALT. PROGRAMS	6	.78%	10	0.93%
PRIVATE SCHOOL	5	.65%	9	0.83%
MCT BY SCHOOL	N/A	N/A	19	1.76%
MALE	362	47.19%	493	N/A
FEMALE	405	52.80%	582	N/A

REFERRAL REASONS	*FY16 YTD*
1. SUICIDAL THREAT	419
2. BEHAVIORAL DYSFUNCTION	124
3. SUICIDAL BEHAVIOR	103
4. SELF-INJURIOUS BEHAVIOR	160
5. HOMICIDAL THREAT	67
6. PHYSICAL ATTACK	48
7. BULLYING (VICTIM)	26
8. BULLYING (PERPETRATOR)	5
9.OTHER	136

REFERRAL REASONS	*FY 15*	*FY 14*	*FY 13*
1. HARM TO SELF	812	758	540
2. HARM TO OTHERS	148	140	127
3. BEHAVIORAL DYSCONTROL	73	110	63
4. BULLYING	71	61	N/A
5. OTHER	74	84	55

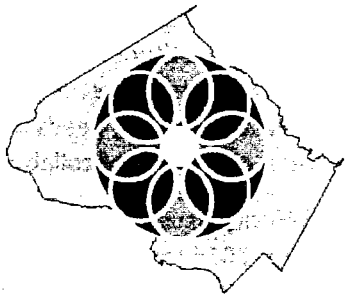
Disposition	*DESCRIPTION*	*FY16 YTD*
1a	Student not currently at risk to self or others	641
1b	No follow-up needed	179
1c	Follow-up recommended	175
2a	Referred for outpatient treatment	432
2b	Inpatient hospitalization (voluntary)	50
2c	Referred for partial hospitalization	4
2d	Emergency petition initiated by CC Staff	4
2e	Other	265

Disposition	*DESCRIPTION*	*FY 15*	*FY 14*	*FY 13*
1a	Student may return to school	566	896	650
1b	No follow-up needed	118	63	26
1c	Student not currently at risk to self or others	622	627	487
1d	Follow-up recommended	185	228	N/A
1e	Student may not return to school	7	16	18
2a	Crisis Center short term tx	15	41	27
2b	Referred for Outpatient tx	620	585	363
2c	Referred for partial hospitalization	12	10	4
2d	Inpatient hospitalization	28	41	19
2e	Emergency petition initiated by CC Staff	11	10	9
2f	Other	392	172	159
2g	Referred to current tx provider	100	77	21

MCTS TO SCHOOLS

Reason	*FY 16*	*Disposition*	*FY 16*
1 Suicidal	11	1. EEP	9
2 Homicidal	2	2. Voluntary to ER	1
3 Thought d/o	3	3. Remained in Community	4
4 Mood d/o	3	4. No answer	0
5 Family Conflict	0	5. Refuses to Participate	0
6 Crime Victimization	2	6. Referred to APS/CPS	0
7 Death	0	7. Refereed APP/VASAP	0
8 Hoarding	0	8. Info Give	0
9 TBI	0	9. Arrested	0
10 Substance	0	10. Other	5
11 Co-Occurring	0		
12 Other	3		
13 None	4		

Elementary: 3 ***Middle: 7*** ***High: 9***
MALE: 10 ***FEMALE: 9***



Healthy Montgomery
Behavioral Health Task Force

Recommendations Presented to the Healthy Montgomery Steering Committee

Executive Summary

March 2016

Executive Summary

Healthy Montgomery is Montgomery County's community health improvement process, an ongoing effort that brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to improve the health and well-being of all Montgomery County residents. It includes data collection, needs assessment, priority-setting, strategic action planning, and the implementation and evaluation of collaborative efforts.

One of the current Healthy Montgomery priority issue areas is behavioral health. The Behavioral Health Task Force (BHTF) was launched in November 2014 following the release of the Healthy Montgomery Behavioral Health Action Plan. BHTF membership includes public and private behavioral health service providers (including mental health and substance abuse) from throughout Montgomery County who treat adults and children in institutional and community settings. Also represented are the County's minority health initiatives and programs, the four County hospital systems, County councils and commissions, academia, family and consumer advocates, and Montgomery County emergency services, police, and corrections. The BHTF is co-chaired by Thom Harr (CEO Emeritus, Family Services, Inc.) and Kevin Young (President, Adventist HealthCare Behavioral Health & Wellness Services).

The purpose of the BHTF is to carry out the strategies defined in the Healthy Montgomery Behavioral Health Action Plan. That is, to:

1. Consider ways in which *info*MONTGOMERY can be enhanced to create an accessible Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services;
2. Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (e.g., hospitals, emergency rooms, correctional facilities, schools, universities) to community behavioral health organizations, primary care organizations and crisis centers;
3. Initiate a process 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 who live in Montgomery County.

The BHTF works within the larger framework of the Healthy Montgomery overarching goals which include: improving access to health and social services; achieving health equity for all residents; and enhancing the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

Three BHTF Subcommittees worked on the recommendations addressing the three strategies above. The *info*MONTGOMERY Subcommittee addressed the first strategy; the Policies and Protocols Subcommittee focused on the second strategy; and the Coordinated Care Subcommittee addressed the third. Each BHTF Subcommittee worked over the course of the past year, discussing and drafting the recommendations. Throughout the year, the BHTF also met, in its entirety, several times to discuss the progress of the Subcommittees and to provide feedback on and discuss the recommendations.

Context

Work on the recommendations of the BHTF has occurred in the midst of many parallel efforts in Montgomery County as well as at the state and national levels. The work also comes at a time when there is a national focus on improving the care of people with behavioral health issues, reducing the costs of incarceration and hospitalization, and improving outcomes for people with behavioral health issues.

At the federal level, legislation has been introduced in both the House and Senate to provide additional resources. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently awarded $22.9 million in planning grants to 25 states, including Maryland, to develop models for Certified Community Behavioral Health Centers. However, only eight states will be funded for implementation. Also, for the past several years SAMHSA has been supporting primary care integration into behavioral health centers, addressing the disturbing fact that people with mental illness have a greatly reduced life span primarily due to untreated chronic diseases such as chronic obstructive pulmonary disease (COPD) and diabetes.

One of the most significant developments occurred shortly before the creation of the BHTF. This development involves Maryland's implementation of the latest Centers for Medicare and Medicaid Services (CMS) waiver funding with a group of local hospitals. This created a cap on "total patient revenues" for hospitals and set a maximum escalation of cost at 3.58% per year for five years with financial sanctions for failure to meet the goals. Behavioral health patients are a significant part of the pool of "high risk, high utilizers" identified by hospitals. To comply with the terms of the waiver, hospitals not only must control costs but reduce re-admissions; creating a move to the development of community-based services (i.e. urgent care clinics) and utilization of existing, lower cost, community services. As a result, the County's six general hospitals have joined together to submit a request for a rate increase, in part to address behavioral health patient disposition and cost through improved services.

Similar efforts are underway for jails as well as hospitals. Incarceration is a high cost, low efficacy alternative for many people with mental health and/or substance abuse problems. As a result, local efforts have focused on this issue. Most recently, Montgomery County appointed a Planning and Implementation Committee for establishment of a mental health court. For those who are eligible, this will allow diversion from jail into treatment. Efforts have also been underway to create a local version of "the Restoration Center," a highly acclaimed project in San Antonio, Texas that provides an alternative to both incarceration and hospitalization for persons with mental illness and/or substance abuse problems.

These local efforts have been greatly enhanced by the comprehensive review of Montgomery County's behavioral health system (*Behavioral Health in Montgomery County* – Report No. 2015-13, July 28, 2015), carried out by the Montgomery County Office of Legislative Oversight (OLO). By assembling an extensive assessment of the current situation, OLO provided not only a starting point for planning an enhanced system but also highlighted the complexities involved not only for consumers but for providers and policy makers.

The complicating factors of substance abuse and unstable housing are recognized in all local systems. An important effort is underway to identify local resources and improve utilization. Housing options are critically needed if other efforts are to succeed. These issues appear in nearly every effort to improve the system and often stand as a barrier to full implementation of alternatives like hospital or criminal justice diversion.

As all of the systems options are explored one additional element is intriguing, the rapid development of technology that might support new approaches. For example, with a shortage of behavioral health prescribers, telehealth may be an approach to extending scarce resources. Smart cards, smart phone apps for consumers, electronic health records, and automated care management systems may all play a role.

Behavioral Health in Montgomery County

Healthy Montgomery and the BHTF use several behavioral health measures to focus Healthy Montgomery's behavioral health work and monitor progress. The measures include emergency department visits for behavioral health conditions, suicide rates, adolescent/adult illicit drug use in the past month, and adults with any mental illness in the past year. Data for Montgomery County reveal the following:

- The rate of emergency department (ED) visits for behavioral health conditions has increased 17% for all ages from 804.4 (per 100,000 population) in 2008-10 to 944.9 (per 100,000) in 2011-13; residents ages 18-34 are almost 4x more likely to visit the ED for behavioral health conditions; while the rate is lower for children (1-17 years) (686.1 in 2011-2013), children ED visits increased the most among age groups from 2008-2010 to 2011-2013 (542.4 to 686.1), a 26% increase.
- Males are 22% more likely than females to visit the ED for behavioral health conditions, but the gap is narrowing slightly. Black/African American residents are 5x times more likely than Asians/Pacific Islander residents, White residents are 3x more likely than Asian/Pacific Islander residents, and Hispanic residents are 2.5x more likely than Asian/Pacific Islanders to visit the ED for behavioral health conditions. Black disparity gap is narrowing slightly. While experiencing the lowest rate, the rate for Asian/Pacific Islanders has increased the most from 200.2 to 237.4 (per 100,000), a 19% increase.
- The suicide rate in Montgomery County has increased 12% for all ages from 6.5 (per 100,000) in 2006-08 to 7.3 (per 100,000) in 2011-13. Older residents (65 years and older) have the highest suicide rate. Also, the suicide rate for White residents is double that for Black/African American residents and Asian residents. The rate for Black/African American residents worsened by 29% (the rate worsened for White residents by 16% and improved by 26% for Asian/Pacific Islander residents; Hispanic suicides were too few to compile rates).
- Adolescent/adult (12 years and older) illicit drug use in the past month increased by 15.2% from 6.1 (per 100,000) in 2006-08 to 7.03 (per 100,000) in 2010-12.
- Adolescents 12-17 years old are twice as likely as adults (26 and older) to have used illicit drugs in the past month.
- Adults (18 years and older) with at least one major depressive episode in the past year increased by 10% from 5.83 (per 100,000) in 2006-08 to 6.39 (per 100,000) in 2010-12.With this rate moving away from the Healthy People 2020 target of 5.8 per 100,000 (Mental Health & Mental Disorders 4.2), a 10% improvement is needed to meet the national target.[1]

In addition to the immense costs to individuals with behavioral health problems and their families that are represented by these data, there are additional social and financial costs. National data reveal that total spending for behavioral health in 2009 was $172 billion, including 61% ($105 billion) from public

[1] Healthy Montgomery Community Health Needs Assessment 2015 (in preparation).

sources (Medicare, Medicaid and other federal, state, and local funding; with Medicaid the largest public source) and 39% from private sources (largely, private insurance and out-of-pocket spending).[1]

The BHTF offers its recommendations in the context of the individual, family, social, and financial costs these data represent in Montgomery County.

Summary Recommendations

*info*MONTGOMERY Subcommittee Recommendations:

1. **Create an accurate, relevant, and updated inventory of behavioral health services in the County through *info*MONTGOMERY.** Specifically, create a network of behavioral health resource specialists to manage the effort to build the data base and create a structure to ensure sustainability.
2. **Enhance *info*MONTGOMERY to improve the usability and accessibility of the information provided and its accessibility to vulnerable populations including people with disabilities, youth, seniors and people of diverse ethnicities, cultures and languages.** Specifically, employ user surveys, convene an advisory group, engage members from the County's diverse communities for guidance in ensuring website is logistically and linguistically accessible and that resources are culturally appropriate, and research best practices to implement changes to the present database including migration to a new platform.
3. **Inform consumers and professionals (e.g., consumers, caregivers, case managers, social workers, school counselors, therapists, physicians, hospitals, and other service providers) about *info*MONTGOMERY, as the gateway to behavioral health resources, using a deliberate, coordinated, and long-term outreach campaign, including targeted outreach to culturally and linguistically diverse populations in the County.**

Policies and Protocols Subcommittee Recommendations:

1. **Establish and fund an Integrated Care Consortium.** The Integrated Care Consortium (ICC) will continue the work started by the Healthy Montgomery BHTF (subsequently taking the place of the BHTF), allowing Healthy Montgomery to focus on other tasks to which it is committed. The ICC will create an infrastructure and leadership structure to move the specific recommendations of the BHTF forward both in the short- and long-term.
2. **Establish a process and assign a high priority to the identification of specific measures that will alleviate the problem of insufficient and inadequate housing for persons with behavioral health problems.** Inadequate supply of short and long-term housing for individuals with behavioral health challenges impacts the cost of care, drives disproportionate use of hospital resources, and ultimately has a negative impact on the behavioral health and physical health and life expectancy of this population.
3. **Identify and implement specific measures that will reduce the barrier that transportation presents in access to care, housing, and supportive services for persons with behavioral health problems.** Barriers such as transportation often have a negative impact on the behavioral

[1] N. Carrizosa, S. Richards. *Behavioral Health in Montgomery County*. July 28th, 2015. Montgomery County Office of Legislative Oversight. Report Number 2015-13. Accessed at: http://www.montgomerycountymd.gov/OLO/Resources/Files/2015_Reports/OLO%20Report%202015-13%20Behavioral%20Health%20in%20Montgomery%20County.pdf

health, physical health, and life expectancy of persons with mental health and/or substance abuse disorders and often lead to increased costs of care in the long run.

Coordinated Care Subcommittee Recommendations:

1. **Identify funding for a study to create guidelines for a County-wide care coordination system (the study would be overseen by the Integrated Care Consortium, if formed).** The County-wide care coordination system to be studied would: 1- focus on the specific needs of individual consumers for their care coordination (a model broader in scope than the hospitals' efforts to coordinate care for those transitioning out of the hospital and to prevent re-hospitalization); 2- be designed based on a model that adopts SAMSHA's guiding principles of recovery[2] and supports SAMSHA's working definition of recovery from mental disorders and/or substance use disorders - that is, a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential; and 3- align with the County hospital systems and existing efforts in the non-profit sector.
2. **Create and implement a pilot for a formalized, coordinated system of care addressing behavioral health (substance abuse and mental health), medical and social needs of 300 adult consumers (18 years and older) who have a mental health diagnosis and *one* of the following – chronic homelessness as defined by the federal Department of Housing and Urban Development (HUD), minimal or no supports, multiple acute hospitalizations and/or emergency department (ED) visits; and/or multiple incarcerations.** According to the Agency for Healthcare Research and Quality (AHRQ),"care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a consumer's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."[3]
3. **Implement a Hub and Pathways Model for Care Management of Behavioral Health consumers.** Specifically, the Hub and Pathways Model is recommended because of its ability to effectively bring together the efforts of various stakeholders in a more collaborative and less duplicative effort than is now possible. The model is particularly effective in incorporating the social determinants of health (i.e., housing, education, income, employment, food sufficiency) with medical care. With research indicating 80% of a person's health status relates to the former it is critically important for persons with mental health and/or substance abuse problems to have these issues addressed as they are often dominant factors.

A critical element in the recommendations of the Coordinated Care Subcommittee is strong support for a shared base of principles and values based on SAMHSA's working definition of recovery from mental disorders and/or substance abuse disorders. Inclusive in this is the use of "peer bridgers" as a part of the system that includes not just professional services but involvement of patients/consumers and, where possible, families. The presence of supportive individuals in the life of a person experiencing

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[2] SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery can be accessed at: https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf)

[3] Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Volume 7- Care Coordination. Accessed at: http://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html

these issues has a potentially marked influence on disease management and outcomes. The SAMHSA principles include:

- Recovery emerges from hope.
- Recovery is person-driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally-based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family and community strengths and responsibility.
- Recovery is based on respect.[4]

For more information about Healthy Montgomery or the work of the BHTF, please visit www.HealthyMontgomery.org

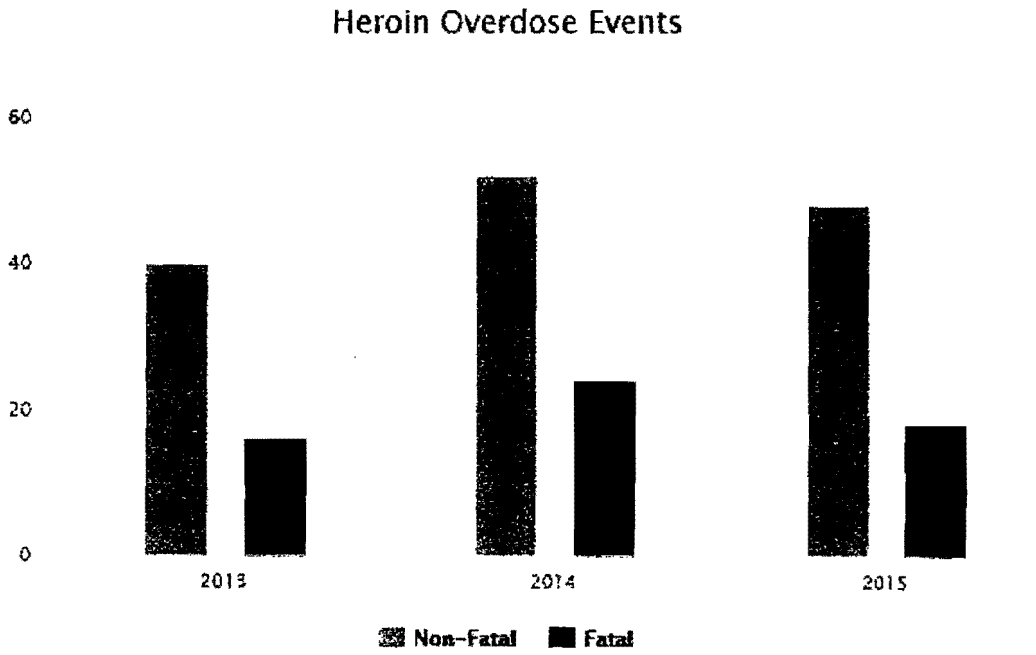
[4] SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery can be accessed at: https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf)

11/20/2015

Montgomery County Department of Police

Heroin Trends in Montgomery County, Maryland

- Non-Fatal and Fatal Heroin Overdose Events 2013- 2015:



Source: Official & Unofficial Police Data

Updated 11/18/2015

	2013	2014	2015
Non-Fatal	40	52	48
Fatal	16	24	18
Total	**56**	**76**	**66**

- Non- Fatal incidents increased 30% from 2013 to 2014
  - Three individuals were identified as experiencing non-fatal heroin overdoses twice on separate dates
- Fatal incidents increased 50% from 2013 to 2014

*Data prior to this epidemic, which began in March 2013, has not been collected with the same level of detail and is unavailable for compa

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- Heroin Related Arrests 2014-2015:

Charge	2014	2015 (Up to 11/20/2015)
Heroin-Possession	70	62
Heroin-Sell	46	42
Heroin-Use	0	1
Total	**116**	**105**

*Records Management System (RMS) was changed mid-2013 and arrests prior to 2014 are unavailable for comparison.
*Arrests reports may have included more than one arrestee and each arrestee was counted individually.
*Arrests involving Heroin Paraphernalia only are not included in the table above.

From DHMH

SUMMARY OF TRENDS IN DEATHS—2007 TO 2014 - Statewide

Total alcohol and drug intoxication deaths

- A total of 1039 drug- and alcohol-related intoxication deaths occurred in Maryland in 2014, a 21% increase over the number of deaths in 2013 and a 60% increase since 2010, after which time the number of deaths began to rise.
- Intoxication deaths have been increasing among all age groups, but are increasing most rapidly among individuals 55 years of age and above.
- The number of deaths increased by 38% among African Americans, 15% among Whites, and 43% among Hispanics between 2013 and 2014. Although the number of deaths has increased among all three groups since 2010, the increase has been greatest among African Americans; the number of deaths doubled within this time period.
- Deaths increased by 27% among men and 8% among women between 2013 and 2014.
- Although the number of deaths has generally been increasing in all regions of the State since 2010, there are several small jurisdictions where the number of deaths has either remained stable, or declined.

Opioid-related deaths

- Eight hundred eighty-seven (887), or 85.7% of all intoxication deaths that occurred in Maryland in 2014 were **opioid**-related. **Opioid**-related deaths included deaths related to **heroin**, **prescription opioids**, and nonpharmaceutical **fentanyl**.
- The number of **opioid**-related deaths increased by 22% between 2013 and 2014, and by 76% between 2010 and 2014.
- Large increases in the number of **heroin** and **fentanyl**-related deaths were responsible for the overall increase in **opioid**-related deaths. The number of **heroin**-related deaths increased by 25% between 2013 and 2014 (from 464 to 578), and there was over a three-fold increase in the number of **fentanyl**-related deaths (from 58 to 185).
- The number of **heroin**-related deaths in Maryland more than doubled between 2010 and 2014. Deaths have increased among all age groups, whites and African Americans, men and women, and in all regions of the State.
- Twenty-five percent of **heroin**-related deaths in 2014 occurred in combination with **alcohol**, 22% with **cocaine,** and 18% with **fentanyl**.
- The overall number of **prescription opioid**-related deaths has remained relatively stable in recent years. However, deaths have been increasing among African Americans and among individuals ages 55 years and above.

- The number of **fentanyl**-related deaths began increasing in late 2013 as a result of overdoses involving nonpharmaceutical **fentanyl,** that is, nonprescription **fentanyl** produced in clandestine laboratories and mixed with, or substituted for, heroin or other illicit substances. **Fentanyl** is many times more potent than heroin, and greatly increases the risk of an overdose death.
- **Fentanyl**-related deaths have increased among all age groups, among whites and African Americans, and among both men and women. The increase has been particularly pronounced among African Americans; there were 74 deaths in 2014 compared with only two in 2012.
- While **fentanyl**-related deaths have been increasing in all regions of the State, the increase has been most rapid in Central Maryland.

Cocaine-related deaths

- The number of **cocaine**-related deaths, which had remained relatively stable since 2008, increased by 29% between 2013 and 2014. There were 198 deaths in 2014 compared to 154 in the year before.
- The number of deaths increased most rapidly between 2013 and 2014 among African Americans and among men.
- Nearly 66% of **cocaine**-related deaths occurred in combination with **heroin**, and 20% in combination with **prescription opioids**.

Benzodiazepine-related deaths

- The number of **benzodiazepine**-related deaths increased from 69 in 2013 to 103 in 2014, an increase of nearly 50%.
- Nearly 60% of all **benzodiazepine**-related deaths occurred in combination with **prescription opioids**.

Alcohol-related deaths

- The number of **alcohol**-related deaths increased by 13% between 2013 and 2014, and by 69% since 2010. There were 270 **alcohol**-related deaths in 2014, compared with 238 in 2013 and 160 in 2010.
- Most alcohol-related deaths occur among individuals between the ages of 45 and 54 years of age, and among men. The number of deaths has been increasing in recent years among both whites and African Americans.
- More than half of all **alcohol**-related deaths occurred in combination with **heroin**.

Figure 10

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Total Number of Drug and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland. January -- March, 2015 and 2014.

State of Maryland	Drug & Alcohol Intoxication Deaths		2015 vs 2014
COUNTY	Jan. - Mar. 2015	Jan. -Mar. 2014	# DIFFERENCE
Allegany County	5	1	4
A. A. County	27	23	4
Baltimore City	116	74	42
Baltimore County	47	40	7
Calvert County	5	9	-4
Caroline County	0	1	-1
Carroll County	11	14	-3
Cecil County	6	10	-4
Charles County	6	6	0
Dorchester County	0	0	0
Frederick County	3	11	-8
Garrett County	1	1	0
Harford County	9	7	2
Howard County	7	3	4
Kent County	2	0	2
Montgomery County	23	10	13
P.G. County	13	16	-3
Queen Anne's County	1	3	-2
Somerset County	6	1	5
St. Mary's County	3	3	0
Talbot County	2	0	2
Washington County	19	11	8
Wicomico County	4	6	-2
Worcester County	2	3	-1
Total	318	253	65

[1] Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

[2] Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3] Counts for 2015 are preliminary.

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	TOTAL INTOXICATION DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	815	694	731	649	671	799	858	1,040	318
WESTERN AREA	110	99	97	96	109	115	138	161	51
GARRETT	1	3	3	3	2	0	6	2	1
ALLEGANY	14	9	9	15	12	14	15	12	5
WASHINGTON	16	26	18	20	21	27	28	40	19
FREDERICK	23	15	23	20	30	26	37	42	3
MONTGOMERY	56	46	44	38	44	48	52	65	23
CENTRAL AREA	550	443	479	411	420	519	557	677	217
BALTIMORE CITY	287	184	239	172	167	225	246	304	116
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	47
ANNE ARUNDEL	71	70	63	56	79	83	78	101	27
CARROLL	14	17	22	15	8	29	24	38	11
HOWARD	16	19	16	10	21	24	29	21	7
HARFORD	31	35	33	43	38	39	36	43	9
SOUTHERN AREA	86	94	93	74	73	93	84	110	27
CALVERT	14	9	14	6	12	12	6	17	5
CHARLES	13	16	11	13	11	13	9	21	6
ST. MARY'S	6	11	9	12	8	12	10	9	3
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	13
EASTERN SHORE AREA	69	58	62	68	69	72	79	92	23
CECIL	25	10	24	24	28	25	26	29	6
KENT	3	4	2	5	2	0	4	6	2
QUEEN ANNE'S	4	5	4	4	5	2	8	10	1
CAROLINE	1	4	2	2	11	4	2	7	0
TALBOT	5	4	3	3	1	5	7	4	2
DORCHESTER	4	5	2	6	2	5	5	0	0
WICOMICO	9	13	12	13	11	21	17	20	4
SOMERSET	6	3	4	1	3	3	4	3	6
WORCESTER	12	10	9	10	6	7	6	13	2

1 Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

3 Counts for 2015 are preliminary.

Child and Adolescent Mental Health Clinic - Wait List

Wait List- March 15, 2016 - April 15, 2016

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
March	8	4	12	26	12	38	34	16	50

Wait List- Feb 15, 2016 - March 15, 2016

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Feb	4	3	7	27	13	40	31	16	47

Wait List- January 15, 2016 - Feb 15, 2016

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Jan	3	1	4	22	17	39	25	18	43

Wait List- December 15, 2015 - Jan 15, 2016

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Dec	3	2	5	25	26	51	28	28	56

Wait List- November 15, 2015 - December 15, 2015

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Nov	0	0	0	16	20	36	16	20	36

Wait List- October 15, 2015 - November 15, 2015

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Oct	0	0	0	17	3	20	17	3	20

Wait List- September 15, 2015 - October 15, 2015

	Home Based Team - Waitlist			Mental Health Clinic Services - Waitlist			Sub Total	Sub Total	Grand Total
FY 2016	Spanish	English	Sub Total	Spanish	English	Sub Total	Spanish	English	All Languages
Sept	0	0	0	4	5	9	4	5	9