

Report on the Maryland Safe to Learn Act of 2018

Submitted by the Maryland Department of Health
December 17, 2018

Senate Bill 1265 (Chapter 30)



TABLE OF CONTENTS

| | |
|---|----|
| Executive Summary | 3 |
| Introduction | 4 |
| Part 1 | |
| Data on the Availability of Mental Health Services..... | 5 |
| I. Demographics..... | 5 |
| II. Risk Factors | 8 |
| III. Need for Behavioral Health Services | 10 |
| IV. Non-school-based Services | 12 |
| V. Providers..... | 22 |
| VI. School-based Behavioral Health Services..... | 24 |
| VII. Gaps in Services | 28 |
| VIII. Emergency Tip Lines | 29 |
| Part 2 | |
| Findings: The Needs of School-Age Children | 31 |
| I. Steps to Identify Gaps. | 31 |
| II. Gaps in Treatment Capacity and Services..... | 31 |
| Part 3 | |
| Delivery Implementation..... | 33 |
| I. Plans for Delivering Services | 33 |
| II. Recommendations on Addressing Gaps..... | 34 |



Karen B. Salmon, Ph.D.
State Superintendent of Schools

Executive Summary

The Maryland Safe to Learn Act of 2018, Senate Bill (SB) 1265, was enacted with the purpose of improving school safety. Section 12 of the Act requires the School Safety Subcabinet to report in general on the availability of mental health services and practitioners for school-age children, the mental health needs of school-age children, and the School Safety Subcabinet's plans for delivering behavioral health and wraparound services to students exhibiting behaviors of concern.

Of the 1,063,206 school-age children and youth in Maryland in 2017, 1,021,054 were enrolled in school, 43,759 were suspended or expelled. A self-report survey assessing the risk behaviors of Maryland middle and high schoolers indicated 7.4% of high school students reported carrying a weapon on school property, 7.8% of high school students reported having been threatened or injured by a weapon while attending school, 18.2% of high school students reported being bullied, and 29.9% of high school students reported feeling sad or hopeless. It is estimated that approximately 22% of school-age children and youth in Maryland experience mental health or substance abuse challenges serious enough to require treatment.

Maryland serves the behavioral health needs of school-age children and youth through community-partnered school behavioral health programs and school-based health centers. Twenty out of 24 of the jurisdictions reported partnering with one or more community behavioral health provider to provide services, while 12 of 24 jurisdictions provide services to children while they are at school.

The findings in this report indicate an uneven distribution of service providers and service utilization across the State. Further, research has demonstrated that children and youth enrolled in Maryland Medical Assistance programs are disproportionately affected by behavioral health disorders and are more likely than their counterparts with private insurance to see a mental health professional or a primary care doctor for emotional and behavioral problems.

However, the majority of community-partnered school behavioral health programs are not providing the full continuum of comprehensive behavioral health services (i.e., behavioral health promotion, prevention, and intervention). A majority of community-partnered school behavioral health programs provide treatment services for students already identified with concerns, yet few provide behavioral health promotion or prevention services. Additionally, community-partnered school behavioral health programs are not consistently collecting, analyzing, and reporting student- and school-level data to document impact of service provision. Further, funding sources have significant impact on whether a full continuum of care is provided through community-partnered school behavioral health versus only a focus on youth already identified and displaying behavioral health concerns.

This report makes recommendations such as offer training, collect data, and promote Maryland’s comprehensive array of behavioral health services to address gaps.

Introduction

School shootings continue to occur around the country at an alarming rate. On March 20, 2018, Maryland experienced a school shooting at Great Mills High School in St. Mary’s County.¹ In an effort to improve school safety, enactment of the Maryland Safe to Learn Act of 2018, SB 1265, became “an aggressive agenda” for the General Assembly and Governor Larry Hogan.² On April 9, 2018, less than 30 days after SB 1265 was first introduced,³ the bill passed both chambers. The same day, Governor Hogan approved the bill as Chapter 30 of the 2018 Acts of Maryland.

In 2013,⁴ the Maryland Center for School Safety⁵ was established as an independent unit within the Department of Education to provide a coordinated and comprehensive policy for school safety in Maryland. The Maryland Center for School Safety is the primary entity responsible for implementing the Maryland Safe to Learn Act and governed by the School Safety Subcabinet (Subcabinet),⁶ which includes the State Superintendent (Chair), the Secretary of State Police, and the Secretary of Health, among others. The Subcabinet has an advisory board⁷ to provide the Subcabinet with advice and assist the Subcabinet in completing its duties.

Section 12 of the Maryland Safe to Learn Act (or Act) requires the Subcabinet to report to the Governor and General Assembly on nine topics. To satisfy the reporting requirements as well as address the Act’s overall efforts to improve school safety, this report is organized into three parts: (1) the availability of mental health services and practitioners for school-age children, (2) the mental health needs of school-age children, and (3) the Subcabinet’s plans for delivering behavioral health and wraparound services to students exhibiting behaviors of concern.

¹ Jounvenal, J., St. George, D., and Truong, D., Student gunman dies after Maryland school shooting; two other students injured, The Washington Post (March 20, 2018), online at https://www.washingtonpost.com/local/public-safety/maryland-authorities-investigating-shooting-at-high-school/2018/03/20/4deeadee-2c39-11e8-8ad6-fbc50284fce8_story.html?utm_term=.3b565cb32ec2 (all Internet materials as last visited July 12, 2018).

² Wiggins, O., and Chason, R., Maryland lawmakers act on school safety and crime ahead of session’s end, The Washington Post (April 9, 2018), online at https://www.washingtonpost.com/local/md-politics/maryland-lawmakers-act-quickly-ahead-of-end-to-legislative-session-at-midnight/2018/04/09/eec27cc2-3c02-11e8-974f-aacd97698cef_story.html?noredirect=on&utm_term=.3c4ae8905e92.

³ Senate Bill 1265 was first introduced on March 13, 2018.

⁴ Chapter 372 to the Acts of 2013

⁵ Education Article § 7–1502.

⁶ § 7–1503.

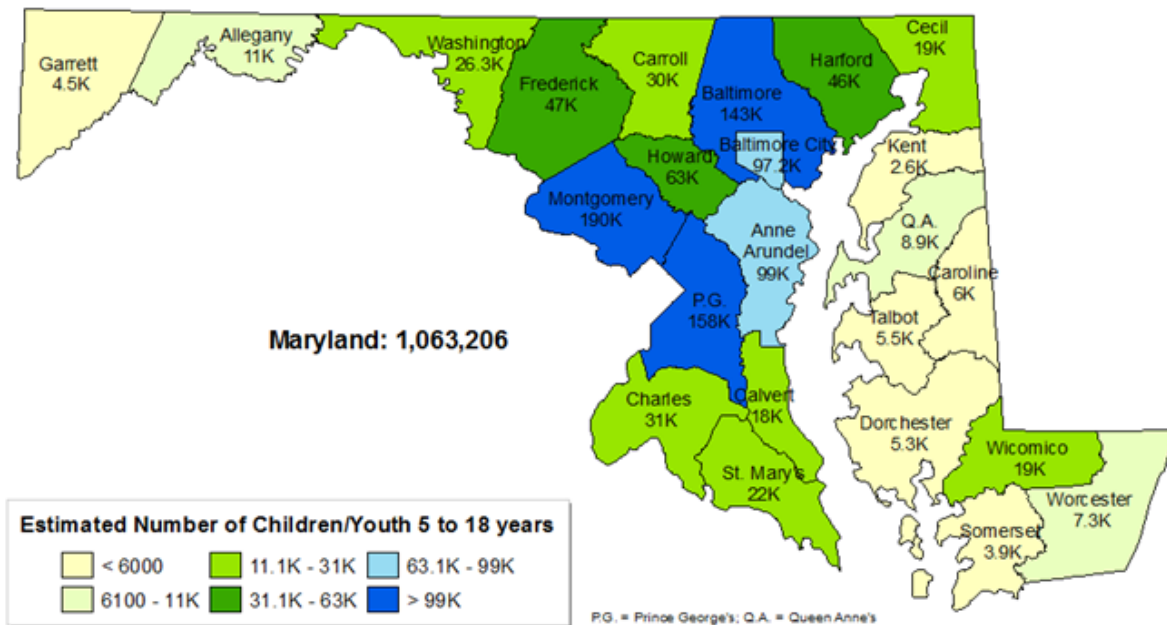
⁷ § 7–1504.

Part 1
Data on the Availability of Mental Health Services

I. Demographics

To address Section 12(a)(1)(ii), which references the availability of “school-age children,” this report will first provide data on the population of children and schools in the State.

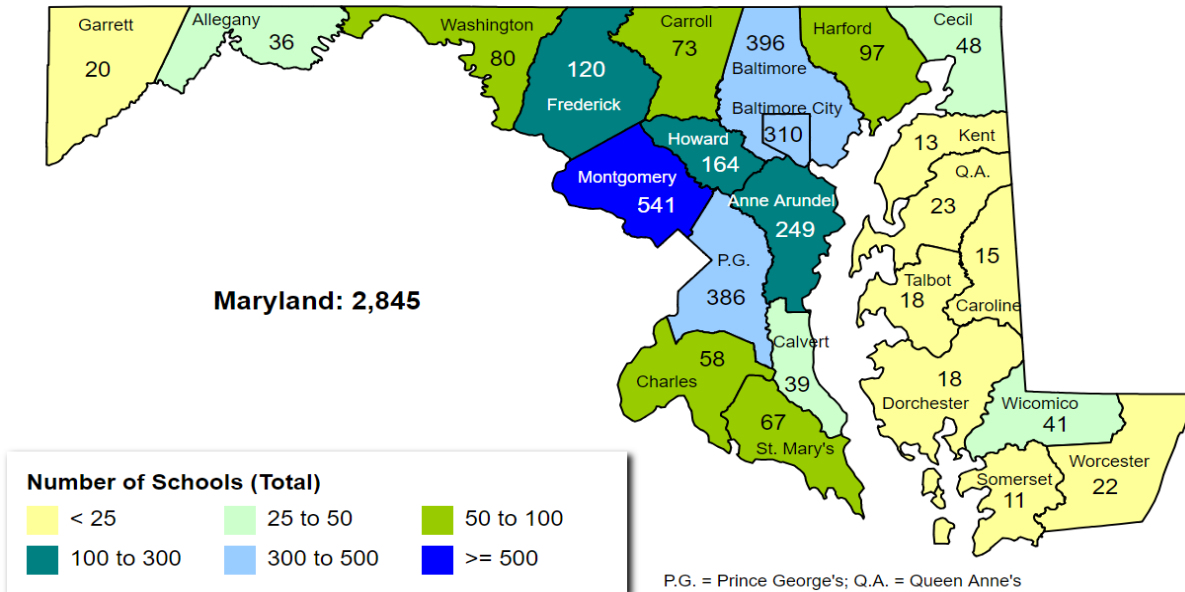
Map 1: Number of School-Age Children and Youth (5 to 18 Years) by Jurisdiction, CY17



Data Source: American Community Survey 2017, Maryland population estimates for children and youth (5 to 18 years).

In CY17, there were slightly over one million (1,063,206) school-age (5 to 18 years) children and youth in Maryland, which represents slightly more than one-sixth of the total population (6,052,177) of the State. As shown in Map 1, nearly two-thirds (64.6%) of these children resided in five jurisdictions in the Baltimore-Washington metropolitan area, including Baltimore City and Montgomery, Prince George’s, Baltimore, and Anne Arundel Counties. On the other hand, counties on the Eastern Shore and far western Maryland had much lower numbers of school-age children.

Map 2: Number of Public and Non-Public Schools by Jurisdiction, September 30, 2017

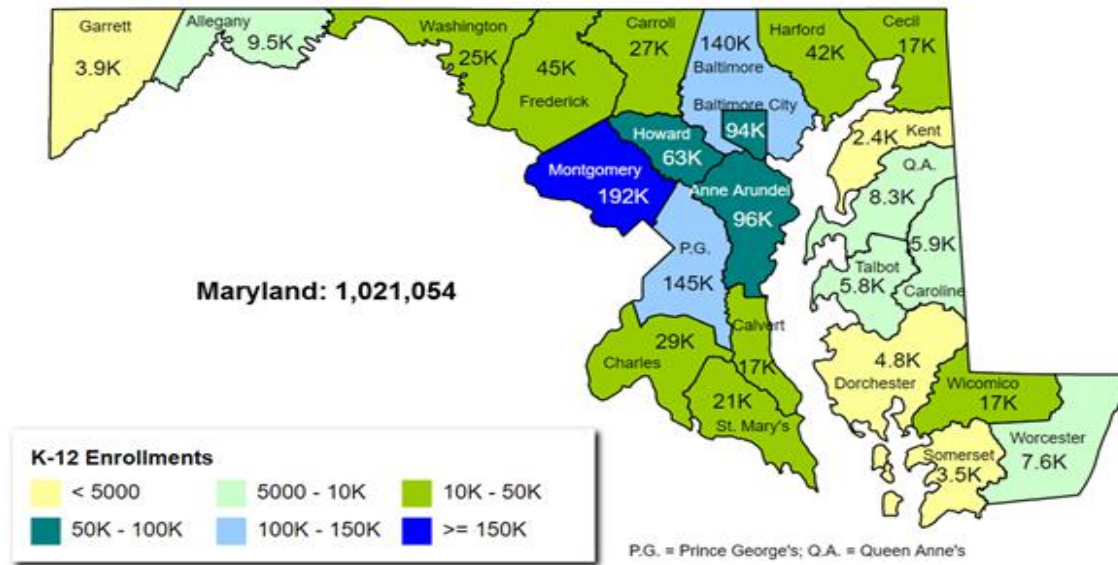


Data Source: Maryland State Department of Education (MSDE), Maryland Public and Non-Public School Enrollment, September 30, 2017.

Notes: Public schools include: elementary, middle, and high schools, combined, vocational tech, special education, charter, alternative education centers, and specialized educational programs. One Seed School is not included in this count since it is not assigned to a specific jurisdiction.

As shown in Map 2, there were a total of 2,845 public and non-public schools in Maryland as of September 30, 2017. Those jurisdictions with the largest numbers of school-age children and youth (i.e., Baltimore City and Montgomery, Prince George's, Baltimore, and Anne Arundel Counties) had the highest concentration of public and private schools, while counties in Mid-Shore had the lowest number of public and non-public schools. Two-thirds (66%) of the public and non-public schools were located in five jurisdictions, including Baltimore City and Montgomery, Baltimore, Prince George's, and Anne Arundel Counties.

Map 3: Kindergarten to Grade 12 Public and Non-Public School Enrollment, September 30, 2017



Data Source: MSDE Maryland Annual Public and Non-Public School Enrollment, September 30, 2017

Note: Public school enrollment, which includes charter schools, was 893,689 and non-public school enrollment was 127,765. Charter school enrollment was 22,368.

In the 2016–2017 academic year, Maryland had a total public and non-public student enrollment between Kindergarten and Grade 12 of 1,021,054, including 893,289 public school enrollments and 127,765 non-public enrollments (see Map 3). Public and non-public school enrollments varied substantially across the State. Montgomery County had the highest number of student enrollments, while Kent, Somerset, Dorchester, and Garrett Counties had the least number of students. Three of the 24 jurisdictions (Montgomery, Prince George’s, and Baltimore Counties) accounted for more than one-half (53%, 477,000) of all enrolled students in Maryland. The number of students enrolled in public schools has increased from 851,640 in 2006 to 893,689 in 2017, reflecting a 4.9% increase. Conversely, enrollment in non-public schools have declined from 179,103 in 2007 to 127,665 in 2017, reflecting a 29% decrease. Since 2012, the number of students who were homeschooled increased statewide from 24,302 to 26,040, reflecting a 7% increase.

Students enrolled in Maryland public schools are racially diverse with nearly two-thirds (62.7%) from minority backgrounds. Black/African-American students accounted for one-third of the enrolled students and slightly more than one-half (54%) of all students from minority backgrounds. Other minority groups included: Hispanic (17.4%), Asian (6.6%), American Indian/Alaskan (0.3%), Hawaiian/Pacific Islander (0.1%), and children of multiracial backgrounds (two or more races) (4.6%). Students were evenly divided by gender with 51% male students and 49% female.

Enrollment in charter schools is included in the public-school enrollment counts. Statewide, in the 2017–2018 school year, 50 charter schools served a total of 22,368 children and youth. In the 2017–2018 school year, a total of 26,040 students were homeschooled in Maryland. Slightly over

one-half (56%) of homeschooled students resided in just 6 of the 24 jurisdictions, including Anne Arundel, Baltimore, Frederick, Harford, Montgomery, and Prince George’s Counties.

II. Risk Factors

To address Section 12(a)(1)(ii), which references the “mental health” needs of school-age children, this report will first provide data on behaviors that may present a risk to the mental health of school-age children.

The 2016–2017 Youth Risk Behavior Survey (YRBS) was used to examine potential safety-related risk behaviors among Maryland high school students. The YRBS is a national survey of health-risk behaviors conducted in middle and high schools every two years in Maryland and around the United States. This self-report survey assesses risk behaviors in six areas: behaviors contributing to unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual risk behaviors, unhealthy diet and physical inactivity.⁸

This review focused on eight key risk behaviors: carrying weapons on school property, being threatened or injured by a weapon on school property, being bullied while on school property, feeling sad or hopeless, alcohol use and binge drinking, use of prescription pain medications, use of heroin, and school suspensions and expulsions.

Carrying a Weapon on School Property in the Past 12 Months:⁹ Statewide, 7.4% of high school students surveyed reported carrying a weapon on school property. Maryland students were nearly twice as likely to report carrying weapons compared to a national sample of high school students. Student responses to this question varied across jurisdictions ranging from a low of 4.8% in Howard County to a high of 12% in Dorchester County. Nearly one-half (11 of 24) of the jurisdictions reported rates above the state average on this indicator. Black/African-American (8.5%) and male (9.3%) students were more likely to report having carried a weapon on school property compared to White (4.7%) and female students (4.5%).

Threatened or Injured by a Weapon on School Property in the Past 12 Months: 7.8% of Maryland high school students reported having been threatened or injured by a weapon while attending school. There was substantial variation in student responses to this question across the state ranging from a low of 5.2% in Calvert County to more than one in ten students in Dorchester (12.9%) and Somerset (11%) Counties. More than one-half (13 of 24) jurisdictions had rates higher than the state average (7.8%) on this indicator. African-American students (8.5%), male (9.7%),

⁸ The six areas referenced in this report were selected from a list of safety related and substance related YRBS indicators. For a complete list of indicators, see <https://nccd.cdc.gov/youthonline/App/Default.aspx>.

⁹ Public Safety Article §5–133(d) prohibits anyone under 21 years old from possessing a regulated firearm absent certain exceptions, e.g., the individual must possess a firearm for employment.

and lesbian, gay, or bisexual (LGB)¹⁰ students (14.2%) were significantly more likely to report being threatened or injured with a weapon on school property.

Bullied on School Property in the Past 12 Months: The survey results indicated that nearly one in every five (18.2%) Maryland high school students reported being bullied in the past 12 months. Rates varied substantially across the State from a low of 13.4% in Baltimore City to a high of 26.8% in Garrett County. Four jurisdictions—Garrett (26.8%), Carroll (26.1%), Kent (26.3%), and Caroline (26.6%) Counties—had the highest rates of bullying, with more than one-quarter of students reporting having been bullied, while Baltimore City (13.4%) and Montgomery (16.3%), Prince George’s (14.5%), and Howard (15.3%) Counties had rates well below the state average. Female (19.9%) and LGB (30.6%) students were substantially more likely to report having been a victim of bullying compared other high school students.

Feeling Sad or Hopeless in the Past 12 Months: More than one-quarter (29.9%) of Maryland high school students reported feeling sad or hopeless in the past 12 months. Rates on this indicator varied substantially across the State ranging from a low of 26.8% in Somerset County to one-third (33.1%) of students in Garrett (33.1%), Allegany (33.2%), and Dorchester (33.2%) Counties. Female (38.7%) and LGB (57.3%) students were more likely to report feeling sad or hopeless compared to other students. Nearly two-thirds (62%) of females who identify as being LGB reported feeling sad or hopeless over the past 12 months.

Alcohol Use and Binge Drinking: One-quarter (25.5%) of Maryland high school students reported using alcohol in the past 30 days and more than one in ten (13%) students report binge drinking one or more times in the past 30 days. Current alcohol use rates varied substantially across the State from 17% in Prince George’s County to 41% in Queen Anne’s County. More than one-third of students from Garrett (36%), Kent (35.9%), and Queen Anne’s (41%) Counties reported using alcohol in the past 30 days. Students in these counties were also more likely than students in other parts of the State to report participating in binge drinking over the past 30 days with more than one in five students in Garrett (23.3%); Kent (20.8%); Queen Anne’s (25.7%) reporting engaging in this activity. In contrast, students from Prince George’s (6.4%) and Montgomery (11.2%) Counties were the least likely to report using alcohol and participating in binge drinking. Female and LGB students were more likely to report using alcohol (females, 28.6%; LGB, 35.9%) and participating in binge drinking (females, 13.9%; LGB, 18.2%).

Use of Prescription Pain Medications: More than one in ten (13.7%) students statewide reported illicit use of prescription pain medication. Student reports of use varied across the State with the highest rates occurring in Dorchester (17.5%), Charles (17.0%), and Somerset (17.1%) Counties

¹⁰ Specific to sexual orientation, the YRBS only collected data “among gay, lesbian, or bisexual students” who self-identified “male” or “female.” Data on transgender individuals was not available for this report.

and the lowest rates reported in Montgomery (10.3%) and Howard (11.2%) Counties. LGB students were twice (28.4%) as likely to report using pain medications than other students.

Use of Heroin: Statewide, 4.3% of Maryland high school students reported ever using heroin. This rate is 2.5 times higher than the national rate of 1.7%. Students from Baltimore City (7.6%) and Dorchester (13.2%), Charles (5.9%), and Kent (5.9%) Counties were most likely to report having used heroin, while students from Carroll (2.5%), Calvert (2.7%), and Montgomery (2.6%) Counties were the least likely to report. It should be noted that students in Baltimore City (7.6%) and Dorchester County (13.2%) reported ever having used heroin at substantially higher rates compared to students from other parts of the state. Male students (5.3%) were more likely to report ever using heroin compared to females (2.4%) and LGB students were more than twice (11.6%) as likely to report using heroin compared other students.

Public School Suspensions and Expulsions:¹¹ In the 2016–2017 school year, a total of 43,759 students were suspended or expelled from school accounting for 5.1% of all public-school enrolled students. Out-of-school suspensions and expulsions¹² accounted for the majority (87.6%) of these events, while the remaining 12.4% were in-school suspensions/expulsions. Suspension and expulsion rates varied substantially across Maryland jurisdictions, ranging from a low of 1.8% in Montgomery County to a high of 18.1% in Somerset County. Suspension and expulsion rates in four jurisdictions, including Somerset (18.1%), Dorchester (15.3%), Wicomico (11.8%), and Kent (10.3%) Counties, were more than twice the state average (5.1%). Male (68.8%) and African-American (59.6%) students were more likely to be suspended or expelled compared to female (31%) and White (23.4%) students. During the 2016–2017 school year, a total of 76,719 suspension or expulsion related offenses were committed by 43,759 students statewide. Slightly more than one-third (35.4%) of these students committed two or more offenses during the school year and nearly one in ten (9.5%) committed four or more offenses. Students were most frequently suspended or expelled for fighting (23%), disrespectful and disruptive behavior (35.4%), and attacks on other students or adults (15.9%). Statewide, 3.1% of students were suspended or expelled as a result of possessing a gun or another weapon on school property.

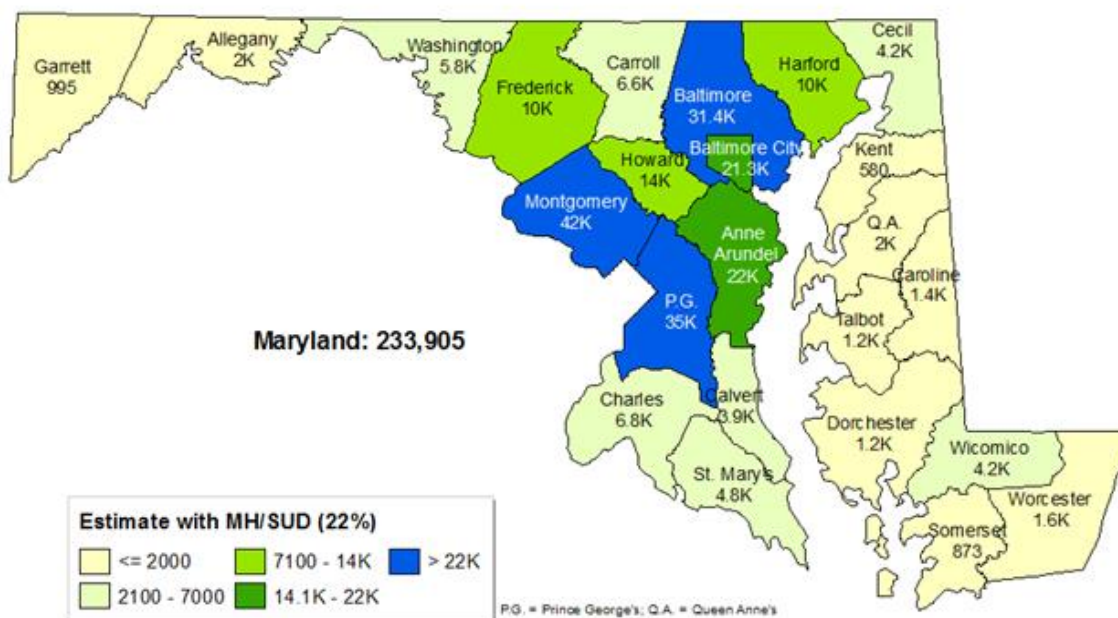
III. Need for Behavioral Health Services

To finish addressing Section 12(a)(1)(ii), which references the mental health “needs” of school-age children, this report will provide data on the population of school-age children with a mental health disorder.

¹¹ MSDE, Suspensions, Expulsions, and Health-Related Exclusions, Maryland Public Schools, 2016–2017.

¹² COMAR 13A.08.01.11(C) states that each school system has the authority and responsibility to maintain school safety and can use the following out-of-school discipline practices when warranted: (1) “long-term suspension,” which is the removal of a student from school for 4 and 10 days; (2) “extended suspension,” which is the exclusion of a student from their regular program for 11 and 45 days; and (3) “expulsion,” which is the exclusion of a student from their regular school program for 45 days or longer.

Map 4: Estimated Number of School-Age Children and Youth (5 to 18 Years) with a Mental Health or Substance Use Disorder



Data Sources: U.S. Census Bureau, American Community Survey, 2017; Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016, available online at, online at <https://www.samhsa.gov/data/report/2015-2016-nsduh-state-specific-tables>; and National Survey of Children's Health, 2003, online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3225084/>.

Mental health and substance use disorders (MH/SUD) are common among school-age (5 to 18 years) children and youth. It is estimated that approximately one in five (22%, 233,905) school-age children and youth (5 to 18 years) in Maryland experience mental health or substance abuse challenges serious enough to require treatment. Behavioral health treatment need estimates were derived from two national surveys: the National Survey on Child Health, which provides the percent of children (3–17 years) with any mental health condition (18%), and the National Survey on Drug Use and Health, which provides the percent of youth (12–17 years) with a substance use disorder (SUD) (4%). These estimates reflect the number of children and youth with MH/SUD who may be in need of treatment but do not reflect the actual demand for services. Studies have shown that between 60 and 90% of children and youth with MH/SUD related disorders do not seek out or receive the services that they need.¹³

As shown in Map 4, the largest concentrations of children and youth with behavioral health needs are located in those jurisdictions with the highest concentrations of school-age children and youth, primarily the Baltimore-Washington metropolitan area, including Baltimore City and Montgomery,

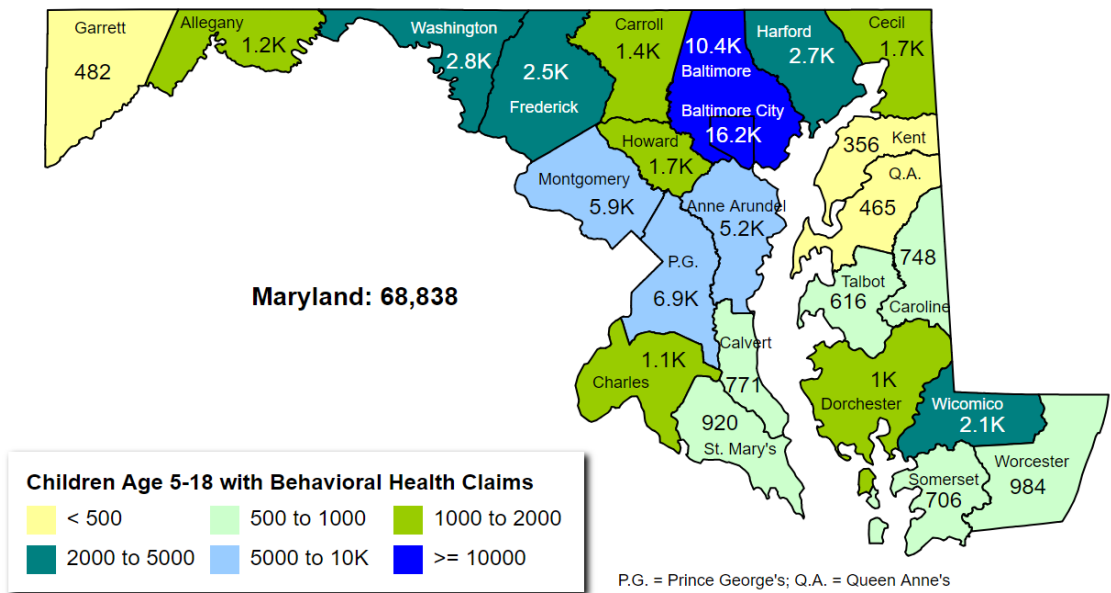
¹³ Knopf, Park, & Mulye, The Mental Health of Adolescents: A National Profile, 2008, Retrieved November 9, 2012, online at <http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf>.

Prince George’s, Baltimore, and Anne Arundel Counties. These five jurisdictions account for nearly two-thirds (65%) of the children and youth in need of MH/SUD services. Based on estimates from the SAMHSA, nine percent of school-age children and youth experience a severe emotional disturbance (SED). Children and youth with SED represent a significant subpopulation of children in need of behavioral health services and account for approximately 95,688 school-age children and youth in Maryland and 41% of those children and youth with behavioral health challenges.

IV. Non-school-based Services

Section 12(a)(2)(i) requires this report to “review, by jurisdiction, the number of outpatient treatment, acute care services, residential-based treatment, support services, and other community-based services utilized by children over the past 3 years.”

Map 5: Use of Behavioral Health Services Among School-Age Children and Youth (5 to 18 Years), FY17



Data Source: Behavioral health service claims data on children and youth (5 to 18 years). Counts are based on claims paid through June 30, 2018.

As shown in Map 5, in FY17, a total of 68,838 school-age children and youth (5 to 18 years) received one or more behavioral health services within the public behavioral health system (PBHS) statewide. This translates to a rate of 65 out of every 1,000 school-age children (5 to 18 years) receiving PBHS services. Based on the estimated need for behavioral health services discussed above, 233,905 school-age children were in need of behavioral health services in FY17. Services provided through the PBHS alone reached nearly one-third (29%) of the children and youth estimated to need services. These utilization numbers exclude a large number of children and youth who may receive behavioral health services funded through private insurance and, therefore,

underrepresents the actual number of children and youth who access behavioral health services in the state.

Based on the 2016 American Community Survey data,¹⁴ statewide slightly more than two-thirds (68.8%) of school-age children and youth (6 to 17 years) were covered by private insurance plans. These rates varied widely across the state from a low of 39.3% in Baltimore City to 84.5% in Howard and Baltimore Counties. In Anne Arundel, Baltimore, Calvert, Carroll, Charles, Harford, Howard, Queen Anne's, and St. Mary's Counties more than 75% of children and youth had private insurance coverage, while less than 50% of children and youth in Baltimore City and Caroline, Dorchester, and Somerset Counties had private insurance coverage. Private insurance benefits in Maryland and across the country typically cover a relatively limited set of behavioral health services, including acute psychiatric inpatient, medication evaluation and management, diagnosis and treatment of substance abuse disorders, outpatient clinical services, and psychological and neuropsychological testing and evaluation services.

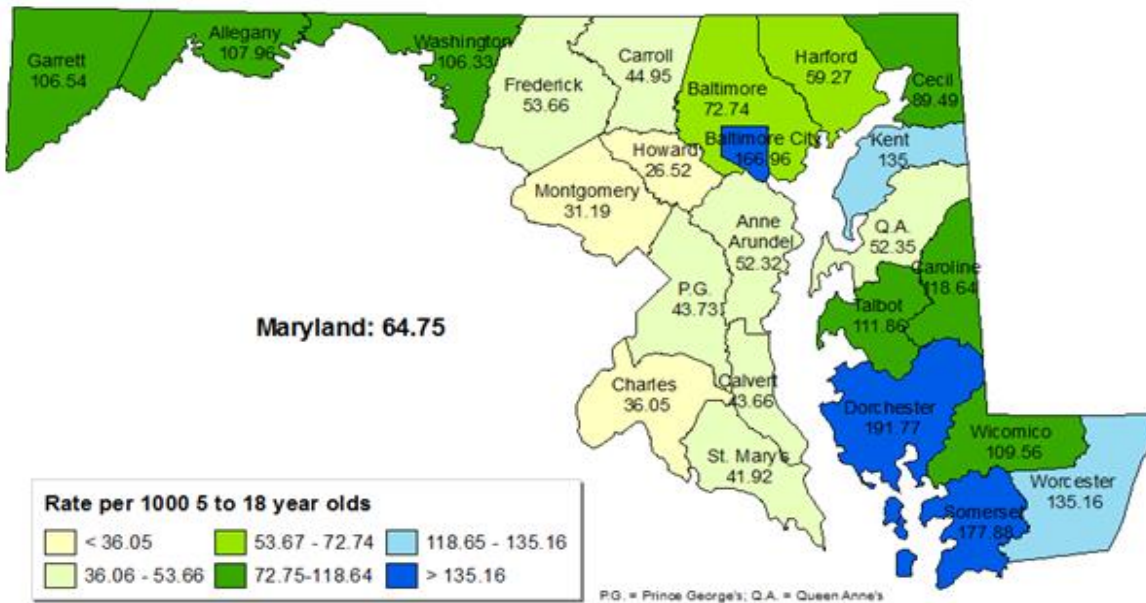
In a recent national survey on disparities in access to mental health care conducted by the National Alliance on Mental Illness, more than one-third (34%) of privately insured respondents reported more difficulty finding mental health providers who would accept their insurance compared to primary care and specialty medical providers. Compared to those covered by public insurance, privately insured individuals were significantly more likely to use out-of-network behavioral health providers incurring higher out of pocket costs.¹⁵ In addition, research has demonstrated that children and youth enrolled in federal Medicaid programs nationally are disproportionately affected by behavioral health disorders and are more likely than their counterparts with private insurance to see a mental health professional or a primary care doctor for emotional and behavioral problems.¹⁶ Consistent with these findings, those children and youth who experience more serious emotional and behavioral disorders that require ongoing intensive residential and community-based services and supports such as mobile treatment and psychosocial rehabilitation services are more likely to receive services through the PBHS.

¹⁴ U.S. Census Bureau, 2012–2106 American Community Survey 5 Year Estimates, ages 6 to 17 years (2016), online at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_B27002&prodType=table.

¹⁵ National Alliance on Mental Illness, Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care, November 2017, online at <https://www.nami.org/About-NAMI/Publications-Reports/...is.../DoctorIsOut.pdf>

¹⁶ Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP (Washington, DC, June 2015), online at <https://www.macpac.gov/publication/june-2015-report-to-congress-on-medicaid-and-chip/>; Medicaid Access in Brief: Children's Use of Behavioral Health Services, MACPAC Issue Brief, June, 2016, online at <https://www.macpac.gov/wp-content/uploads/2016/06/Childrens-access-to-behavioral-health-services.pdf>.

Map 6: Rate per 1,000 School-Age Children and Youth Who Receive PBHS Services by Jurisdiction, FY17



Data Source: Behavioral Health Service Claims data on children and youth (5 to 18 years). Data is based on claims paid through June 30, 2018. Rate based on population of children and youth 5 to 18; U.S. Census Bureau, American Community Survey, 2017.

As shown in Map 6, rates of behavioral health service use varied substantially across the state ranging from a low of 26 per 1,000 school-age children in Howard County to more than 160 per 1,000 in Baltimore City and Dorchester and Somerset Counties. Five jurisdictions (Baltimore City and Dorchester, Somerset, Kent, and Worcester Counties) had PBHS service use rates more than two times higher than the state average. The jurisdictions with higher PBHS service rates are those with higher proportions of children and youth that are eligible for Medicaid. In FY17, more than one-third (38.7%) of children (birth to 17 years) statewide were eligible for Maryland Medicaid. In Maryland, Medicaid eligibility varies by jurisdiction, ranging from a low of 22% in Carroll and Howard Counties to more than 60% in Baltimore City and Dorchester and Somerset Counties.

Table 1: Number of School-Age (5 to 18 Years) Children and Youth who Received Public Behavioral Health Services between FY15 and FY17 in Maryland by Service Category

| Service Category | FY15 | FY16 | FY17 | Change FY15–FY17 |
|--|---------------|---------------|---------------|-----------------------------|
| Individual Practitioners | 21,716 | 21,963 | 23,470 | 1,754 |
| Outpatient Clinic | 39,120 | 41,325 | 43,458 | 4,338 |
| Federally Qualified Health Center | 2,114 | 2,490 | 2,681 | 567 |
| Hospital-Based Services | 15,060 | 15,109 | 15,668 | 608 |
| Acute Psychiatric Inpatient | 3,210 | 3,281 | 3,277 | 67 |
| Behavioral Health Emergency Room | 5,646 | 6,082 | 6,493 | 847 |
| Residential Treatment Center | 623 | 589 | 524 | (99) |
| Residential Rehabilitation | 50 | 38 | 45 | (5) |
| Crisis Residential | 28 | 25 | 25 | (3) |
| Psychiatric Residential Treatment Facilities Waiver | 1 | 19 | 55 | 54 |
| Case Management | 834 | 1,230 | 1,545 | 711 |
| Mobile Treatment | 270 | 270 | 297 | 27 |
| Psychiatric Rehabilitation | 10,631 | 12,198 | 13,554 | 2,923 |
| Support Employment | 128 | 105 | 127 | (1) |
| Respite Care | 333 | 349 | 330 | (3) |
| SUD Level 1 Outpatient | 1,726 | 2,527 | 2,185 | 459 |
| Opioid Maintenance Treatment | 55 | 84 | 57 | 2 |
| SUD Residential | 216 | 361 | 363 | 147 |
| Total Served | 62,659 | 65,543 | 68,838 | 6,179 |

Data Source: Behavioral health service claims data based on claims paid through June 30, 2018.

Note: Total are unduplicated counts of children served and do not reflect the sum of children served by service category since children may receive services across multiple service categories. Counts for Hospital-Based Services includes all individuals who received any hospital outpatient or inpatient service including emergency room services.

Table 1 displays the number of school-age children and youth who received PBHS services by type of service between FY15 and FY17. The number of children and youth served increased from 62,659 in FY15 to 68,838 in FY17, reflecting a 9.8% increase. Most of this increase in utilization is in outpatient treatment services provided by individual practitioners and outpatient clinics, case management, and youth psychiatric rehabilitation services.

Outpatient Behavioral Health Services: As shown in Table 1, there are several community-based outpatient behavioral health services available to children and youth in the PBHS, including therapy and counseling services provided by independent behavioral health practitioners, outpatient mental health centers, federally qualified health center (FQHC), outpatient services provided by hospitals, and Level 1 SUD outpatient services. Outpatient behavioral health services are the most frequently used services among school-age children and youth who receive PBHS services. Nearly two-thirds

(63%) receive outpatient clinic services and slightly more than one-third (34%) receive services from individual practitioners. Five jurisdictions (Baltimore City and Anne Arundel, Baltimore, Montgomery, and Prince George's Counties) account for the majority of children who receive outpatient treatment either in mental health centers (61%) or through independent behavioral health practitioners (68%). An examination of PBHS use rates of independent practitioners and outpatient mental health centers differed substantially across jurisdictions.

In FY17, 22 out of every 1,000 school-age children received PBHS services from independent practitioners. Use of independent practitioners ranged from a low of 8.7 per 1,000 school-age children in Charles County to a high of 67.3 per 1,000 children in Baltimore City. Rates of use in Baltimore City (67.3) and Allegany (53.3) and Dorchester (48.7) Counties were more than twice the state rate of 22. In contrast, Charles (8.7), Howard (11.2), and Montgomery (11.7) Counties had rates substantially lower than the state rate. Statewide, outpatient mental health centers served, on average, 40.9 children per 1,000 school-age children and youth, nearly double the number served by independent practitioners. Again, use rates differed by jurisdiction from 15.2 per 1,000 children in Howard County to 157.9 per 1,000 children in Dorchester County. Six jurisdictions (Baltimore City and Caroline, Dorchester, Kent, Somerset, and Talbot Counties) had more than twice the state outpatient mental health centers service use rate, while Howard and Montgomery Counties had rates much lower than the state average. Children and youth can also access behavioral health services through FQHC.

In FY17, there were 12 FQHCs located in eight jurisdictions (Baltimore City and Anne Arundel, Cecil, Garrett, Montgomery, Prince George's, Somerset, and Washington Counties). These centers served children and youth from across the State. In FY17, a total of 2,681 school-age recipients of PBHS services received outpatient behavioral health services in FQHCs, accounting for 3.9% of school-age PBHS service users. More than two-thirds (72%) of the children and youth who used FQHC services resided in four jurisdictions (Baltimore City and Baltimore, Somerset, and Wicomico Counties). In FY17, the statewide utilization of FQHC services was 2.6 children and youth per 1,000 school-enrolled children. Utilization rates also varied substantially across the state, ranging from zero in Kent County to a high of 83 children per 1,000 school-enrolled children in Somerset County.

Additionally, a total of 2,185 children and youth utilized SUD Level 1 outpatient services statewide in FY17. Nearly one-half (47%) of these youth were from one of four jurisdictions, including Baltimore City (209) and Baltimore (422), Montgomery (192), and Prince George's (176) Counties. Between FY15 and FY17, use of SUD outpatient services increased from 1,726 to 2,185 respectively, reflecting a 26% increase. In FY17, 2.05 per 1,000 school-age youth utilized this service. Again, utilization rates differed substantially across the State from a low of 0.73 per 1,000 in Howard County to 11 per 1,000 in Allegany County. Allegany, Dorchester, Worcester, and Wicomico Counties all had rates more than three times higher than the state rate. A total of 57

youth statewide received services from opioid treatment programs in FY17. Three jurisdictions, (Baltimore City and Anne Arundel and Baltimore Counties) accounted for two-thirds (66%) of the youth who received opioid treatment programs services.

Hospital-Based Behavioral Health Services: Nearly one in every four (23%, 15,668) school-age children and youth who received PBHS services in FY17 received hospital-based inpatient or outpatient behavioral health services. Nearly two-thirds (62%) of children and youth who received hospital-based behavioral health care resided in Baltimore City or in Baltimore, Anne Arundel, or Montgomery Counties. While nearly one-quarter (23%) of children used hospital-based behavioral health services, a much smaller number (5%) were hospitalized for a behavioral health condition annually. In FY17, there were 3.08 children who were hospitalized for every 1,000 school-age children. These rates varied substantially across jurisdictions, ranging from a low of 1.17 per 1,000 in Prince George’s County to a high of 7.71 per 1,000 in Baltimore City. Both Baltimore City and Washington County had inpatient rates more than two-times the statewide rate.

Statewide, nearly one in every ten (9.4%) school-age children who received PBHS services utilized hospital emergency rooms one or more times for behavioral health related concerns during FY17. Between FY15 and FY17, emergency room use among school-age recipients of PBHS services increased by 15% from 5,646 in FY15 to 6,493 in FY17. Use of emergency rooms varied substantially across the state. In FY17, four jurisdictions (Baltimore City and Baltimore, Anne Arundel and Montgomery Counties) accounted for about one-half (56.2%) of school-age emergency room users statewide. In FY17, the statewide rate of emergency room use was 6.11 per 1,000 school-age recipients of PBHS services. Emergency room use rates also differed substantially across jurisdictions ranging from a high of 17.5 per 1000 in Dorchester County to a low of 2.47 per 1,000 in Prince George’s County. Emergency room rates in four jurisdictions, including: Baltimore City (15.3) and Somerset (14.9), Allegany (12.2), and Dorchester (17.5) counties were more than twice the state average. As discussed earlier in this report, those jurisdictions with the highest public behavioral health service use rates generally have higher poverty rates and larger proportion of children and youth who are eligible for Maryland Medical Assistance (Medicaid). Conversely, those jurisdictions with the lowest PBHS service use rates (i.e., Prince George’s, Montgomery, and Howard Counties) have higher proportions of children and youth with private insurance coverage.

Residential Care: In FY17, 524 school-age youth received mental health residential treatment center (MH-RTC) services, while 363 adolescents received SUD residential services statewide. As shown in Table 2, utilization of MH-RTC services decreased from 623 in FY15 to 524 in FY17, representing a 16% decrease. Over the same period, use of SUD Residential services increased by 68% from 216 in FY15 to 363 in FY17. In FY17, slightly more than one-half (53%) of children who received MH-RTC services resided in four jurisdictions (Baltimore City and Baltimore, Frederick, and Montgomery Counties). Similarly, one-half (51%) of youth who used SUD

Residential services resided in three jurisdictions (Baltimore City and Baltimore and Montgomery Counties). In FY17, statewide rates of MH/SUD residential service use among school-age youth were relatively low, with rates of 0.492 per 1,000 and 0.341 per 1,000 respectively. MH-RTC utilization rates ranged from a low of 0.19 in Howard County to a high of 2.44 per 1,000 in Dorchester County, while SUD residential rates ranged from 0 in Kent County to 2.01 in Somerset County.

Targeted Case Management (TCM): TCM services can be provided to a child or youth based on three levels of intensity, from Level I to Level III. Youth who have been determined financially eligible may also receive additional intensive behavioral health services under the Medicaid State Plan Amendment, §1915(i) of the Social Security Act.¹⁷ Youth that do not have Medicaid may also qualify for the TCM Plus program which is limited to 50 youth. TCM services are available to school-age children and youth statewide. In FY17, a total of 1,545 children received TCM services, representing only 2% of all school-age children who received PBHS services. Three jurisdictions, including Baltimore (255), Washington (343), and Wicomico (178) Counties, accounted for one-half of all children who received TCM service. In FY17, 1.4 per 1,000 school-age children received TCM services. Utilization rates varied considerably across the State, ranging from 0.18 per 1,000 in Montgomery County to 13 per 1,000 in Washington County. In Washington, Somerset, and Wicomico Counties, TCM utilization rates were more than five times higher than the state rate. Overall, the statewide TCM services for children and youth has steadily increased between FY15 and FY17. In FY15, a total of 834 individuals received TCM services, which increased to 1,545 by FY17.

Intensive Community-Based Services: In the PBHS, several intensive community-based service and support alternatives are available for children and youth with the most serious behavioral health challenges, including psychiatric rehabilitation and mobile treatment services. Psychiatric rehabilitation program (PRP) services are available in all jurisdictions. In FY17, nearly one in every five (19.6%, 13,554) school-age children who received PBHS services utilized PRP services (see Table 2). As shown in Table 2, the number children and youth enrolled in PRP services has increased by 2,923 (27%). Nearly two-thirds (62.1%) of these PRP users were from one of three jurisdictions (Baltimore City and Baltimore and Montgomery Counties). In FY17, the utilization rate was 13 per 1,000 school-age children and youth. Across the State, rates varied by jurisdiction from 2.2 per 1,000 in Garrett County to 54.1 per 1,000 in Baltimore City. Service use rates in both Somerset (49.4) and Baltimore City (54.1) were more than three times higher than the state rate. In eight jurisdictions (Calvert, Carroll, Charles, Garrett, Howard, Montgomery, Queen Anne's, and St. Mary's Counties), PRP utilization rates were less than half of the state rate. In FY17, mobile treatment services were used by 298 school-age children and youth residing 15 of 24 jurisdictions. The vast majority (82%) of these users were from Baltimore City or Baltimore County. The

¹⁷ 42 U.S.C. §1396n.

statewide utilization rate for this service is extremely low at 0.28 per 1,000 school-age children and youth.

Behavioral Health Initiatives Designed to Increased Access and Use of Behavioral Health Services: Over the past few years, the Maryland Department of Health and the Behavioral Health Administration have implemented a number of innovative programs to enhance statewide access and use of behavioral health services, including the implementation of tele-behavioral health, Behavioral Health Integration in Pediatric Primary Care, and programs that target services to young adults experiencing first episode psychosis.

1. Tele-behavioral Health Services

In FY17, a total of 1,750 children and youth (birth to 17 years) who received services in the PBHS received tele-behavioral health services in Maryland. These services were provided to children residing in all jurisdictions except Kent County. All of the tele-behavioral health consultations were directed toward children and youth with mental health challenges. Five jurisdictions, including Baltimore City (228) and Baltimore (383), Harford (220), Somerset (170), and Wicomico (389) Counties, accounted for most (79%) of the child and youth service recipients while Queen Anne's (1), Talbot (1), Calvert (2), Caroline (3), Frederick (3), Kent (0), and Montgomery (4) Counties served fewer than five children and youth. The use of tele-behavioral health services statewide among children and youth increased from 1,750 in FY17 to 2,220 in FY18, reflecting a 27% increase over the 12-month period.

2. Student Assistance Program (SAP)

SAP provides training and implementation support to schools to better identify and respond to youth who are at-risk or currently using substances in Baltimore City and Allegany and Prince George's Counties. SAP is a critical component to a larger workforce development initiative in the State to train schools and behavioral health providers to better respond to the needs of youth with substance use and co-occurring MH/SUD. This initiative advances locally and federally funded substance use prevention efforts by training school personnel and support staff to strengthen their ability to screen, early identify, intervene, and make referrals to treatment for the purpose of preventing future opioid-related overdose deaths. There are three components to the SAP initiative:

- training school staff in Botvin Life Skills Substance Use Prevention Curriculum who will then deliver this curriculum to middle and high school students;
- web-based Screening Brief Intervention and Referral to Treatment (SBIRT) Training for school nurses and counselors through the <https://md.kognito.com/> training platform; and
- telepsychiatry consultation and training of local health providers on how to access opioid use disorder telepsychiatry.

Through this initiative 77 school personnel have been trained in Botvin Life Skills Curriculum and 75 school counselors and nurses have completed the SBIRT Training.

3. Behavioral Health Integration in Pediatric Primary Care (BHIPP)

BHIPP supports pediatric and primary care provider's ability to respond to the behavioral health needs of youth and their families through provision of training and consultation that enhance their capacity to treat this population. Through additional funding, BHIPP will expand its efforts to include training and consultation to obstetrician and gynecology practitioners, therefore increasing access to care for pregnant and postpartum women with MH/SUD. This too is a critical step in advancing the somatic and behavioral health of Maryland residents through offering co-located services. In some cases, through this effort, clinicians are embedded in medical offices to address the MH/SUD needs of individuals. These training and consultation efforts are an integral part of a larger workforce development initiative to train school personnel as well as behavioral health and medical practitioners to respond to the needs of youth and families with behavioral health disorders. Such initiatives do not include direct engagement with school-age youth but rather provide training to support school staff and practitioners to enhance their skills to early identify, engage, and provide intervention for youth and families who are at risk of developing or who have been diagnosed with a behavioral health disorder.

Since its inception in FY12, BHIPP has engaged one or more primary care physicians (PCPs) in every jurisdiction in Maryland. As of June 30, 2017, a total of 617 PCP providers have been enrolled in the program and 1,878 behavioral health consultations have been provided. PCP enrollment in the program has increased dramatically since its inception from 106 providers in 2012 to 618 providers in 2017, reflecting a nearly six-fold increase in PCP enrollment. The majority of enrolled PCPs are located in five jurisdictions in the Baltimore-Washington metropolitan area, including Baltimore City and Montgomery, Baltimore, Prince George's, and Anne Arundel Counties. Since FY14, PCP consultations have increased more than three-fold from 210 calls in FY14 to 778 calls in FY17.

4. Maryland Behavioral Health Training Platform

The mdbehavioralhealth.com platform is a website that hosts various trainings to advance the knowledge of the behavioral health workforce that provides intervention to youth (12 to 24 years) with substance use and co-occurring MH/SUD. This is a continuation of efforts aimed to train the behavioral health workforce to increase their capacity to respond to the expanding needs of youth and their families statewide. Through this workforce development initiative, clinicians, peer recovery support specialists, and schools with CP-SBH can receive training to better address the

youth population in various contextual settings. The training series has been expanded to include the following offerings:

- The Maryland Youth Care Coordinator Training Series;
- Peer Recovery Specialists—An Interprofessional Training;
- Maryland Early Intervention Program; and
- Community-Partnered School Behavioral Health Implementation Modules.

5. Maryland Suicide Prevention and Early Intervention Network (MD-SPIN)

MD-SPIN grant aims to increase the number of Maryland youth (10 to 24 years) identified and referred to quality behavioral health services. MD-SPIN has implemented suicide risk screening in pediatric emergency departments to identify youth experiencing suicidal ideation but do not have a chief complaint of suicidal ideation. Additionally, MD-SPIN has provided training opportunities for Kindergarten to Grade 12 teachers, middle-school- and high-school-aged students, primary care physicians, and other child-serving professions and agencies. MD-SPIN provides safeTALK workshops and Kognito modules that are available online for free through December 2019. Kognito is an innovative state-of-the art, interactive avatar-based online suicide prevention and mental health training. MD-SPIN is currently developing online suicide prevention training modules to be sustained beyond the end of the grant.

6. Maryland Early Intervention and First Episode Psychosis Program

Maryland has developed an innovative statewide network of specialized programs that provide early identification and treatment services to adolescents and young adults (14 to 30 years), who are at risk for or experiencing early signs of a serious mental illness with psychosis. The purpose of these programs is to reduce chronicity and improve the likelihood that young people with early onset psychosis will be able to effectively manage their illness, participate in the community, and live a life of their choosing. Statewide, there are three specialized programs, including OnTrack Maryland, Johns Hopkins Early Psychosis Intervention Center, and the Maryland Early Intervention Program that have extensive expertise and offer a range of specialized, evidence-based treatment, recovery support, consultation, and education and training services, including:

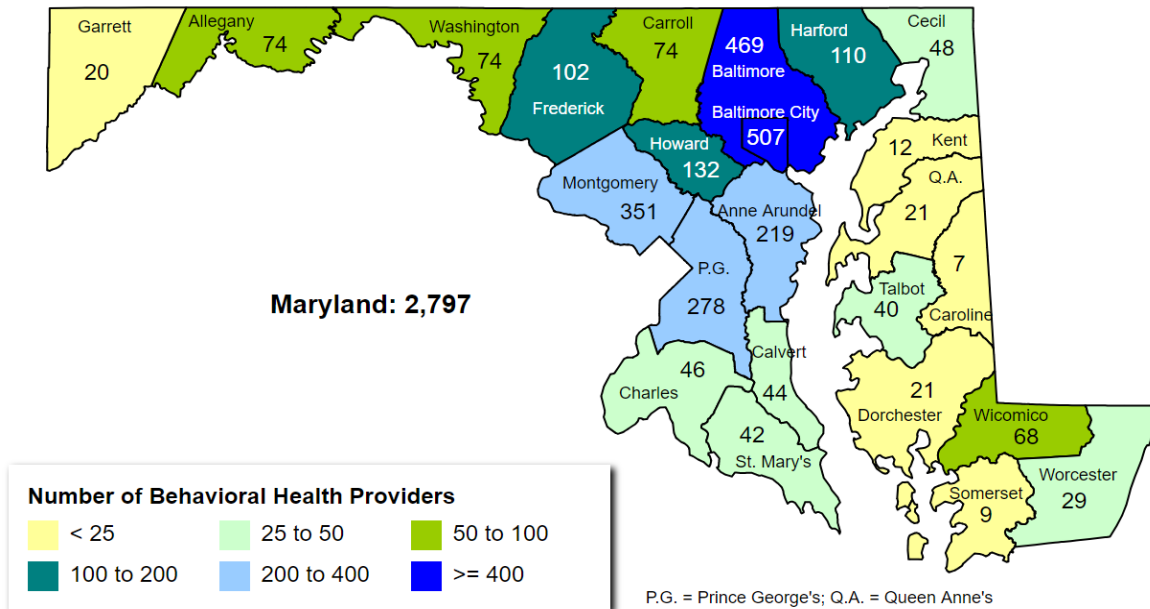
- **early identification, evaluation, and referral services** to identify adolescents and young adults and engage them in treatment and connect them to community-based services and supports;
- **outreach and education** to providers and other groups interested in learning more about the early stages of mental illnesses with psychosis;
- **comprehensive, individualized, evidence-based treatment services** to individuals experiencing early psychosis and their families;
- **consultation services** to professionals working with individuals experiencing early psychosis and their families; and

- **training and implementation support** to professionals establishing early intervention teams.

V. Providers

Section 12(a)(2)(iii) requires this report to “review, by jurisdiction, the number of mental health and behavioral health service providers licensed by the State who provide services to children.”

Map 7: Number of Public Behavioral Health Service Providers Who Delivered Services To Children (5 to 18 Years) by Jurisdiction, FY17



Data Source: Behavioral health service claims data, FY17.

Note: Provider counts represent service provider entities available in each jurisdiction. Some service providers have multiple locations and provide services across multiple jurisdiction.

Maryland offers a comprehensive array of behavioral health services to school-age children and youth (5 to 18 years). The service delivery system for children and youth supports a full continuum of care that includes outpatient behavioral health services, intensive community-based treatment and support services, acute inpatient hospital care, residential treatment services and recovery support services.¹⁸ This report focuses on behavioral health services and supports provided by Maryland’s PBHS. The PBHS provides behavioral health services to eligible children and adults who are enrolled in Medicaid or who are uninsured. Services are delivered statewide by local provider agencies and independent practitioners and coordinated by a network of local core service agencies, local addiction authorities, and local behavioral health authorities located in each of Maryland’s 24 jurisdictions. This provision of behavioral health services is overseen by the

¹⁸ Recovery support services are supported through state and federal grant funding and will not be further discussed for the purposes of this report.

Behavioral Health Administration and the service delivery system is evaluated on an ongoing basis to identify opportunities for enhancement and expansion to serve youth accessing the PBHS.

As shown in Map 7, a total of 2,797 behavioral health service providers delivered services to school-age children and youth (5 to 18 years) across the State. The largest concentration of service providers is located in Baltimore City (507) and Baltimore (469), Montgomery (351), Prince George’s (278), and Anne Arundel (219) Counties. These five jurisdictions account for nearly two-thirds (65%) of all behavioral health providers statewide. The greatest service provider capacity is located in those jurisdictions that have the highest number of school-age children and youth with behavioral health needs (see Map 4). A number of the more rural counties, on the Eastern Shore, such as Kent, Caroline, and Somerset Counties, have much less provider capacity to meet the behavioral health needs of their young people (see Map 7).

Table 2: Number of Behavioral Health Providers Serving School-Age Children and Youth by Jurisdiction, FY15 to FY17

| Service Category | Outpatient Behavioral Health | | | Hospital-Based Services | | | Residential Based Care | | | Case Management | | | Mobile Treatment | | | Respite | | | Psychiatric Rehabilitation | | | Supported Employment | | |
|------------------|------------------------------|--------------|--------------|-------------------------|-----------|-----------|------------------------|-----------|-----------|-----------------|-----------|-----------|------------------|-----------|-----------|-----------|----------|----------|----------------------------|------------|------------|----------------------|-----------|-----------|
| | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 | 2015 | 2016 | 2017 |
| Allegany | 55 | 65 | 61 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 3 | 1 | 1 | 1 | 0 | 0 | 0 | 5 | 6 | 5 | 1 | 1 | 0 |
| Anne Arundel | 170 | 168 | 201 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 8 | 9 | 2 | 2 | 2 |
| Baltimore County | 391 | 402 | 421 | 4 | 4 | 4 | 4 | 4 | 4 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 1 | 1 | 29 | 32 | 33 | 0 | 2 | 0 |
| Baltimore City | 358 | 385 | 383 | 15 | 15 | 15 | 8 | 7 | 9 | 7 | 6 | 6 | 4 | 4 | 4 | 1 | 1 | 1 | 41 | 51 | 65 | 2 | 4 | 2 |
| Calvert | 41 | 38 | 40 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 0 |
| Caroline | 5 | 7 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Carroll | 69 | 76 | 66 | 1 | 1 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 4 | 3 |
| Cecil | 23 | 31 | 41 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 4 | 2 | 2 | 2 |
| Charles | 23 | 33 | 37 | 1 | 1 | 1 | 0 | 1 | 1 | 2 | 2 | 3 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 3 | 2 | 0 | 0 | 1 |
| Dorchester | 19 | 20 | 16 | 2 | 2 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 |
| Frederick | 68 | 78 | 86 | 1 | 1 | 1 | 4 | 4 | 6 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 4 | 5 | 1 | 1 | 2 |
| Garrett | 14 | 14 | 17 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 |
| Harford | 86 | 87 | 98 | 2 | 2 | 2 | 0 | 0 | 0 | 2 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 | 5 | 1 | 0 | 0 |
| Howard | 104 | 115 | 115 | 2 | 2 | 2 | 3 | 4 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 5 | 1 | 2 | 1 |
| Kent | 5 | 7 | 8 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Montgomery | 266 | 294 | 329 | 6 | 6 | 6 | 5 | 5 | 6 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 5 | 7 | 11 | 1 | 3 | 2 |
| Prince George's | 221 | 243 | 236 | 6 | 6 | 5 | 2 | 3 | 4 | 2 | 2 | 2 | 1 | 1 | 2 | 0 | 0 | 0 | 17 | 23 | 27 | 0 | 0 | 1 |
| Queen Anne's | 13 | 15 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Somerset | 6 | 6 | 5 | 1 | 1 | 1 | 2 | 2 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 0 | 0 | 0 |
| St. Mary's | 29 | 25 | 34 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 3 | 3 | 0 | 0 | 1 |
| Talbot | 25 | 27 | 34 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 0 |
| Washington | 57 | 61 | 59 | 2 | 2 | 2 | 1 | 0 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 0 | 0 | 0 | 5 | 5 | 6 | 2 | 2 | 0 |
| Wicomico | 37 | 46 | 53 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 0 | 3 | 3 | 3 | 5 | 7 | 7 | 1 | 1 | 1 |
| Worcester | 23 | 20 | 26 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 |
| TOTAL | 2,108 | 2,263 | 2,390 | 54 | 54 | 53 | 37 | 37 | 47 | 31 | 31 | 35 | 14 | 13 | 14 | 10 | 7 | 7 | 135 | 171 | 199 | 19 | 26 | 21 |

Data Source: Behavioral health claims data, paid through June 30, 2018.

Notes: Outpatient Behavioral Health services includes, Individual Practitioners, MH Outpatient Clinics, SUD Level I Outpatient, and FQHC Outpatient providers. Residential Based Care includes Residential Treatment Centers, Crisis Residential, Residential Rehabilitation, SUD Residential, and Psychiatric Residential Treatment Waiver Providers. Hospital-Based Services includes hospital behavioral health outpatient services, acute psychiatric inpatient services and emergency room services.

Table 2 displays the number of behavioral health providers by type of service and jurisdiction between FY15 to FY17. Child and adolescent service providers were grouped into eight service categories: outpatient behavioral health treatment, hospital-based care, residential-based care, case management, mobile treatment, respite, psychiatric rehabilitation, and supported employment services. Between FY15 and FY17, the total number of public behavioral health service providers providing services to school-age children increased from 2,409 to 2,797 statewide, representing an increase of 388 providers. Most of this expansion is accounted for by increases in outpatient behavioral health treatment (72%) and psychiatric rehabilitation (16%) provider capacity. The majority (19 out of 24) jurisdictions increased provider capacity over this time period. The largest capacity increases occurred in Baltimore City and Montgomery, Anne Arundel, and Baltimore Counties, accounting for just over one-half (52%, 201) of the increase in provider capacity between FY15 to FY17.

VI. School-based Behavioral Health Services

Section 12(a)(2)(iv) requires this report to “review, by jurisdiction, the number and types of school-based services, programs, and professionals involved in the provision of behavioral and mental health services.”

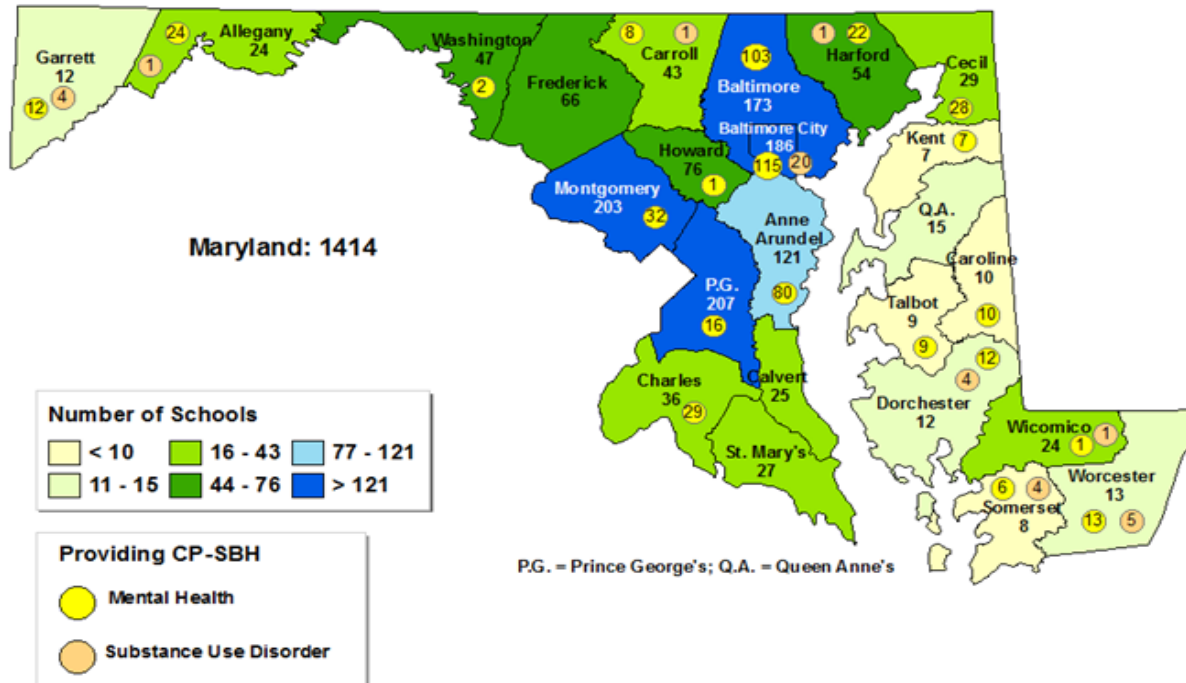
Maryland serves the behavioral health needs of school-age youth through statewide initiatives that provide services to prevent, early identify, intervene and treat youth with behavioral health needs across various settings through efforts such as community-partnered school behavioral health and school-based health centers.

Community-Partnered School Behavioral Health (CP-SBH): CP-SBH programs are available in 20 of 24 jurisdictions and allow students to access behavioral health services while in the school setting, increasing access to care for youth who may not have accessed these services in the community setting. These programs are founded on partnerships between community-based provider agencies and school systems, and in some cases individual schools, who work collaboratively to identify and intervene with students in need of behavioral health services while in the school building. The CP-SBH approach provides the opportunity for schools to expand their behavioral health capacity through enhanced staffing, resources, skills and knowledge through these community partnerships.

Map 8 displays the number of schools within each jurisdiction and the number of schools that provide CP-SBH MH/SUD services. The numbers are based on survey data obtained from the schools during the 2014–2015 school year. As shown in Map 8, most (20 out of 24) of the jurisdictions reported partnering with one or more community behavioral health provider organizations to provide CP-SBH services. Four jurisdictions (Frederick, Calvert, Queen Anne, and St. Mary’s Counties) reported that they did not have partnerships with behavioral health providers. Mental health services and supports were offered in all jurisdictions providing CP-SBH services, while only nine jurisdictions offered SUD services (see Map 8). Those jurisdictions with

the greatest concentrations of schools and school-age children, including Baltimore City and Baltimore, Prince George's, and Anne Arundel Counties had higher numbers of CP-SBH schools.

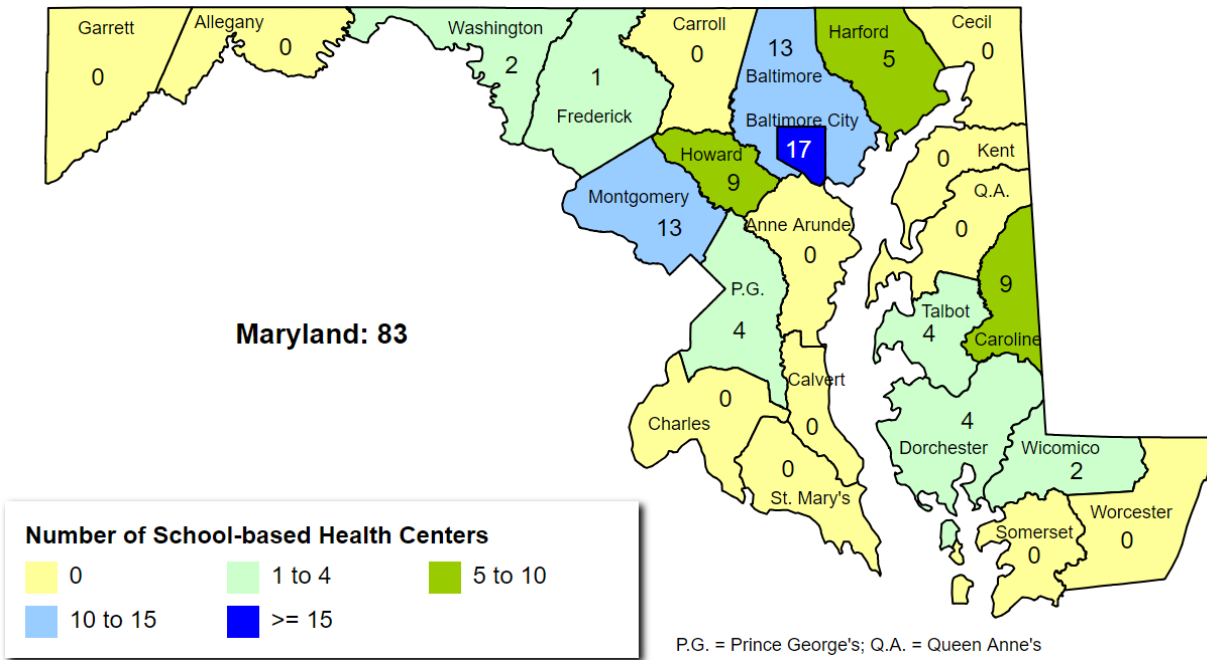
Map 8: Number of Schools Providing Community-Partnered School Behavioral Health Services, FY15



Data Source: Lever, Stephan, Castle, Bernstein, Connors, Sharma, & Blizzard, Community-Partnered School Behavioral Health: State of the Field in Maryland, Baltimore, MD: Center for School Mental Health, Community, 2015.

School-Based Health Centers (SBHC): SBHCs are located in 12 of 24 jurisdictions and provide a variety of essential preventive and primary health care services, including behavioral health, primary health, and other supportive services, to children while they are at school. SBHCs were initiated in Maryland in 1985 with the intent to improve children’s access to essential healthcare services and to reduce missed school days due to illness. In Maryland and nationally, SBHCs have been shown to be effective at managing chronic health conditions, and thus increasing attendance. Map 9 displays the number and location of SBHCs by jurisdiction. As shown in Map 9, the majority (73%, 61) of these centers are located in five jurisdictions: Baltimore City (17) and Baltimore (13), Montgomery (13), Howard (9), and Caroline (9) Counties. Slightly over one-half (52%, 43) of the SBHCs provide mental health or substance abuse services.

Map 9: School-based Health Centers by Jurisdiction, 2018



Data Source: MSDE SBHC Data, FY18, online at <http://marylandpublicschools.org/about/pages/dsfss/sssp/sbhc/index.aspx>.

Behavioral Health Services in Schools: All schools in Maryland are required to provide a coordinated program of pupil services for all student which shall include but are not limited to school counseling, school psychology, pupil personnel, and health services. Behavioral health services in schools focus on the health, personal, interpersonal, academic and career development of students.¹⁹ Included in this program are mental health services for all students. The student services team works to provide support to classroom teachers and identifies school-based interventions for student mental health needs.

School counselors, school social workers and school psychologists each provide mental health support in schools. Individual and group counseling are provided to students to address social and emotional needs and identification of experiences and reactions to those experiences in order to help students cope with issues of distress in their lives. A first line of support, school counselors and school social workers can identify students in distress and work with them to develop skills to handle the stress and disturbing social/emotional issues in their lives. Additionally, school counselors, school social workers, school health specialists and school psychologists deliver a program of services to address student needs through classroom guidance. School psychologists also identify mental distress, complete assessments related to mental health, and provide supportive counseling as needed. These school staff make referrals to other professionals when indicated, as

¹⁹ COMAR 13A.05.05.01.

does the school nurse and the pupil personnel worker. These professionals and other staff members support the mental health of students through the organization of clubs and activities that address issues that are often related to depression and suicide, such as Gay-Straight Alliances. Student support staff train teachers and other school staff in child abuse warning and signs, signs of depression and suicide and other topics that put student at risk of mental health issues.

VII. Gaps in Services

Section 12(a)(2)(ii) requires this report to “identify the gaps in available community-based mental and behavioral health services for school-age children, by jurisdiction.”

As shown above, it is estimated that approximately one in five (22%, 233,905) school-age children and youth are in need of MH/SUD services. Five jurisdictions, primarily in the Baltimore-Washington Metropolitan region have the largest concentrations of school-age youth and account for nearly two-thirds of the children in need of MH/SUD treatment services (see Map 4). In FY17, 2,797 PBHS service providers delivered behavioral health services to 68,838 school-age children and youth across the state. The services provided through the PBHS reached slightly less than one-third (29%) of the school-age children in need of MH/SUD treatment services. As noted previously, the PBHS provides services to a subpopulation of those children in need of MH/SUD services, specifically those children and youth enrolled in Medicaid or who are uninsured. Many other school-age children likely receive MH/SUD services through private insurance. Service utilization data on this population is not available for inclusion in this report.

The findings in this report indicate that provider capacity and the availability of public behavioral health services for school-age children and youth vary widely across the State. As shown in Map 7, nearly two-thirds (65.2%) of the behavioral health service providers that serve children are concentrated in five jurisdictions: Baltimore City and Baltimore, Montgomery, Prince George’s, and Anne Arundel Counties. However, a number of the more rural counties on the mid and lower shore and in far western Maryland have fewer available service providers and less overall capacity to meet the behavioral health needs of children and youth (see Map 7). Innovative service delivery approaches, such as the use of tele-behavioral health services and behavioral health consultation services to primary care physicians, are available statewide and are designed to enhance access to needed behavioral health services.

In addition to the uneven distribution of service providers, the availability and utilization of different types of behavioral health services vary substantially across the State. As shown in Table 2, while there is substantial statewide capacity to provide a variety of outpatient mental health services, the availability and use of other more intensive community-based service alternatives, such as mobile treatment, psychosocial rehabilitation, case management, and respite services are more limited and unevenly distributed. For example, while TCM services are available statewide,

it appears to be underutilized with 2.2% of school-age children who receive PBHS services accessing the service. Three jurisdictions, including Baltimore (255), Washington (343), and Wicomico (178) Counties, accounted for one-half of all children who received the service. In addition, while nearly one in five school-age children who received services in the PBHS accessed psychosocial rehabilitation services, utilization rates varied dramatically across the State. While Baltimore City and Somerset County had utilization rates more than three times higher than the state average, in eight jurisdictions (Calvert, Carroll, Charles, Garrett, Howard, Montgomery, Queen Anne's, and St. Mary's Counties), the utilization rates were less than half the state rate. Fewer than 300 school-age children utilized high intensity mobile treatment services with more than three-quarters of these youth residing in Baltimore City or Baltimore County.

A number of SUD services are available through the PBHS to school-age youth across the State, including SUD Level 1 outpatient services, opioid treatment programs, and SUD residential services. 3.2% (2,185) of children who used PBHS services accessed SUD outpatient services in FY17. Rates of service use were highest in Allegany, Worcester, and Dorchester Counties and lowest in Howard, Montgomery, and Prince George's Counties. The reach and use of opioid treatment and SUD residential services among school-age youth receiving PBHS services was very limited. Statewide, 30 opioid treatment programs served a total of 57 school-age youth and 8 SUD residential providers served 363 youth in FY17 with the majority of the provider capacity located in just three jurisdictions (Baltimore City and Baltimore and Anne Arundel Counties).

VIII. Emergency Tip Lines

In September 2018, the State resolved a gap in behavioral health services related to school-age children by connecting two state programs.

In partnership with the Maryland Emergency Management Agency (MEMA), which serves the State by providing “tools ... to prepare for, mitigate against, respond to, and recover from the consequences of emergency and disaster events,”²⁰ the Maryland Center for School Safety initiated an anonymous reporting system for “[s]tudents, parents, faculty, staff, and members of the communit[y] ... to report threats to the safety and/or well-being of students.”²¹ This reporting system is called the MDBSAFE School Safety Tip Line.

Because the tip line is “available to receive tips concerning mental health crises [and] drug activity” among “other issues affecting ... Maryland students,”²² the Maryland Center for School Safety, MEMA, and the Behavioral Health Administration are collaborating to connect MEMA calls related to behavioral health crises to the State's behavioral health crisis hotline, Maryland Crisis Connect (Call 2-1-1, Press 1). The Behavioral Health Administration established Maryland Crisis Connect to provide 24/7 “support, guidance, and assistance” to “callers in need of crisis

²⁰ Maryland Emergency Management Agency, online at <https://mema.maryland.gov/Pages/AboutMEMA.aspx>.

²¹ MDBSAFE APK, online at <https://downloadapkfree.com/com.p3tips.mdbsafe>.

²² *Ibid.*

intervention, risk assessment for suicide, homicide or overdose prevention, support, guidance, and information or linkage to community behavioral health providers.”²³

While coordinating services between the School Safety Tip Line and Maryland Crisis Connect, the objective of the interagency collaboration was to maintain human connection when the caller is transferred from one crisis line to the other. The School Safety Tip Line call center is operated by the Maryland Joint Operations Center (MJOC), a branch within MEMA. MJOC staff triage calls from across the State 24/7. When the School Safety Tip Line receives a call deemed appropriate for a behavioral health crisis response, the MJOC staff will call Maryland Crisis Connect, which is operated by a 211 vendor, while keeping the caller on the line. Therefore, there will be a warm transfer from the School Safety Tip Line to Maryland Crisis Connect, where the caller will have access to trained crisis counselors “available to assist individuals struggling with issues such as substance use, depression, anxiety, suicidal/homicidal ideation or intent, physical and sexual abuse, eating disorders, sexual identity concerns, running away, relationship problems, divorce, sexually transmitted disease, school issues or any other identified concern.”²⁴ Also, when a caller is on the phone with Maryland Crisis Connect, the caller can be connected with other crisis and non-crisis services in the caller’s area.

Data will be tracked to report on the demographic and disposition information.

²³ Maryland Department of Health, Maryland Crisis Connect, online at <https://health.maryland.gov/suicideprevention/Pages/Maryland-Crisis-Hotline.aspx>.

²⁴ *Ibid.*

Part 2
Findings: The Needs of School-Age Children

I. Steps to Identify Gaps.

Section 12(a)(2)(v) requires this report to “assess what steps are being taken by State or local government agencies to identify areas of service delivery in schools and in the community that are not meeting the current demand or where sufficient services do not exist.”

MSDE, in partnership with critical stakeholders and child serving agencies, developed a report in response to 2017 Senate Bill 1060 that identified school systems that provided CP-SBH programs in Maryland. CP-SBH programs are an initiative that supports the provision of behavioral health services for students while in the school building and increases access to services for students with MH/SUD. The 2017 report provided incredible insight into strengths and opportunities related to Maryland’s service delivery system for school-age youth and has provided critical information to support statewide planning and expansion efforts in this area. Embedding behavioral health services in the school setting is a critical step forward in advancing the needs of youth through prevention, early identification, intervention, treatment, and recovery efforts. However, as was observed in the 2017 report, CP-SBH programs will need to expand to increase their capacity to address the needs of students statewide. Results from the 2015 Maryland CP-SBH survey suggest that 63% of Maryland schools do not have access to CP-SBH services.

II. Gaps in Treatment Capacity and Services

Section 12(a)(2)(vi) requires this report to “identify any gaps in treatment capacity and school- and community-based mental health services that are limiting the ability of students to access needed care.” The following are findings from the 2015 Maryland CP-SBH survey in the areas of prevalence, quality, and sustainability:

A. Prevalence

Prevalence of CP-SBH services varies widely across the State (ranging from no schools to all schools in a school system). CP-SBH is available in 20 of 24 jurisdictions, with 37% of the schools providing mental health services but only 2% providing substance use services across the State. Within SBHCs, mental health visits were provided in eight jurisdictions for a total of 33 of the 74 SBHCs. The majority of CP-SBH programs are not providing the full continuum of comprehensive behavioral health services (i.e., behavioral health promotion, prevention, and intervention). A majority of CP-SBH programs provide treatment services for students already identified with concerns, yet few provide behavioral health promotion or prevention services.

Among all programs providing comprehensive CP-SBH offered treatment services, about half offered prevention services while only 25% offered mental health promotion. It is important to note that questions related to behavioral health promotion and prevention did not inquire about frequency and intensity and may be indicative of a one-time activity versus a more strategic and comprehensive implementation plan. The survey did also not collect information on the extent to

which evidence-based programs are implemented for prevention, promotion, or treatment services. A limited number of CP-SBH programs effectively integrate substance use prevention and intervention services within their daily practice.

B. Quality

Among the CP-SBH programs that exist in Maryland, there is tremendous variability to the extent programs are implementing best practices to maximize high quality of care. CP-SBH programs are not consistently collecting, analyzing, and reporting student- and school-level data to document impact of service provision. At the state and national levels, documenting student outcomes, including academic, behavioral, social, and emotional functioning and progress, as well as linking these data to CP-SBH services provided, can be very challenging. Documenting program effectiveness, unfortunately, is inconsistent, time consuming, logistically challenging, and historically an underfunded activity. While challenging to achieve, data collection, analysis, and reporting is increasingly recognized and required for not only documenting of quality services but also for maintaining and securing continued funding. CP-SBH providers would benefit from additional training related to providing effective behavioral health services in schools and may need access to additional training to provide empirically-supported services across a multi-tiered system of support.

C. Sustainability

Sustainable models of CP-SBH programming braid together diverse funding streams including fee-for-service and local and state funding sources. Substance use services are heavily reliant upon grant dollars which have significantly reduced in recent years. Financing substance use services in schools has been particularly challenging related to recent decreases in prevention funding. Based on the Maryland CP-SBH survey, approximately 2% of Maryland public schools offer community-partnered, school-based substance use services.

Across jurisdictions, three funding streams were used on average. Fee-for-service was the most common funding stream for CP-SBH across 15 of the 24 jurisdictions. Reliance on only one or two funding sources can be challenging to long-term program sustainability. Programs that had braided and leveraged funding across several funding sources had greater likelihood of sustainability. This category was followed by financing provided by local and state funding sources. Funding sources have significant impact on whether a full continuum of care is provided through CP-SBH versus only a focus on youth already identified and displaying behavioral health concerns. The reliance on fee-for-service revenue to support CP-SBH increases the likelihood of a focus on predominantly treatment services versus behavioral health promotion and prevention.

Part 3

Delivery Implementation

I. Plans for Delivering Services²⁵

Section 12(a)(1)(i) requires the Subcabinet to “evaluat[e] the plans for delivering behavioral health and wraparound services to students exhibiting behaviors of concern that mental health services coordinators are required to develop under § 7–1511 of the Education Article, as enacted by Section 4 of this Act.” Wraparound services, as defined by legislation, are mentoring, tutoring, child care, housing referrals, transportation, crisis intervention, substance abuse prevention and treatment, legal aid, academic counseling, and career counseling services provided to students.²⁶

The mental health services coordinators for each jurisdiction were identified by the September 1, 2018, deadline.²⁷ However, at the time that this report was drafted, the coordinators were preparing their plans. Therefore, the Subcabinet was not able to provide an evaluation of the coordinators’ behavioral health and wraparound services delivery plans in this report before December 1, 2018. In the interim, the Subcabinet would like to highlight a structure already in place.

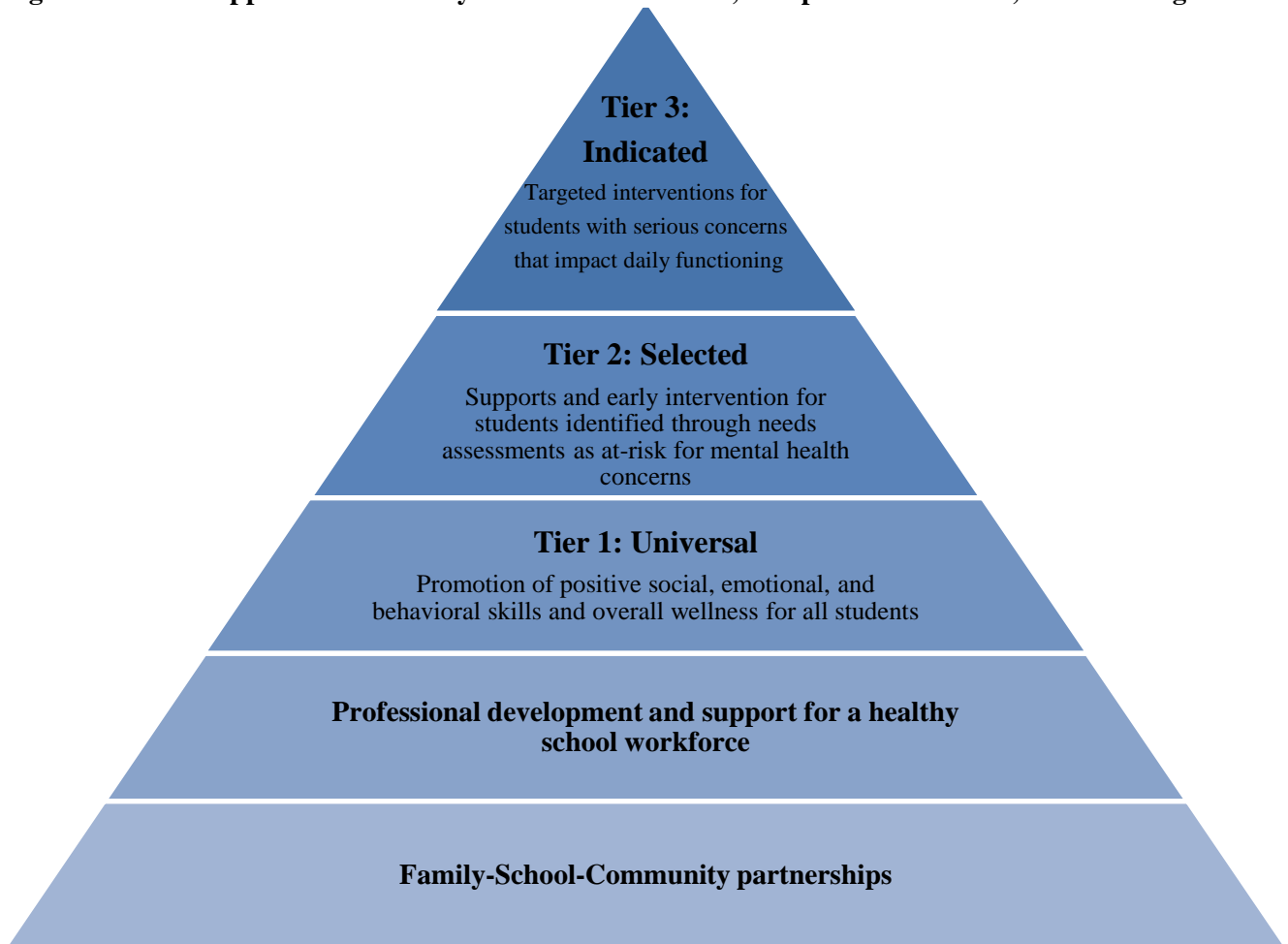
Through the multi-tiered system of supports (MTSS) framework, a structure that is already being used by MSDE to support positive behavioral intervention and supports, the mental health services coordinator, and other designated staff will facilitate the delivery of services and training across tiers to address the needs of the broader student body and students with behavioral concerns. The MTSS model includes three tiers of support: Tier I, which is universal (all students); Tier II, which is targeted (some students); and Tier III, which is individualized (individual students). Utilization of this framework will support the needs of youth across tiers by increasing access to behavioral health and wraparound services for students with behavioral concerns and their families through early identification and referral to treatment efforts and coordinating with academic resources to support the implementation of preventive and proactive interventions for the broader student body.

²⁵ § 7–1511(b)(4) requires the mental health services coordinator at each local school system to “develop plans for delivering behavioral health and wraparound services to students who exhibit behaviors of concern.” In October 2018, the mental health services coordinators were consulted in review of this report.

²⁶ § 7–1501(m).

²⁷ § 7–1511(a).

Figure 1: Tiered Approach to Delivery of Behavioral Health, Wraparound Services, and Training



The MTSS framework supports the scaling of Tier I, II, and III interventions and allows school systems the flexibility of implementing individualized approaches at each tier to meet the needs of their student body. This model addresses gaps in treatment and capacity by leveraging the school system’s existing resources and utilizing the role of the mental health services coordinator to provide linkages to additional services and supports as necessary.

II. Recommendations on Addressing Gaps

Finally, Section 12(a)(2)(vii) requires this report to “make recommendations on how to address any gaps in treatment and capacity identified.” Based on the data in Part 1 of this report, the Subcabinet makes the following recommendations to reduce gaps.

Recommendation 1: Encourage schools and jurisdictions to expand their partnerships with CP-SBH to more fully engage and utilize the behavioral health resources available in communities across the state, with an emphasis on enhancing partnerships with SUD providers.

Recommendation 2: Increase the statewide availability and use of case management services, high intensity community-based services, such as mobile treatment and psycho-social rehabilitation, and

tele-behavioral health services among school-age youth, with a focus on those jurisdictions with limited behavioral health resources and the greatest needs.

Recommendation 3: Build on the BHIPP and CP-SBH partnering models to expand access to behavioral health technical assistance and consultation services to school behavioral health personnel and educators.

Recommendation 4: Develop and disseminate mental health and substance use prevention and treatment information to schools, families, and communities to increase awareness of mental health and substance use disorders and how to access behavioral health resources.

Recommendation 5: Develop a common census across the State to measure the prevalence and availability of CP-SBH programs. The School Health Assessment and Performance Evaluation System, www.theSHAPEsystem.com, provides a free platform for schools to assess their school-based behavioral health service array and staffing, including both school-employed and community-partnered behavioral health staff.

Recommendation 6: Expand resources for school-based early identification, intervention, and treatment initiatives to better respond to the needs of students with SUD and co-occurring MH/SUD's.

Recommendation 7: Expand statewide efforts to provide training and infrastructure support necessary for school systems to use evidence-based screening to early identify students who are at-risk for developing a SUD.

Recommendation 8: Develop and implement strategies to enhance youth and parent/guardian engagement and participation in the development and implementation of school safety and MH-SUD awareness, prevention and training policies, protocols and activities.

Recommendation 9: Develop opportunities to engage the local educational agency mental health services coordinators and school safety coordinators in areas of mutual need, support, training, and technical assistance from MSDE and the Maryland Center for School Safety.