Report on the Maryland Safe to Learn Act of 2018

Submitted by the School Safety Subcabinet, Maryland Center for School Safety
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Section 12

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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 mental health services coordinators' plans for delivering behavioral health and wraparound services to students exhibiting behaviors of concern.[1]

Of the 1,063,206 school-age[2] children and youth in Maryland in 2017, 1,021,054 were enrolled in a public or private school[3] and 43,759 were suspended or expelled. The 2016–2017 Youth Risk Behavior Survey, which was used to assess 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.[4]

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

This report shows that there is an uneven distribution of service providers and service utilization across the State. According to Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) data, children and youth enrolled in federal Medicaid 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.

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

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[1] This report focuses on behavioral health services and supports provided by Maryland's Public Behavioral Health System.
[2] Education Article § 7–301 deems the ages of compulsory school for children to be 5 to 18 years old.
[3] Public school enrollment, which includes charter schools, was 893,689 and non-public school enrollment was 127,765.
[4] 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 (all Internet materials as last visited on July 12, 2018); and National Survey of Children's Health, 2003, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3225084/.

programs provide treatment services for students identified with concerns, yet few provide behavioral health promotion or prevention services since limited funding is available to support collecting, analyzing, and reporting student- and school-level data to document the impact of the services provided.

This report makes recommendations regarding training that could be offered to school staff, strategies for enhancing data collection efforts, and promotion of Maryland's comprehensive array of public behavioral health services to address gaps.

Introduction

In 2013,[5] the Maryland Center for School Safety[6] was established as an independent unit within the Maryland State Department of Education to provide coordinated and comprehensive policies 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),[7] which includes the State Superintendent (Chair), the Secretary of State Police, and the Secretary of Health, among others. The Subcabinet has an advisory board[8] to provide the Subcabinet with advice and assist the Subcabinet in completing its duties.

School shootings continue to occur around the country at an alarming rate. On February 14, 2018,[9] a young adult opened fire at Marjory Stoneman Douglas High School in Parkland, FL killing 17 and wounding 17 more. Within a month, on March 13, 2018, SB 1265 was introduced in the Maryland General Assembly.[10] A week later, on March 20, 2018, Maryland experienced a school shooting of its own at Great Mills High School in St. Mary's County.[11] 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.[12] On April 9, 2018, less than 30 days after SB 1265 was first introduced,[13] the bill passed both chambers. Governor Hogan signed the bill into law as Chapter 30 of the 2018 Acts of Maryland.

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[5] Chapter 372 to the Acts of 2013.
[6] Education Article § 7–1502.
[7] § 7–1503.
[8] § 7–1504.
[9] Rozs, Balingit, Wan, and Berman, "A horrific, horrific day": At least 17 killed in Florida school shooting, The Washington Post (Feb. 15, 2018), online at https://www.washingtonpost.com/news/education/wp/2018/02/14/school-shooting-reported-at-florida-high-school/?utm_term=.af1b0e2ef29b.
[10] Other legislation was introduced as early as March 5, 2018. On March 7, 2018, the Speaker of the House and the President of the Senate introduced HB 1816 and SB 1257, Safe Schools Act of 2018, by request of Governor Hogan. House Bill 1816 (2018), online at http://mgaleg.maryland.gov/2018rs/bills_noln/hb/fhb1816.pdf; Senate Bill 1257 (2018), online at http://mgaleg.maryland.gov/2018rs/bills_noln/sb/fsb1257.pdf.
[11] 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)..
[12] 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.
[13] SB 1265 was first introduced on March 13, 2018.

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 delivery of behavioral health and wraparound services to students exhibiting behaviors of concern.

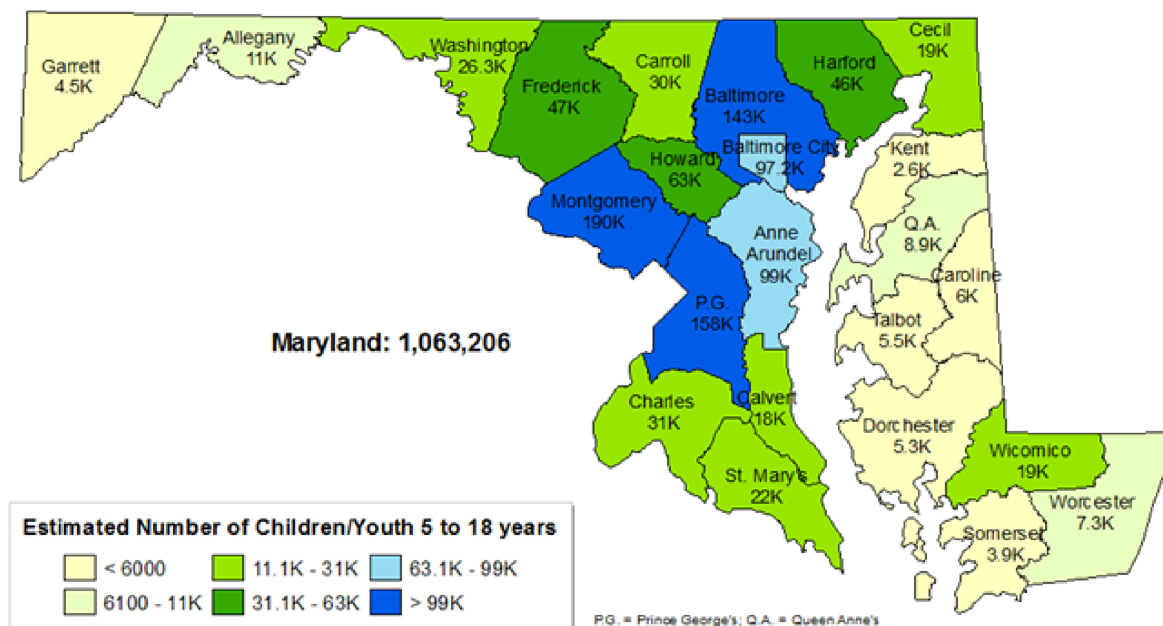
Part 1
Data on the Availability of Mental Health Services

Section 12(a)(1)(ii) of SB 1265 requires the Subcabinet to provide a description of the availability of behavioral health services and practitioners for "school-age children.[14] The demographics of the population of school-age children in Maryland, the number of public and private schools in the State, and the mental health risk factors experienced by school-age children are presented below. This section concludes with a review of the services and practitioners available to address the identified behavioral health service needs of Maryland's children and youth.

I. Demographics

In CY17, there were slightly over one million (1,063,206) school-age (5 to 18 years) children and youth in Maryland. School-age children include students enrolled in public and non-public schools. The total population of the State is 6,052,177, indicating school-age children represent one sixth of the state population. As shown in Map 1, nearly two-thirds (64.6%) of these children resided in five jurisdictions in the Baltimore-Washington metropolitan area (Baltimore City and Montgomery, Prince George's, Baltimore, and Anne Arundel Counties). Counties on the Eastern Shore and far western Maryland had much lower numbers of school-age children.

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).

[14] § 7–301 deems the ages of compulsory school for children 5 to 18 years old.

II. Risk Factors

To address Section 12(a)(1)(ii), which references the "mental health" needs of school-age children, this report will 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)[15] was used to examine potential safety-related risk behaviors among Maryland high school students.[16] 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 eight health topics: unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors; dietary behaviors; physical activity; obesity, overweight, and weight control; and other health topics.[17]

This report focused on eight key risk behaviors within the YRBS health topics: 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:[18] 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.

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 12.9 % in Dorchester and 11% in Somerset Counties. More than one-half (13 of 24) of the jurisdictions had rates higher than the state average (7.8%) on this indicator.

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%), Caroline (26.6%), Kent (26.3%), and Carroll (26.1%) Counties—had the highest rates of bullying, with more than one-quarter of

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[15] Centers for Disease Control and Prevention (CDC), 1991–2017 High School Youth Risk Behavior Survey Data, online at http://nccd.cdc.gov/youthonline/.

[16] The high-school students surveyed include both public and non-public school enrolled students in Maryland.

[17] 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.

[18] Unlike other weapons like knives, 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.

students reporting having been bullied, while Montgomery (16.3%), Howard (15.3%), Prince George's (14.5%) Counties and Baltimore City (13.4%) had rates well below the state average.

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 Allegany (33.2%), Dorchester (33.2%), and Garrett (33.1%) Counties. Female (38.7%) and LGB (57.3%) students were more likely to report feeling sad or hopeless compared to other students.

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 Queen Anne's (41%), Garrett (36%), and Kent (35.9%) 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 Kent (20.8%), Garrett (23.3%), and Queen Anne's (25.7%) reporting engaging in this activity. In contrast, students from Montgomery (11.2%) and Prince George's (6.4%) Counties were the least likely to report using alcohol and participating in binge drinking.

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%), Somerset (17.1%), and Charles (17.0%) Counties and the lowest rates reported in Montgomery (10.3%) and Howard (11.2%) Counties.

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 Dorchester County (13.2%), Baltimore City (7.6%), Charles County (5.9%), and Kent County (5.9%) were most likely to report having used heroin, while students from Calvert (2.7%), Montgomery (2.6%), and Carroll (2.5%), Counties were the least likely to report use. It should be noted that students in Dorchester County (13.2%) and Baltimore City (7.6%) reported ever having used heroin at substantially higher rates compared to students from other parts of the state.

Public School Suspensions and Expulsions:[19] 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 expulsions[20] accounted for the majority (87.6%) of these events, while the remaining 12.4% were in-school suspensions/expulsions.

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

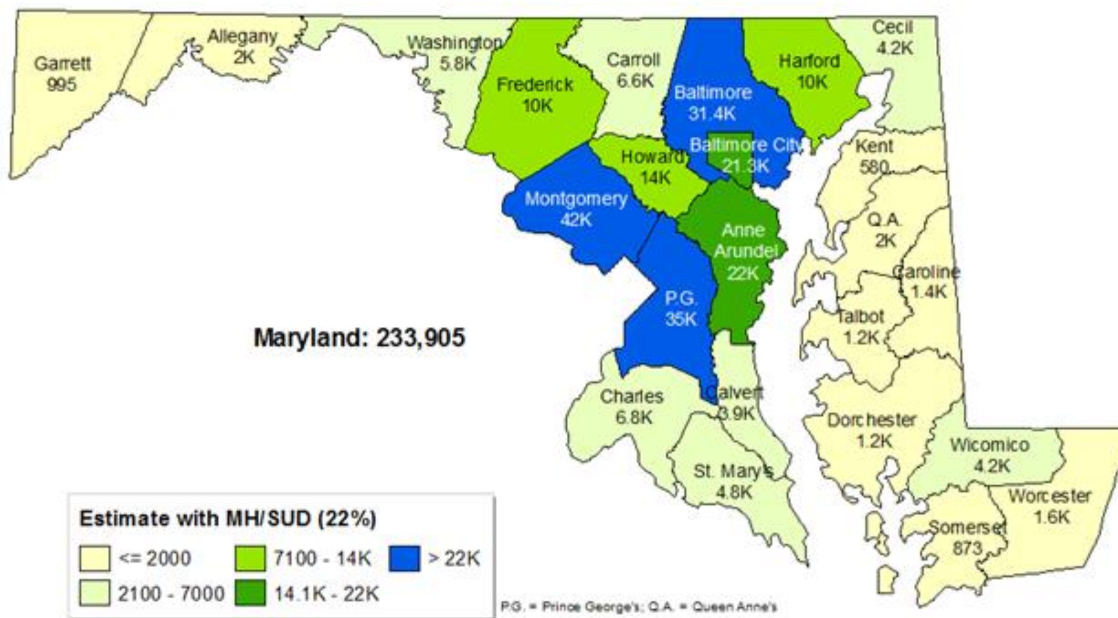
[20] COMAR 13A.08.01.11(C) states that each school system has the authority and responsibility to maintain school safety and can use the following out-of-school discipline practices when warranted: (1) "long-term suspension," which is the removal of a student from school for 4 and 10 days; (2) "extended 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.

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%). 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 behavioral health disorder.

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/.

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 to 17 years) with any mental health condition (18%), and the National Survey on Drug Use and Health, which provides the percent of youth (12 to 17 years) with a substance use disorder (SUD) (4%). These estimates reflect the number of children and youth with mental health and substance use disorders (MH/SUD) who may be in need of treatment based upon the above-mentioned national measures, 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.[21]

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, 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 Behavioral Health 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."

[21] 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.

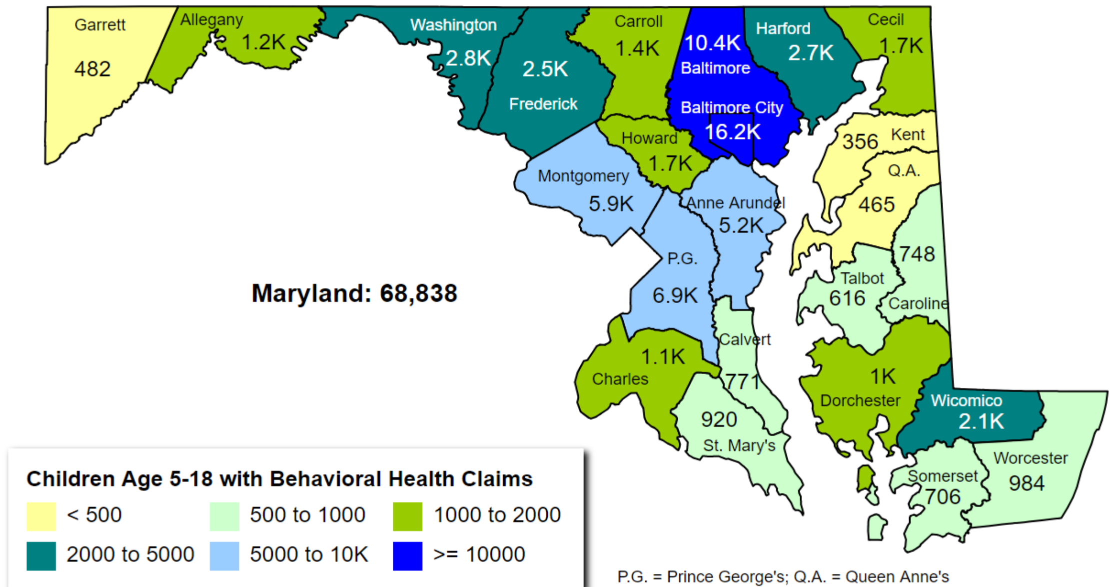
Table 1: Number of School-Age (5 to 18 Years) Children and Youth who Received Public Behavioral Health Services between FY15 and FY17 in Maryland by Service Category

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		19	55	54
Targeted 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 I 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 PBHS service claims paid through June 30, 2018.
Note: Totals are unduplicated counts of children served and do not reflect the sum of children served across service categories, since children may receive services across multiple service categories. Counts for hospital-based services include all individuals who received any hospital-based behavioral health treatment, including outpatient, inpatient and emergency room services. Grey shading indicates user counts less than 10 to protect potential disclosure of individuals.

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.

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



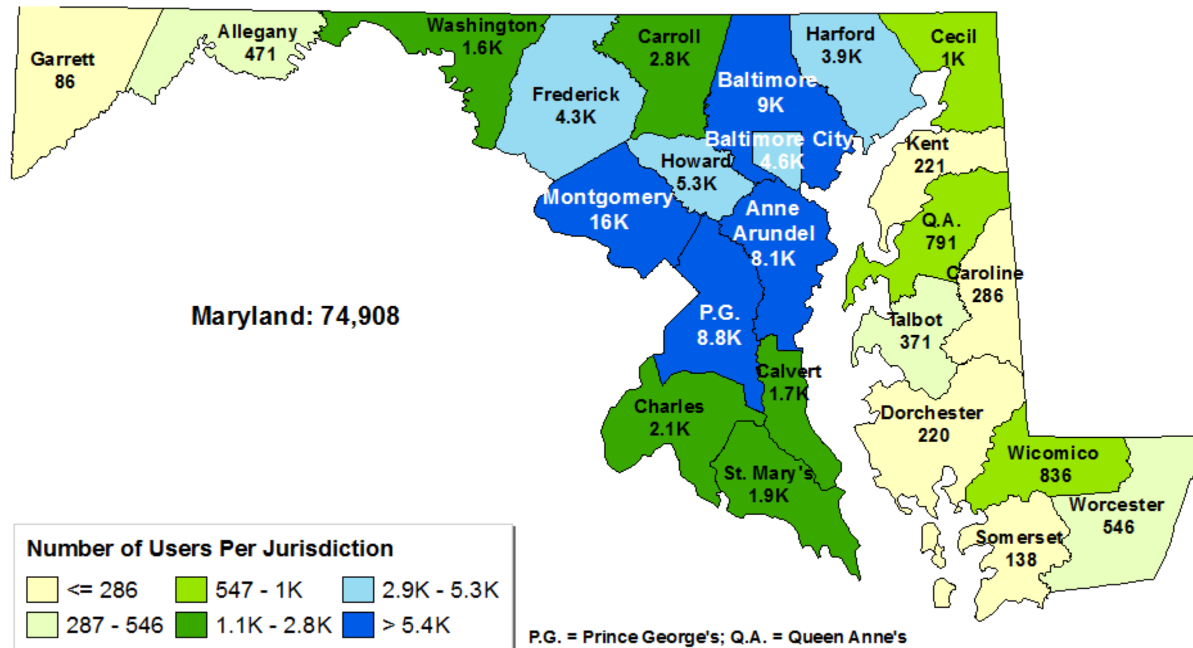
Data Source: Behavioral health service claims data on children and youth (5 to 18 years). Counts are based on PBHS service claims paid through June 30, 2018.

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.

An analysis of behavioral health service use among children and youth (5 to 18 years) covered by commercial and private insurance was performed using the Maryland All Payer Claims Data Base (MCDB). The analysis was based on CY14 and includes fully-insured and self-insured Employee Retirement Income Security Act of 1974 (ERISA)[22] and self-insured Non-ERISA commercial claims for institutional (hospital) and professional behavioral health services. Calendar year 2014 was the most recent year that complete data for both fully-insured and self-insured ERISA and self-insured Non-ERISA data was submitted by health plans. Following the Supreme Court of the United States opinion, *Gobeille* v. *Liberty Mutual Ins. Co.*,[23] court case ruling on March 1, 2016, self-insured ERISA health plans were no longer required to submit claims to APCD data systems. It is estimated that self-Insured ERISA claims account for one-third of all health service claims submitted to APCD systems.

[22] Public Law 93–406.
[23] 577 U.S. ___, 136 S. Ct. 936 (2016).

Map 6: Use of Behavioral Health Services Among School-Age Children and Youth with Private Insurance (5 to 18 Years), CY14



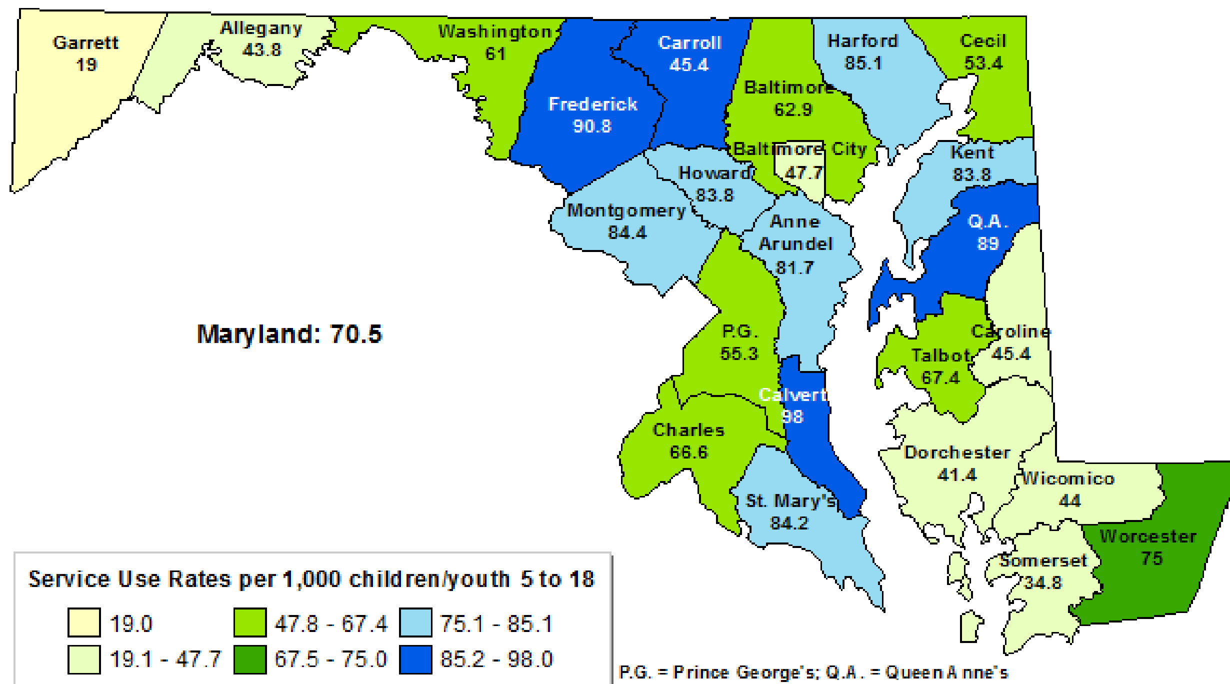
Data Source: Maryland Claims Database (MCDB) – Maryland Healthcare Commission, CY2014. **Notes:** Includes 2014 fully–insured and self-insured ERISA and self-insured Non-ERISA commercial data. The map displays unique user counts across professional and hospital inpatient and outpatient behavioral health services.

Map 6 displays the number and rate of behavioral health service recipients among school age children and youth covered by private insurance plans. Statewide in CY14, 442,891 children and youth 5 to 18 years were enrolled in private health plans, representing 42% of all school-age children and youth. Enrollment in private health plans varied substantially across the state ranging from 55% in Frederick County to a low of 17.5% in Somerset County. Nearly one in five (16.9%) of these children and youth used one or more hospital-based or professional behavioral health services. As shown Map 6, in CY14, a total of 74,908 privately insured children and youth received one or behavioral health services statewide. These children and youth utilized behavioral health services at a comparable rate to children receiving PBHS services, with 70 out of every 1,000 school-age children and youth receiving privately insured behavioral health services compared to 65 per 1,000 in the PBHS. As shown in Map 6, more than one-half (55.9%) of the privately insured child and youth behavioral health service recipients resided in one of four jurisdictions, including: Montgomery (21.4%, 16,041), Baltimore (11.9%, 8,987), Prince George's (11.7%, 8,765), and Anne Arundel (10.8%, 8,092) Counties. Kent (0.29%, 221), Dorchester (0.29%, 220), Somerset (0.18%, 138), and Garrett (0.11%,86) Counties had the lowest number of privately insured behavioral health service users.

In a recent national survey on disparities in access to mental health care conducted by the National Alliance on Mental Illness (NAMI), 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.[24] 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.[25] 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 psychiatric rehabilitation services are more likely to receive services through the PBHS.

Map 8: Rate per 1,000 School-Age Children and Youth Who Receive Privately Insured Behavioral Health Services by Jurisdiction, CY14



Data Source: Maryland Claims Database (MCDB) – Maryland Healthcare Commission, CY14.
Note: Includes 2014 fully-insured and self-insured ERISA and self-insured non-ERISA commercial data. The map displays unique user counts across professional and hospital inpatient and outpatient behavioral health services.

As shown in Map 7, rates of public 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

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[24] 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
[25] 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.

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.

As shown in Map 8, in CY14, behavioral health service use rates for privately insured children and youth varied widely across the state, ranging from a low of 19 per 1,000 school-age children in Garrett County to 98 per 1,000 in Calvert County with a state use rate of 70 per 1,000 children and youth. The highest use rates were in three jurisdictions, including: Garrett (98 per 1,000), Carroll (91.5 per 1,000) and Frederick (90.8 per 1,000) Counties. Dorchester (41.4 per 1,000), Somerset (34.8 per 1,000), and Garrett (19 per 1,000) Counties had the lowest use rates (See Map 8). Those jurisdictions with lower privately insured behavioral health service use rates generally had higher utilization of PBHS services.

Behavioral health outpatient professional services and hospital-based outpatient services were the most frequently utilized with nearly two-thirds (62.6%) of privately insured users accessing outpatient professional services and nearly one-half (48.1%) accessing hospital/institutional based outpatient services. Inpatient psychiatric treatment was infrequently utilized by these children and youth, with less than two percent (1.7%) hospitalized annually. The statewide use rate for inpatient psychiatric services was 1.2 per 1,000 school age children and youth and ranged from zero in St Mary's County to 5.8 per 1,000 in Somerset County. Comparatively, children and youth in the PBHS have more than twice the rate of psychiatric hospitalizations (3.08 per 1,000). Use rates for outpatient professional service ranged from 10.6 per 1,000 in Garrett County to 69.5 per 1,000 in Frederick County with a statewide rate of 44.1 per 1,000 children and youth. These rates are comparable to use rates for outpatient clinic services among PBHS service recipient at 40.9 per 1,000 children and youth.

A. PBHS Outpatient Behavioral Health Services

Table 2: Utilization of Outpatient Behavior Health Services by Jurisdiction, FY15 to FY17

Jurisdiction	Independent Practitioners			Outpatient Clinics			FQHC			Level I SUD Outpatient Adolescent			Opioid Treatment Program		
	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017
ALLEGANY	461	494	574	678	661	659				63	334	118			
ANNE ARUNDEL	1,877	1,693	1,556	2,838	3,359	3,717	35	50	74	112	150	131		21	18
BALTIMORE COUNTY	3,465	3,425	3,616	5,398	5,645	6,038	281	327	335	188	238	209		10	10
BALTIMORE CITY	6,051	6,197	6,543	7,718	7,832	8,160	780	830	750	334	391	422			10
CALVERT	377	353	359	475	469	463		0		19	30	28	0		
CAROLINE	139	153	132	614	608	651				14	29	31	0		0
CARROLL	461	465	507	717	782	908				50	59	46			
CECIL	286	320	354	1,286	1,381	1,335	49	86	119	66	70	54			
CHARLES	239	257	270	809	868	842		16	19	54	67	70	0	0	0
DORCHESTER	285	316	259	765	797	840				23	31	39	0		0
FREDERICK	569	560	576	1,801	1,932	2,138				62	88	100		0	0
GARRETT	97	100	154	353	361	365			18	8	19	18			
HARFORD	902	951	1,045	1,790	1,794	1,704	27	29	36	41	60	51			
HOWARD	620	632	700	819	920	955	24	60	42	31	50	46	0	0	0
KENT	48	51	46	277	296	313			0	7	13	9	0	0	0
MONTGOMERY	1,879	1,971	2,231	3,251	3,414	3,802	49	103	145	181	192	212	0	0	0
PRINCE GEORGES	1,737	1,690	1,952	4,063	4,571	4,913	59	103	187	186	290	176	0	0	0
QUEEN ANNE	130	157	165	315	310	322	0	0		6	8	14		0	0
SOMERSET	98	100	113	361	385	390	245	257	288	15	22	21	0	0	0
ST. MARY	313	285	326	552	623	623				47	42	68			
TALBOT	113	128	153	497	509	519				5	10	15	0		0
WASHINGTON	806	858	920	2,088	2,061	2,060				81	128	102		12	
WICOMICO	467	504	597	1,077	1,147	1,085	496	556	568	86	133	133			0
WORCESTER	295	302	322	572	599	655	36	39	72	47	73	69	0		0
UNKNOWN			0				0	0	0	0	0		0	0	0
Total	**21,716**	**21,963**	**23,470**	**39,120**	**41,325**	**43,458**	**2,114**	**2,490**	**2,681**	**1,726**	**2,527**	**2,185**	**55**	**84**	**57**

Data Source: PBHS service claims data based on claims paid through June 30, 2018.
Note: Totals are unduplicated counts of children served and do not reflect the sum of children served across service categories, since children may receive services across multiple service categories. Grey cells indicate user counts below 10 to protect individual privacy.

As shown in Table 2, there are a number of 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 clinics, federally qualified health centers (FQHC), Level I SUD outpatient services and opioid treatment program services. Between FY15 and FY17, use of independent practitioner and outpatient clinic services increased by 8.1% and 11.3% respectively. Outpatient behavioral health services are the most frequently used services among school-age children and youth who receive PBHS services. Nearly two-thirds (63%) received outpatient clinic services and slightly more than one-third (34%) received services from individual practitioners in FY17. 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 service-use

rates in FY17 for independent practitioners and outpatient mental health centers differed substantially across the 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), Montgomery (11.7), and Howard (11.2) Counties had rates substantially lower than the state rate. Statewide, outpatient mental health clinics 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 clinic 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 FQHCs.

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 Level I SUD outpatient services statewide in FY17. Nearly one-half (47%) of these youth were from one of four jurisdictions, including and Baltimore County (422), Baltimore City (209), Montgomery County (192), and Prince George's County (176). Between FY15 and FY17, use of SUD outpatient services increased from 1,726 to 2,185 respectively, reflecting a 26% increase (see Table 2). 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 program services.

B. Hospital-Based Behavioral Health Services

Table 3: Utilization of Hospital-Based Services by Jurisdiction, FY15 to FY17

Jurisdiction	Hospital-Based Services			Inpatient Hospital			Emergency Room		
	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017
ALLEGANY	177	177	236	0	64	61	132	138	131
ANNE ARUNDEL	983	1,044	1,028	256	289	250	438	494	491
BALTIMORE COUNTY	3,366	3,357	3,440	587	582	638	886	980	994
BALTIMORE CITY	5,277	5,004	5,122	779	716	750	1,388	1,342	1,483
CALVERT	91	126	125	40	47	45	56	82	81
CAROLINE	96	97	95	24	30	20	61	66	71
CARROLL	268	288	291	75	60	69	117	137	137
CECIL	226	246	244	29	42	36	105	131	129
CHARLES	118	152	160	46	48	44	58	70	90
DORCHESTER	130	150	131	45	40	20	90	99	93
FREDERICK	345	369	380	140	149	148	247	286	294
GARRETT	57	48	52	15	11	16	40	36	35
HARFORD	562	578	568	122	126	123	206	244	226
HOWARD	452	460	513	112	125	130	181	193	220
KENT	33	39	52				15	23	27
MONTGOMERY	849	925	1,081	360	366	398	496	585	685
PRINCE GEORGES	701	715	776	156	157	185	337	336	391
QUEEN ANNE	63	62	67	15	13	14	37	32	43
SOMERSET	78	80	89	19	20	16	48	52	59
ST. MARY	116	138	169	41	45	42	61	89	116
TALBOT	67	77	80	21	13	18	42	53	56
WASHINGTON	542	514	496	179	234	177	363	336	333
WICOMICO	315	315	328	60	74	53	188	202	237
WORCESTER	148	148	145	28	25	19	47	67	71
UNKNOWN	0	0	0	0	0	0			
Total	**15,060**	**15,109**	**15,668**	**3,210**	**3,281**	**3,277**	**5,646**	**6,082**	**6,500**

Data Source: PBHS service claims data based on claims paid through June 30, 2018.
Note: Totals 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. Grey shaded cells indicate user counts below 10 to protect individuals' privacy. Hospital-based services is inclusive of all behavioral health services provided by hospitals, including outpatient, inpatient, and emergency room services.

As shown in Table 3, 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. This proportion remained stable between FY15 and FY17. In FY17, nearly two-thirds (62%) of these children and youth resided in Baltimore City or in Baltimore, Anne Arundel, or Montgomery Counties. While nearly one-quarter (23%) of these children and youth used hospital-based behavioral health services, a much smaller number (5%) were hospitalized for a behavioral health condition annually (FY15 to FY17). 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 1 in every 10 (9.4%) school-age children who received PBHS services utilized hospital emergency rooms one or more times for behavioral health related concerns during FY17. As shown in Table 3, between FY15 and FY17, emergency room use among school-age recipients of PBHS services increased by 15% from 5,646 in FY15 to 6,500 in FY17. Use of emergency rooms varied substantially across the state. For example, 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: Dorchester County (17.5), Baltimore City (15.3), and Somerset County (14.9), Allegany County (12.2) 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 a larger proportion of children and youth who are eligible to receive PBHS services. 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.

C. Residential Services

Table 4: Utilization of Residential Services by Jurisdiction, FY15 to FY17

Jurisdction	Residential Treatment Center			Residential Rehabilitation			SUD Residential Adolescent			Crisis Residential		
	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017
ALLEGANY	11											
ANNE ARUNDEL	31	39	34				33	54	35		0	
BALTIMORE COUNTY	101	113	103				36	60	51			
BALTIMORE CITY	126	109	85	10		10	49	99	106			
CALVERT			11		0	0				0	0	0
CAROLINE	10				0					0	0	
CARROLL	17	11			0	0		11		0	0	0
CECIL	20	15	16	0	0	0				0	0	0
CHARLES	13	16	18		0	0			10	0	0	0
DORCHESTER	15	15	13	0	0	0				0	0	0
FREDERICK	23	24	40					16				0
GARRETT					0	0					0	0
HARFORD	32	26	19		0	0		10	11	0	0	0
HOWARD		10	12									
KENT						0			0			0
MONTGOMERY	71	69	50	11		13	15	22	30			
PRINCE GEORGES	49	44	33				11	18	14			
QUEEN ANNE				0	0	0				0	0	0
SOMERSET				0			0			0	0	0
ST. MARY	10	15	18	0	0				23	0	0	0
TALBOT				0	0			0		0	0	
WASHINGTON	25	21	24	0	0	0		14		0	0	0
WICOMICO	25	14		0	0	0	11		14	0	0	
WORCESTER				0						0	0	
Total	**623**	**589**	**524**	**50**	**38**	**45**	**216**	**361**	**363**	**28**	**25**	**25**

Data Source: PBHS service claims data based on claims paid through June 30, 2018.
Note: Totals are unduplicated counts of children served and do not reflect the sum of children served across service categories, since children may receive services across multiple service categories. Grey cells indicate user counts below 10 to protect individuals' privacy.

As shown in Table 4, utilization of MH-RTC services decreased from 623 in FY15 to 524 in FY17, representing a 16% decrease. In FY17, 524 school-age youth received mental health residential treatment center (MH-RTC) services, while 363 adolescents received SUD residential services statewide. Over the same period, use of SUD residential services increased by 68% from 216 in FY15 to 363 in FY17 (see Table 4). 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.

D. Intensive Community-Based Services and Supports

Table 5: Utilization of Intensive Community-Based Services by Jurisdiction, FY15 to FY17

Jurisdiction	Targeted Case Management			Psychiatric Rehabilitation			Mobile Treatment Services			Respite Services			Supported Employment			PRTF Waiver Services		
	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017
ALLEGANY	14		21	171	192	266				0	0	0			0	0	0	0
ANNE ARUNDEL	66	53	94	536	641	733										0	0	0
BALTIMORE COUNTY	134	124	93	1,436	1,666	1,771	89	76	84	35	39	30				0		14
BALTIMORE CITY	94	199	255	4,282	4,821	5,255	121	127	161	53	43	41			15	0		
CALVERT	14	27	27	49	44	53		0	0			0			0	0	0	
CAROLINE			16	73	86	103				25	34	29	0			0	0	0
CARROLL	11	21	28	117	146	179		0	0						12	0	0	0
CECIL	15	37	44	309	327	304	0	0	0	0						0	0	
CHARLES	67	51	50	117	140	149		12		0	0	0				0	0	
DORCHESTER		20	37	161	183	175	0	0	0	11	12	14	0	0	0	0	0	0
FREDERICK	36	73	88	257	384	503			0	42	56	59				0		
GARRETT	17	20	16		11	10	0	0	0	0	0	0	10			0	0	0
HARFORD	68	55	27	415	448	433			0	11	12	12				0		
HOWARD	16	13	15	154	161	200		0								0		
KENT	0		11	31	29	26	0	0	0					0		0	0	0
MONTGOMERY	14	19	35	325	320	423		0		11			40	31	39		0	0
PRINCE GEORGES	17	17	42	1,075	1,229	1,388	13	15	13	0		0		0	0	0	0	
QUEEN ANNE	0			19	19	25	0	0	0							0	0	0
SOMERSET			30	154	192	196	0	0	0	36	27	31				0	0	
ST. MARY	25	30	33	84	97	106				0	0	0			11	0		
TALBOT	0		12	139	123	97	0	0	0	18	17	15	0	0		0	0	0
WASHINGTON	189	288	343	266	422	527	25	29	21							0	0	
WICOMICO	21	111	178	320	383	472	0	0	0	62	65	66		13	13	0		
WORCESTER		29	39	132	134	160	0	0	0				0		0	0	0	0
UNKNOWN	0				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**834**	**1,230**	**1,545**	**10,631**	**12,198**	**13,554**	**270**	**270**	**297**	**333**	**349**	**330**	**128**	**105**	**127**		**19**	**55**

Data Source: PBHS service claims data based on claims paid through June 30, 2018.
Note: Totals 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. Grey shaded cells indicate user counts below 10 to protect individuals' privacy.

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 targeted case management, psychiatric rehabilitation, mobile treatment services, respite services, supported employment and PRTF waiver services. Psychiatric rehabilitation program (PRP) services are available in all jurisdictions. As shown in Table 5, the number of children and youth utilizing of PRP services increased from 10,631 in FY15 to 13,554 in FY17, representing a 27.5% increase. In FY17, nearly one in every five (19.6%, 13,554) school-age children who received PBHS services utilized PRP services (see Table 5). 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 297 school-age children and youth residing in 15 of 24 jurisdictions. As shown in Table 5, the number of child and youth users of mobile treatment services increased from 270 in FY15 to 297 in FY17, reflecting a 10% increase. The vast majority (82%) of these users were from Baltimore City or Baltimore County (FY17). The statewide utilization rate for this service is extremely low at 0.28 per 1,000 school-age children and youth.

Targeted Case Management (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.[26] 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. As shown in Table 5, the use of this service increased by 85.2% between FY15 and FY17 from 834 to 1,545 respectively. However, they represent only 2% of all school-age children who received PBHS services in FY17. Three jurisdictions, including Baltimore (255), Washington (343), and Wicomico (178) Counties, accounted for one-half of all children who received TCM service (FY17). 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.

E. Behavioral Health Initiatives Designed to Increased Access and Use of Behavioral Health Services

Over the past few years, the Maryland Department of Health, Behavioral Health Administration, has implemented a number of innovative programs to enhance statewide access and use of behavioral health services, including the implementation of tele-behavioral health throughout the State, 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 Wicomico County (389), Baltimore County (383), Baltimore City (228), Harford County (220), Somerset County (170), accounted for most (79%) of the child and youth

[26] 42 U.S.C. §1396n.

service recipients while and Montgomery (4), Caroline (3), Frederick (3), Calvert (2), Queen Anne's (1), Talbot (1), and Kent (0) 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 is a critical step in advancing the somatic and behavioral health of Maryland residents by offering co-located services. In some cases, through this effort, behavioral health 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 community-partnered school behavioral health 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 which was not the primary complaint presented at the visit. 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, designed to assist adults and youth in having the conversation with someone about suicidal intentions and Kognito modules. Kognito is an innovative state-of-the art, interactive avatar-based online suicide prevention and mental health training. MD-SPIN is currently developing additional 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. These programs all have staff with 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.

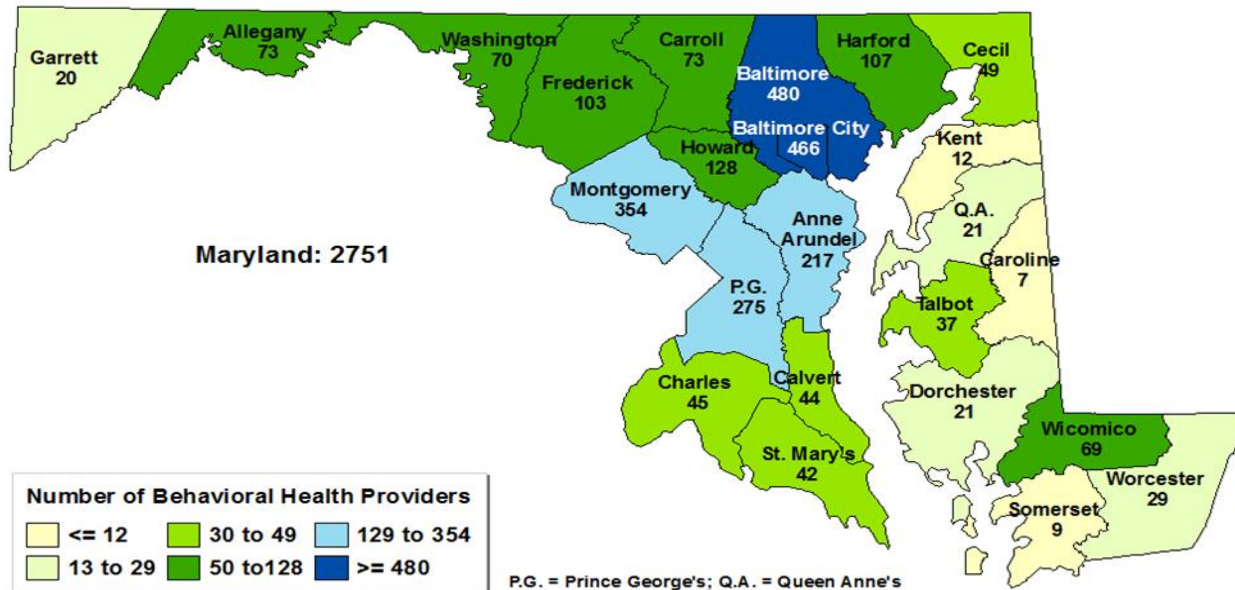
V. Providers

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."

Maryland has a comprehensive array of public behavioral health services available 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.[27] Information on behavioral health services and supports provided by Maryland's PBHS is included in this section of the report. 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 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.

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

Map 9: Number of Public Behavioral Health Service Providers Who Delivered Services to School-Age 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.

As shown in Map 7, in FY17, a total of 2,751 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 (480) and Baltimore (466), Montgomery (354), Prince George's (275), and Anne Arundel (217) 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 9).

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			PRTF Waiver		
Years	2015	2016	2017	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	0	0	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	0	0	0
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	0	0	0
Baltimore City	358	385	383	15	15	15	8	6	8	7	6	6	4	4	4	1	1	1	41	51	65	2	4	2	0	1	1
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	0	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	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	0	0	0
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	0	0	0
Charles	23	33	37	1	1	1	0	0	0	2	2	3	1	1	1	0	0	0	0	3	2	0	0	1	0	1	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	0	0	0
Frederick	68	78	86	1	1	1	4	4	4	1	1	1	1	1	1	1	1	1	4	4	5	1	1	2	0	0	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	0	0	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	0	0	0
Howard	104	115	115	2	2	2	3	3	3	0	0	1	0	0	0	0	0	0	3	4	5	1	2	1	0	1	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	0	0	0
Montgomery	266	294	329	6	6	6	4	5	6	0	0	0	1	0	1	0	0	0	5	7	11	1	3	2	1	0	0
Prince George's	221	243	236	6	6	5	2	2	2	2	2	2	1	1	2	0	0	0	17	23	27	0	0	1	0	1	2
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	0	0	0
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	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	0	0	0
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	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	0	0	0
Wicomico	37	46	53	1	1	1	1	1	1	2	2	2	1	1	0	3	3	3	5	7	7	1	1	1	0	0	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	0	0	0
TOTAL	**2,108**	**2,263**	**2,390**	**54**	**54**	**53**	**36**	**33**	**39**	**31**	**31**	**35**	**14**	**13**	**14**	**10**	**7**	**7**	**135**	**171**	**199**	**19**	**26**	**21**	**1**	**4**	**8**

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

Notes: Outpatient behavioral health services includes, individual practitioners, mental health outpatient clinics, SUD Level I Outpatient, and FQHC outpatient providers. Residential-based care includes residential treatment centers, crisis residential, residential rehabilitation, and SUD residential. 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 nine service categories: outpatient behavioral health treatment, hospital-based care, residential-based care, case management, mobile treatment, respite, psychiatric rehabilitation, supported employment and PRTF Waiver services. Between FY15 and FY17, the total number of public behavioral health service providers providing services to school-age children increased from 2,408 to 2,766 statewide, representing an increase of 358 providers. Most of this expansion is accounted for by increases in outpatient behavioral health treatment (79%) and psychiatric rehabilitation (18%) 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%, 187) 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.

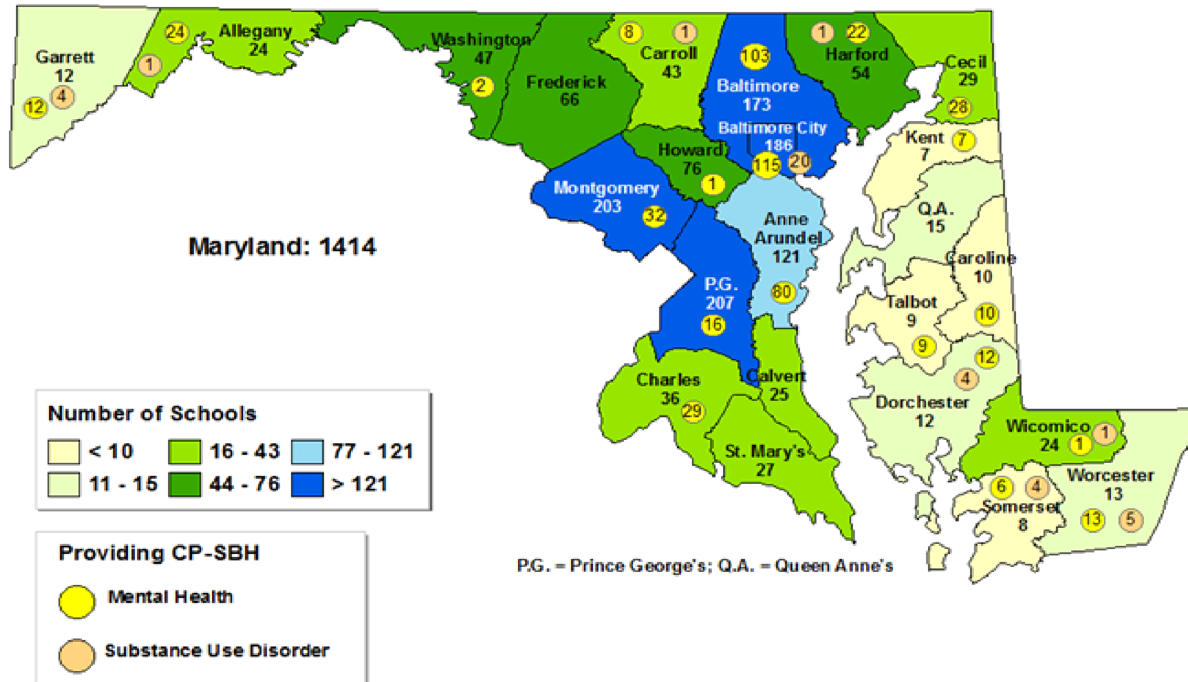
A. Community-Partnered School Behavioral Health (CP-SBH)

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 10 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 10, 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 10). 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 10: Number of Schools Providing Community-Partnered School Behavioral Health Services, FY15

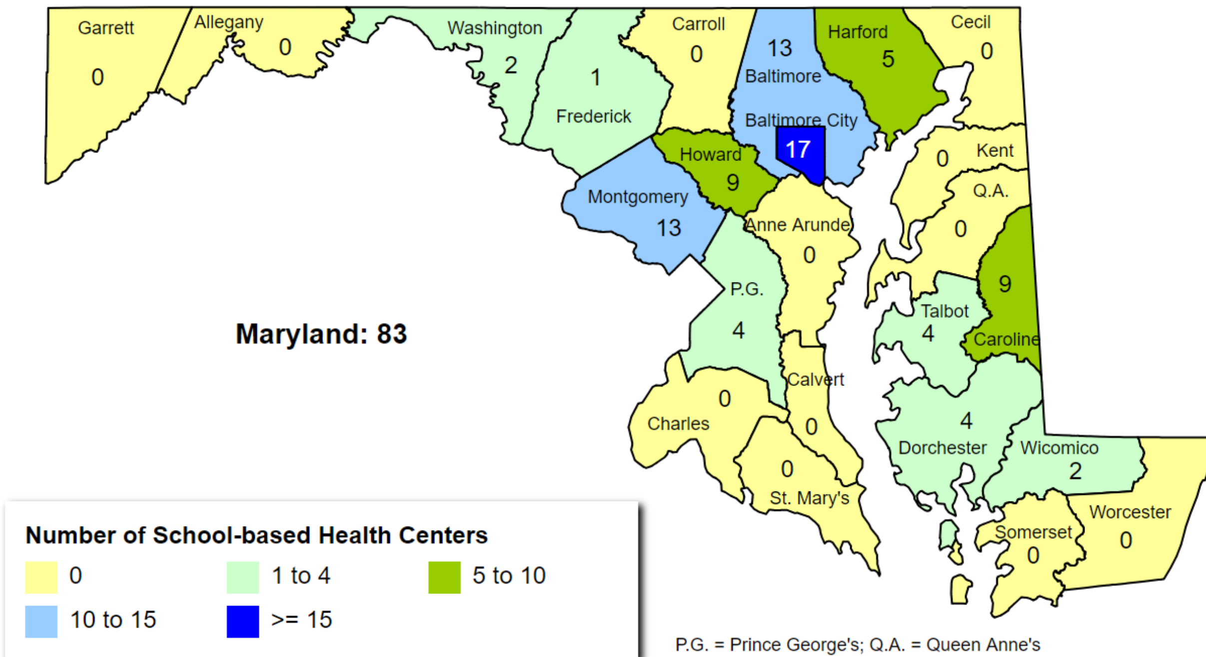


Data Source: Lever, Stephan, Castle, Bernstein, Connors, Sharma, & Blizzard, Community-Partnered School Behavioral Health: State of the Field in Maryland, Baltimore, MD: Center for School Mental Health, Community, 2015.

B. 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 and youth 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 11 displays the number and location of SBHCs by jurisdiction. As shown in Map 11, 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 11: 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.

C. Behavioral Health Services in Schools

All schools in Maryland are required to provide a coordinated program of pupil services for all students which shall include but are not limited to school counseling, school psychology, pupil personnel, and health services.[28] Behavioral health services in schools focus on the health, personal, interpersonal, academic and career development of students. 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 emotional distress, complete assessments related to mental health, and provide supportive counseling as needed. These school staff make referrals to other professionals when indicated, as does the school nurse and the pupil personnel worker. These professionals and other staff members support the mental health of students through the

[28] COMAR 13A.05.05.01.

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, psychiatric 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 Washington (343), Baltimore (255), 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 psychiatric rehabilitation services, utilizations 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 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 I 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,"[29] the Maryland Center for School Safety initiated an anonymous reporting system to streamline reporting by students, family members, parents, faculty, staff, and members of the community of possible threats to the safety and/or well-being of students. This school safety tip line is called Safe Schools Maryland, (call 1–833–MD–B–SAFE, 1–833–632–7233, or download the application on a cellular phone).[30]

Because Safe Schools Maryland is available to receive tips concerning any activity that makes the reporter "feel uncomfortable, nervous, or frightened about the safety of their school, themselves, or others,"[31] the Maryland Center for School Safety, MEMA, and the Behavioral Health Administration collaborated 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 intervention, risk assessment for suicide, homicide or overdose prevention, support, guidance, and information or linkage to community behavioral health providers."[32]

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[29] Maryland Emergency Management Agency, online at https://mema.maryland.gov/Pages/AboutMEMA.aspx.
[30] Office of Governor Larry Hogan, Governor Larry Hogan Announces "Safe Schools Maryland" School Safety Initiative, online at http://governor.maryland.gov/2018/10/03/governor-larry-hogan-announces-safe-schools-maryland-school-safety-initiative/.
[31] *Ibid.*
[32] Maryland Department of Health, Maryland Crisis Connect, online at https://health.maryland.gov/suicideprevention/Pages/Maryland-Crisis-Hotline.aspx.

While coordinating services between the Safe Schools Maryland 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 Safe Schools Maryland 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 Safe Schools Maryland 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 Safe Schools Maryland 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."[33] 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.

[33] *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 addressing 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. A strategy for paying for these data collection efforts may also need to be explored.

C. Sustainability

Sustainable models of CP-SBH programming braid together diverse funding streams including fee-for-service and local and state funding sources. 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 verses behavioral health promotion and prevention.

Part 3
Delivery Implementation

I. Plans for Delivering Services[34]

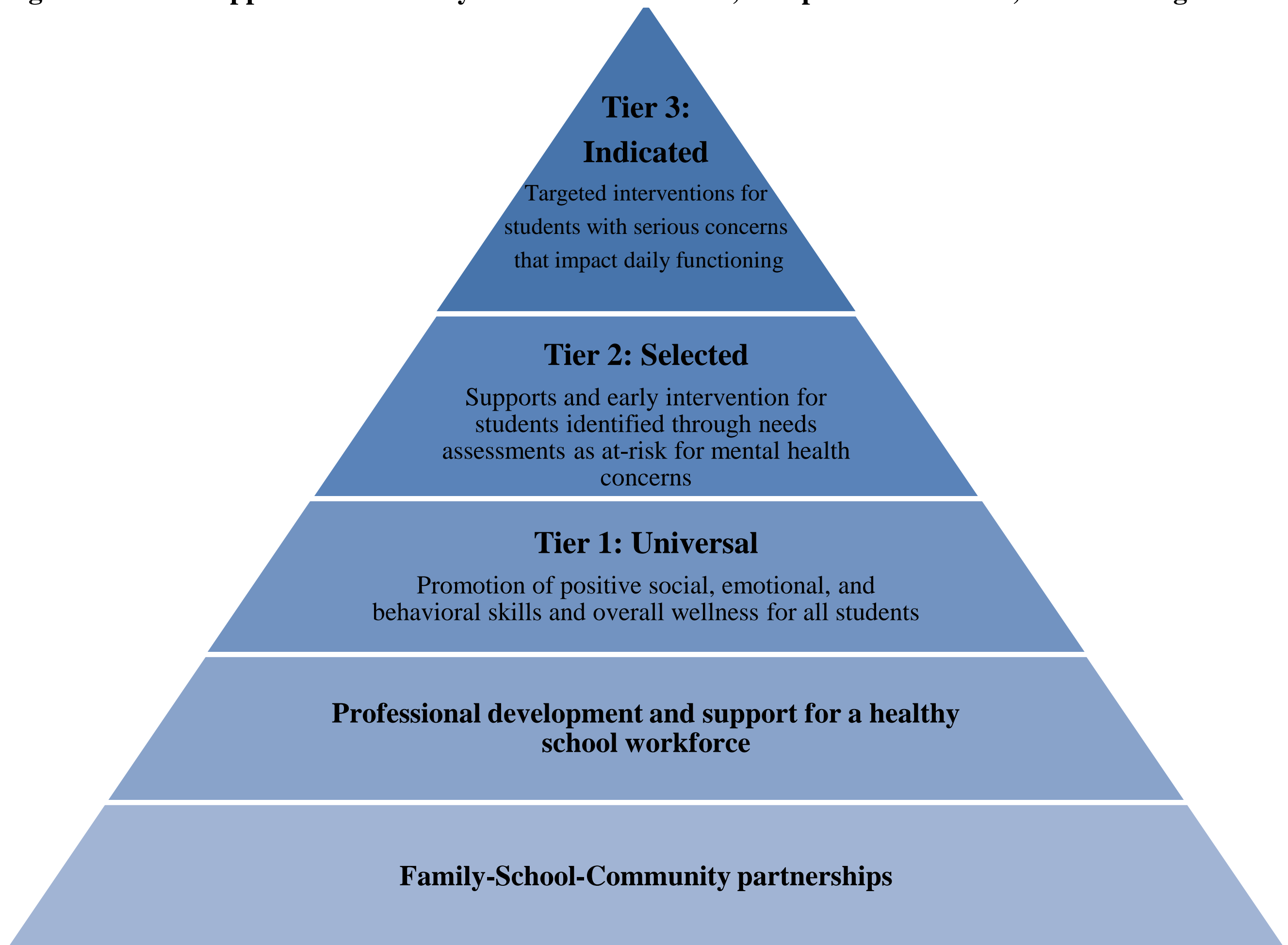
Section 12(a)(1)(i) requires the Subcabinet to "evaluat[e] the plans for delivering behavioral health and wraparound services to students exhibiting behaviors of concern that mental health services coordinators are required to develop under § 7–1511 of the Education Article, as enacted by Section 4 of 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.[35]

The mental health services coordinators for each jurisdiction were identified by the September 1, 2018, deadline.[36] However, at the time that this report was drafted, the coordinators were preparing their plans. Therefore, the Subcabinet will not be 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.

[34] § 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.
[35] § 7–1501(m).
[36] § 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. It is also recommended that BHA and MSDE continue their collaborative efforts to develop an action plan based on the findings of this report.

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. Consideration should also be given to the expansion of behavioral health services in school wellness centers.

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, availability, and quality 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 state and federally funded 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. This should include training in cultural and linguistic competence.

Recommendation 8: Develop and implement strategies to enhance youth and parent/guardian engagement and participation in the expansion and implementation of school safety and MH/SUD awareness that supplement ongoing efforts to reduce chronic absenteeism and to strengthen prevention and training policies, protocols, and activities including the development of a threat assessment.

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.

APPENDIX

Service Descriptions

Individual Practitioners are independent behavioral health professionals who are licensed by MDH professional boards to provide services independently or in group practices. Their specific disciplines include physicians, psychologists, licensed social workers and counselors and similar therapeutic professionals.[37]

Outpatient Clinic refers to a licensed and accredited organizational entity called an Outpatient Mental Health Center which provides a set of ambulatory therapeutic service through a multi-disciplinary team.[38]

Federally Qualified Health Center (FQHC) is a reimbursement designation from the Federal Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and MH/SUD services to persons of all ages, regardless of their ability to pay or health insurance status.[39]

Hospital-Based Services are behavioral health services clinics operated by a licensed hospital.[40]

Acute Psychiatric Inpatient care involves skilled psychiatric services in a hospital setting. The care delivered includes both medical and nursing care and is expected to be delivered on a 24-hour basis, including weekends. For individuals not certified for involuntary admission, and in areas where residential crisis services, hospital diversion programs, or Core Service Agency (CSA) crisis response systems are available, these levels of care should be explored, when appropriate, before authorization for an inpatient stay is given.[41]

Behavioral Health Emergency Room allows for assessment and intervention for a participant who is in an emergency department (ED) and appears to be exhibiting acute behavioral issues. This service allows for assessment and intervention for a participant who is in an emergency department (ED) and appears to be exhibiting acute behavioral issues.[42]

Residential Treatment Center offers 24-hour inpatient care in a facility licensed under COMAR 10.07.04. An RTC provides children and adolescents who have long-term and serious emotional disturbance with residential care in a structured therapeutic milieu and provides a range of diagnostic and therapeutic mental health services. RTC treatment focuses on maximizing a

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[37] See Beacon Health Options, online at http://maryland.beaconhealthoptions.com/provider/manual/CH06_16-Outpatient-Mental-Health-Services.pdf (an outpatient service).
[38] *Ibid.* (an outpatient service).
[39] *Ibid.* (an outpatient service).
[40] *Ibid.* (an outpatient service).
[41] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_01-Inpatient-Hospital-Psychiatric-Services.pdf.
[42] *Id.,* at http://maryland.beaconhealthoptions.com/provider/manual/CH06_04-MH-ED-Services.pdf.

participant's development of appropriate living skills. This is a very intense level of care and can only be provided when therapeutic services available in the community are insufficient or have failed to address the participant's need.[43]

Residential Rehabilitation services (RRP) are provided by a program approved under COMAR 10.21.22 and provide residential support and rehabilitation for participants who have severe and persistent mental illness. Such participants are supported with off-site psychiatric rehabilitation program (PRP) services that are provided in the RRP residence at either a general or intensive level of support.[44]

Crisis Residential services (RCS) are funded with State general funds and are short-term, intensive, mental health and support services for children, adolescents, and adults in a community-based, nonhospital, residential setting rendered by a provider approved under COMAR 10.21.26.[45]

Psychiatric Residential Treatment Facilities Waiver are 1915(i) services. They are intensive behavioral health services for children, youth, and families and builds upon the prior 1915(c) RTC waiver that allowed states to provide home and community-based care to participant's that would otherwise be institutionalized. Included in the 1915(i) program are an array of diagnostic and therapeutic mental health services, including 24-hour availability of mental health and/or crisis services, which are provided to the child or adolescent and family using a wraparound approach that includes intensive care coordination with an individualized plan of care. Specialized services not otherwise available through the Medicaid program include mobile crisis stabilization, respite services, intensive in-home services, expressive and experiential behavioral services, and family and peer support services.[46]

Targeted Case Management: Targeted case management (TCM) programs are available to assist participants with gaining access to the full range of available mental health services, as well as to any needed medical, social, financial, counseling, educational, housing, and other supportive services needed in order to maintain stability in the community.[47]

Mobile Treatment: Mobile treatment services (MTS) and assertive community treatment (ACT) programs are community-based, intensive, outpatient services providing mobile, assertive mental health treatment and support services to participants with mental illness who may be homeless or for whom more traditional forms of outpatient treatment have been ineffective. Services are

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[43] Beacon Health Options Provider Manual, online at http://maryland.beaconhealthoptions.com/provider/manual/CH06_02-Residential-Treatment-Services.pdf.
[44] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_13-MH-RRS.pdf.
[45] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_10-MH-Residential-Crisis.pdf.
[46] Beacon Health Options, Reimbursement in the Public Behavioral Health System (PBHS), online at http://maryland.beaconhealthoptions.com/provider/prv_info.html.
[47] Beacon Health Options Provider Manual, online at http://maryland.beaconhealthoptions.com/provider/manual/CH06_15-MH-CMS.pdf.

provided by a multidisciplinary team, are mobile, and are provided in the participant's natural environment (e.g., home, street, shelters).[48]

Psychiatric rehabilitation program (PRP) services provide rehabilitation and support for participants to develop and enhance their community and independent living skills. Services may be provided at a PRP facility (onsite); at a residence, job, or another appropriate location in the community (off-site); or at a combination of the two (blended onsite and off-site).[49]

Supported Employment provides job development, job coaching, and ongoing employment support services to individuals with serious mental illness for whom competitive employment has not occurred, has been interrupted, or has been intermittent.[50]

Respite Care services are provided to relieve the caregiver and are delivered in hourly, daily, and weekend increments.[51]

SUD Level I Outpatient services are a combination of assessment, referral, and outpatient treatment. Before providing SUD Level I services, the provider will develop a written individualized treatment plan, with the participation of the participant, based on the comprehensive assessment and placement recommendation. This plan will be updated every 90-days. It will be reviewed and approved by a licensed behavioral health practitioner. It will include:

- An assessment of the participant's needs;
- Long-range and short-range treatment plan goals;
- Specific interventions for meeting the treatment plan goals;
- Target dates for completion of treatment plan goals;
- Criteria for successful completion of treatment;
- Referrals to ancillary services, if needed; and
- Referrals to recovery support services, if needed.

Each individual and group counseling session will be documented in the participant's record through written progress notes, after each counseling session. Before discharge, the provider will give the participant a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.[52]

Opioid Maintenance Treatment and opioid treatment programs (OTP) services include the use of methadone, Vivitrol, or buprenorphine dispensed under a physician's order in addition to counseling and recovery support services. Clinical services provided should address any and all substance use disorders present for each participant. Periodic random urine drug screens are

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[48] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_05-MH-Mobile-Treatment-&-Asse.pdf.
[49] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_12-MH-PRP.pdf.
[50] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_06-MH-Supported-Employment.pdf.
[51] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_07-MH-Respite-Services.pdf.
[52] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_37-Level-1-Outpatient-Treatment-Services.pdf; see also http://maryland.beaconhealthoptions.com/provider/manual/CH06_36-Level-1-Assessment-Referral.pdf.

required. OTPs may provide participants with take-home medication at the discretion of the Medical Director, following the guidelines provided in 42 CFR Part 8, §8.12(h)(4)(i).[53]

SUD Residential include halfway houses, medium intensity residential services, and intensive residential services.

Halfway Houses (Low Intensity, Level 3.1 Residential services) are only reimbursable through the state of Maryland's Grant Funds; administered by the local addictions authorities (LAAs). Halfway Houses are not reimbursable through federally or state funded Medicaid or Dual Eligibility (Medicaid and Medicare).[54]

Medium Intensity Residential services are provided in a structured residential environment, in combination with medium intensity treatment and ancillary services to support and promote recovery to participants. Therapeutic services in an ASAM Level 3.3 setting provides structured SUD treatment to adults needing between 20 to 35 hours of therapeutic activities per week; and meeting all expectations as outlined in COMAR 10.09.06.[55]

Intensive Residential services are provided in a structured residential environment, in combination with intensive treatment and ancillary services to support and promote recovery to participants. Therapeutic services in an ASAM Level 3.7 setting require a planned regimen of 24-hour evaluation, care, and treatment in a residential setting. The Residential SUD Treatment facility must also provide a minimum of 36 hours of SUD therapeutic activities per week for ASAM level 3.7 and meet all expectations as outlined in COMAR 10.09.06.[56]

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[53] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_38-Level-1-Opioid-Treatment-Services.pdf.
[54] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_31-31-Low-Intensity-Halfway-House.pdf.
[55] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_32-33-Medium-Intensity-Residential-Treatment.pdf.
[56] *Id.*, at http://maryland.beaconhealthoptions.com/provider/manual/CH06_33-35-High-Intensity-Residential-Treatment.pdf.