Governor's Task Force on the
Needs of Persons with Co-Occurring Mental Illness and Substance Use Disorders

Interim Report

Submitted to

Governor Robert L. Ehrlich, Jr.
The Senate Education, Health and Environmental Affairs Committee
The House Health and Government Operations Committee

EXECUTIVE SUMMARY

People in Maryland who have mental illness and substance use disorders struggle to receive the coordinated treatment they need largely because (1) two State agencies have oversight responsibilities for these services, (2) each of the agencies, plus Medicaid, fund mental health and substance use disorder treatment services, and (3) staff generally are not trained in treating both these disorders. The literature has established the need for integrated care for treating such individuals. The cost of not doing so results in increased hospitalization, incarceration, poor outcomes, and lost employment.

To address this significant issue, HB433 was signed into law establishing the Governor's Task Force on the Needs of Persons with Co-occurring Mental Illness and Substance Use Disorders. This group is comprised of representatives from most state departments and several administrations within those departments (e.g. Department of Health and Mental Hygiene (DHMH), AIDS Administration, Mental Hygiene Administration (MHA), Alcohol and Drug Abuse Administration (ADAA), Department of Human Resources (DHR), Department Of Public Safety and Corrections (DPSCS), Public Defender's, State's Attorney's office, etc.) and community stakeholders. The focus is on making recommendations to create a system of care that serves people more effectively and uses dollars wisely. The inclusion of other state agencies that also serve these individuals in different ways is to have a comprehensive approach to this problem and to recognize the need of this population not only for treatment but also for ancillary services (income, housing, employment, education, etc.) A five-committee structure focused on various areas (clinical, workforce competence, systems integration, financing and reimbursement, and information) manages the bulk of the work of the task force. This report is the beginning of a set of recommendations that will be submitted in the final report to the legislature in December 2005.

Introduction:

HB433 establishing this Task Force was signed into law in the spring of 2003. The Task Force has been meeting monthly since November 2003. State departmental representatives and involved community stakeholders comprise the Task Force

membership, as provided in the legislation (see list of members in Appendix A). An interim report is due on 12/1/04 and a final report on 12/1/05.

The Problem and Related Issues:

Data:

- National statistics indicate that 41-65% of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder (Surgeon General's report, 1999).
- In 2002, more than half of adults with co-occurring serious mental illness and a substance use disorder (a total of 2 million adults) received neither specialty substance use disorder treatment nor mental health treatment (NSDUH report, 6/23/04, see references, Appendix D).
- Maryland addiction programs identify 11-22% of people in addiction treatment as having a co-occurring mental illness. Since the national data is representative and includes Maryland, clearly our state is not accurately identifying those consumers with both disorders.
- The MHA data reports 20-25% of those treated in the mental health system have a co-occurring substance use disorder. As these percentages are based on claims data only, and substance abuse/dependence is listed as a secondary disorder in this system, individuals with co-occurring disorders are not accurately identified. Anecdotal reports from individual providers such as University of Maryland Community Psychiatry indicate as many as 70% of consumers seeking mental health treatment have positive drug screens, but this is not reflected in state data.
- Ineffectively treating people with co-occurring disorders translates to additional costs for increased hospitalization, incarceration, poor outcomes, and decreased employment. Additionally, those who are inadequately treated experience more relapses and diminished quality of life.
- Typical and illustrative story: Mary (not her real name) is 30 years old and pregnant with her second child. She has a history of physical and sexual abuse as a child. She earned her GED at age 20 and has had intermittent employment, with the longest job lasting 8 months. Her mother has a history of untreated depression. As a teenager (likely to deal with the symptoms resulting from the trauma she experienced), she began drinking and smoking marijuana. At 25, she began using heroin. She has been psychiatrically hospitalized 3 times following a suicide attempt at age 16 and recurring suicidal thoughts. She frequently cuts herself as a release and sometimes "cuts too deep." She is facing eviction and has limited treatment. Current diagnoses are depression, post-traumatic stress disorder, and polysubstance abuse. There is no program where she lives in which she can receive comprehensive integrated treatment for both disorders.

Problems in Maryland's Health Care System:

A 2003 survey of addiction and mental health treatment providers noted that:

- The majority of providers find the current system ineffective for serving people with co-occurring disorders—adults and children and adolescents.
- Inadequately trained staff, funding difficulties, and system design are cited as reasons for this ineffectiveness. (Maryland Mental Health Coalition and Addiction Treatment Advocates of Maryland. Co-occurring Disorders in Maryland: Status and Recommendations. Mental Health Association of Maryland, 2004.)

Goals/Objectives of Task Force

Make recommendations to assist Maryland to develop a:

- System that spends resources wisely.
- System of treatment that is effective and that reduces incarceration, hospitalization, and homelessness.
- System that incorporates the best practices of integrated care for individuals with co-occurring disorders.
- System of care that promotes recovery from these dual disorders.
- System model that incorporates the components of the Continuous, Comprehensive, Integrated Systems of Care (CCISC) principles of care (see Appendix C)

Legislated Tasks

(1) Identify and recommend creative ways to provide and deliver comprehensive, integrated, cost-effective services to the population with co-occurring mental illness and substance use disorders;
(2) Identify and recommend various methods of funding services through private and public sources;
(3) Make recommendations regarding both short-term and long-term residential services for people with co-occurring disorders, including recommendations on the number of units needed and a timeline for providing residential services;
(4) Make recommendations regarding how the Mental Hygiene Administration and Alcohol and Drug Abuse Administration may implement cross-training for mental illness and addiction counselors; and
(5) Make recommendations regarding necessary legislation to implement the Task Force's recommendations.

The full text of the legislation may be referenced in Appendix B.

Task Force Structure

The work of the Task Force is being performed through five committees that report to the larger group:

- **Clinical Committee**: Addresses clinical issues and ancillary services, including housing, community support, rehabilitation, transportation, and recovery.
- **Workforce Competence Committee**: Addresses issues surrounding clinical competencies, certification, and continuing education.
- **Systems Integration Committee**: Addresses the bifurcation of structure, the multiple funding streams in the current system, and the need for coordination of services beyond the purview of DHMH. (E.g., housing, employment/training, supportive services) and will make recommendations regarding integration.
- **Financing and Reimbursement Committee:** Addresses creative funding strategies and making recommendations regarding these.
- **Information Systems Committee:** Addresses MIS and data questions and issues.

In an effort to develop the work of the committees, the task force has sought technical assistance from the Center for Substance Abuse Treatment (CSAT) Co-Occurring Center of Excellence, primarily regarding screening and funding issues.

Current Recommendations:

- From the Financing and Reimbursement Committee: The Task Force recommends that DHMH participate with the Task Force in the free technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA) CSAT funded Co-Occurring Center for Excellence (COCE) regarding financing structures at the State level that facilitate integrated treatment.

- From the Information Systems Committee:

1. The Task Force recommends that DHMH adopt new data reporting requirements to better identify individuals with co-occurring illness. The task force will make recommendations regarding the minimum data set needed by 12/31/04. It is recommended that DHMH adopt these requirements by 12/31/05.
2. The Task Force recommends that ADAA and MHA need to identify current providers who report offering integrated care in each jurisdiction to quantify and qualify specifically what they offer. The Leadership Group of DHMH should survey providers by 1/31/05 with the instrument developed by the Maryland Co-Occurring State Incentives Grant (COSIG) grant workgroup, a workgroup comprised of representatives from the task force and other interested stakeholders.

- From the Clinical Committee: The Task Force recommends that DHMH adopt a screening tool to identify individuals with co-occurring disorders in all publicly funded and/or licensed addiction and mental health programs. The Task Force will recommend screening tools to the DHMH by 3/31/05 and recommends implementation of such screening by 7/1/05.

- From the Systems Integration Committee: The Task Force recommends that DHMH, in conjunction with the Task Force, undertake the following tasks:

1. To formulate an "Implementation Committee" to institute state-level changes in policies and regulations, and to actively look at funding from the standpoint of the maximization of the use of existing resources. Additionally, this body should be charged with the exploration of creative funding in order to fill identified service gaps in the overall system of care.
2. Through the Implementation Committee, Task Force, the Legislature and all other parts of state-level infrastructure, support efforts on the part of the Leadership Team, especially in recent plans to plan for a more coordinated effort for screening and assessment. Hopefully, it is through a coordinated process that Maryland will ultimately obtain better data toward service provision and planning.
3. To apply proactively, also through an Implementation Committee, for federally funded resources for systems change such as the COSIG and the Policy Academy.
4. As a follow-up to the December, 2003 Leadership Symposium, within the Implementation Committee, to develop a state-level "Policy Academy" which includes a statewide plan to incentivize counties to implement systematic initiatives, utilizing evidence-based practices along with the findings from pilots in Worcester County, Montgomery County and Baltimore City.
5. To develop a Continuous Quality Improvement (CQI) process to assist each county jurisdiction move all programs and clinicians toward Dual Diagnosis Capability (DDC, see appendix C), within the context of existing resources, and with the support from the State in the form of training and technical assistance.
6. To institute a State-level Co-Occurring Disorders Advisory Committee, comprised of membership as reflected by the breadth of membership and levels of authority in the present Task Force, providing expertise that recognizes the complex needs of this population.

Action Plan for the Next Year

- **Clinical Committee**: will be charged with:
  (1) Making recommendations regarding mental illness and substance abuse disorder screening tools to be used in publicly funded programs,
  (2) Making recommendations regarding residential treatment needs as required by the legislation. The committee will be looking at homelessness data, waiting lists for residential treatment in both the mental health and substance abuse treatment systems, etc. in order to make these recommendations.
- **Workforce Competence**: charged with:
  (1) Making recommendations regarding cross-training plans to enable the system to become dual diagnosis capable as defined in Appendix C.
  (2) Studying the licensing and certification requirements for mental health and substance abuse treatment clinicians and making recommendations for any changes needed to improve the capabilities of new clinicians.
- **Systems Integration**: Charged with:

(1) Making recommendations for a statewide plan to design a system that provides dual diagnosis capable and dual diagnosis enhanced services as defined in Appendix C.
(2) Making recommendations for coordination and integration of all services needed to improve outcomes. The committee will look at needs for stable affordable housing, income, and supportive services.

- **Financing and Reimbursement:** Charged with:
  (1) Making recommendations for creative funding mechanisms for integrated services,
  (2) Studying the current financing system and recommending any changes needed to improve and streamline funding for services for treatment of co-occurring disorders.
- **Information Systems:** Charged with:
  (1) Making recommendations for reasonable data collection needed to quantify the needs of individuals with co-occurring disorders, and to measure meaningful outcomes to gauge success in treating these individuals.
- **Task Force as a Whole:**
  (1) Make recommendations for any legislation required to make systems change toward a comprehensive integrated system of care for individuals with co-occurring disorders.

Respectfully submitted,

Marta Hopkinson, M.D.
Chair
Maryland Task Force on the Needs of Individuals with Co-occurring Mental Illness and Substance Use Disorders

Appendix A:
Task Force Members

Task Force Members		Representing:
Executive Committee		
Marta J. Hopkinson	Chair	Maryland Psychiatric Society
O. Lee McCabe	Vice-Chair	Maryland Psychological Association
Tom Godwin	Staff	Mental Hygiene Administration
Pat Miedusiewski	Liason	Department of Health and Mental Hygiene (non-appointed)

Name	Representing
George Brown	Co-Occurring Disorder Consumer
Robert A. Burns	Rehabilitative Services
Peter Cohen	Alcohol and Drug Abuse Admin.
Honorable Judge Charlotte Cooksey	State Court Judge
Lois Fisher	Office of Public Defender
Jennifer P. Franks	Dept. Housing & Community Dev.
Joan Gillece	Mental Hygiene Administration
Tracey A. Gilmore	State Attorney's Office
Arlene D. Hackbarth	Public
Dawn James	Public
Craig S. Juengling	Md. Hospital Association
Deana Krizan	MD Legislative Council-Social Workers
Dale Meyer	Community Behavioral Health
Fred C. Osher	State's Public Academic Health Center
Yvonne M. Perret	Co-Occurring Disorder Workgroup
Richard Rosenblatt	Dept. Pub. Safety & Correctional Svcs.
Greg D. Shupe	Dept. of Human Resources
Carol A. Sullivan	Md. Nurse's Assoc Rep.
Naomi Tomoyasu	AIDS Administration
Gloria Valentine	Dept. of Social Services
Harlie W. Wilson	Faith Based Community Provider

Appendix B:
HB433e

HOUSE BILL 433

Unofficial Copy 2003 Regular Session
J1 (3lr1362)

ENROLLED BILL
Health and Government Operations/Finance –

Introduced by **Delegates Nathan-Pulliam, Barkley, Burns, C. Davis, Harrison, Jones, McDonough, Murray, Paige, and V. Turner V. Turner, Hurson, Hammen, Benson, Boutin, Bromwell, Costa, Donoghue, Elliott, Goldwater, Haynes, Hubbard, Kach, Mandel, Morhaim, Oaks, Pendergrass, Redmer, Rosenberg, Rudolph, Smigiel, and Weldon**

Read and Examined by Proofreaders:

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Proofreader.

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Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this
_____ day of ____________ at ____________________ o'clock, _____M.

____
Speaker.

CHAPTER_______

1 AN ACT concerning
2 **Task Force on the Needs of Persons with Co-Occurring Mental Health**
3 ***Illness* and Substance Abuse Disorders**
4 FOR the purpose of establishing a Task Force on the Needs of Persons with
5 Co-Occurring Mental Health *Illness* and Substance Abuse Disorders; providing
6 for the composition of the Task Force; requiring the Task Force to elect a
7 chairman and vice-chairman of the Task Force from among the Task Force's
8 members; requiring the Mental Hygiene Administration and the Alcohol and
9 Drug Abuse Administration to provide staffing for the Task Force; prohibiting
10 members from receiving compensation but entitling members to reimbursement
11 of expenses under a certain law; requiring the Task Force to study and make
12 recommendations regarding certain ways of delivering certain services, securing
13 funding, and providing certain training to a certain population; requiring the
2 HOUSE BILL 433
1 Task Force to submit certain reports to the Governor and certain committees on
2 or before certain dates; requiring the Mental Hygiene Administration to conduct
3 a certain study and submit a certain report to certain committees on or before a
4 certain date; providing for the termination of this Act; and generally relating to
5 a Task Force on the Needs of Persons with Co-Occurring Mental Health *Illness*
6 and Substance Abuse Disorders.
7 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
8 MARYLAND, That:
9 (a) There is a Task Force on the Needs of Persons with Co-Occurring Mental
10 Health *Illness* and Substance Abuse Disorders.
11 (b) The Task Force consists of the following members appointed by the
12 Governor:
13 (1) one representative of the Mental Health Administration;
14 (2) one representative of the Alcohol and Drug Abuse Administration;
15 (3) one representative of the Department of Human Resources;
16 (4) one social worker from the Department of Social Services;

17 (5) one representative of the Department of Rehabilitative Services;
18 (6) one representative of the AIDS Administration;
19 (7) one representative of the Department of Juvenile Justice;
20 (8) one representative of the Faith-Based Community Providers;
21 (9) one representative of the Department of Housing and Community
22 Development;
23 (10) one representative of the Department of Public Safety and
24 Correctional Services;
25 (11) one State court judge;
26 (12) one representative of the State's Attorney's Office;
27 (13) one representative from the Public Defender's Office;
28 (14) one representative who is a consumer of co-occurring disorder
29 services or who has a family member who uses such services;
30 (15) one representative of the Co-Occurring Disorders Workgroup of the
31 National Council on Alcoholism and Drug Dependence, Inc. - Maryland and Mental
32 Health Association of Maryland;
3 HOUSE BILL 433
1 (16) one representative from the Maryland Psychiatric Society;
2 (17) one representative from the Maryland Nurses Association; and
3 (18) one representative from the Maryland Hospital Association;
4 (19) one representative from the Community Behavioral Health
5 Association of Maryland;
6 (20) one representative from the Maryland Legislative Council of Social
7 Workers; and
8 *(21) one representative from the Maryland Psychological Association;*
9 *(22) one representative from the State's Public Academic Health Center;*
10 *and*
11 (18) (21) *(23)* two consumers.
12 (c) The members of the Task Force shall elect the chairman and
13 vice-chairman from among the Task Force's members.
14 (d) The Mental Hygiene Administration and the Alcohol and Drug Abuse
15 Administration shall provide staff for the Task Force.
16 (e) A member of the Task Force:
17 (1) may not receive compensation; but
18 (2) is entitled to reimbursement for expenses under the Standard State
19 Travel Regulations, as provided in the State budget.
20 (f) The Task Force shall:
21 (1) identify and recommend creative ways to provide and deliver
22 comprehensive, integrated, cost-effective services to the population with co-occurring
23 mental health *illness* and substance abuse disorders;
24 (2) identify and recommend various methods of funding services through
25 private and public sources;
26 (3) make recommendations regarding both short-term and long-term
27 residential services for people with co-occurring disorders, including
28 recommendations on the number of units needed and a timeline for providing
29 residential services;
30 (4) make recommendations regarding how the Mental Hygiene
31 Administration and Alcohol and Drug Abuse Administration may implement
32 cross-training for mental health *illness* and addiction counselors; and
4 HOUSE BILL 433
1 (5) make recommendations regarding necessary legislation to implement
2 the Task Force's recommendations.
3 (g) (1) The Task Force shall issue an interim report of its findings and
4 recommendations to the Governor and, subject to § 2-1246 of the State Government
5 Article, the Senate Education, Health, and Environmental Affairs Committee and the
6 House Health and Government Operations Committee on or before December 1, 2004.

Appendix B:
HB433e

7 (2) The Task Force shall issue a final report on its findings and
8 recommendations to the Governor and, subject to § 2-1246 of the State Government
9 Article, the Senate Education, Health, and Environmental Affairs Committee and the
10 House Health and Government Operations Committee on or before December 1, 2005.
11 SECTION 2. AND BE IT FURTHER ENACTED, That:
12 (a) The Mental Hygiene Administration shall conduct or commission a study
13 on the relationship between substance abuse and mental illness among counties in
14 Maryland.
15 (b) When appropriate, the study shall utilize existing resources and data
16 available from such entities as the Maryland Health Care Commission and the Task
17 Force to Study Increasing the Availability of Substance Abuse Treatment.
18 (c) The Mental Hygiene Administration shall report to the Governor, the
19 Maryland Legislative Black Caucus, the Senate Education, Health, and
20 Environmental Affairs Committee, *the Senate Finance Committee,* and the House
21 Health and Government Operations Committee on or before January 1, 2004, in
22 accordance with § 2-1246 of the State Government Article, on the findings and
23 recommendations of the study.
24 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
25 October 1, 2003. It shall remain effective for a period of 2 years and 3 months and, at
26 the end of December 31, 2005, with no further action required by the General
27 Assembly, this Act shall be abrogated and of no further force and effect.

Adapted from the American Association of Community Psychiatrists (AACP) Position Statement On: Program Competencies In A Comprehensive Continuous Integrated System Of Care (CCISC) For Individuals With Co-Occurring Psychiatric And Substance Disorders

Authored by Kenneth Minkoff, M.D.
June 2001, Revised November 2001

Clinical Consensus Best Practice Principles

1. **Dual diagnosis is an expectation, not an exception.** This expectation has to be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
2. The core of treatment success is any setting is the availability of **empathic, hopeful treatment relationships** that provide integrated treatment and coordination of care during each episode of care, and, for the most complex patients, provide continuity of care across multiple treatment episodes.
3. Assignment of responsibility for provision of such relationships can be determined using **the four quadrant national consensus model for system level planning,** based on high and low severity of the psychiatric and substance disorder.
4. Within the context of any treatment relationship, **case management and care, based on the client's impairment or disability, must be balanced with empathic detachment, confrontation, contracting, and opportunity for contingent learning**, based on the client's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.
5. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and **integrated dual primary treatment** is required.
6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a

disease and recovery model. Each disorders has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. **Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change.** Appropriately matched interventions may occur at almost any level of care.

7. Consequently, there is no one correct dual diagnosis program or intervention. **For each individual, the proper treatment must be matched** according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are dual diagnosis programs that at least meet minimum criteria of dual diagnosis capability, but each program has a different "job", that is matched, using the above model, to a specific cohort of patients.
8. Similarly, **outcomes must be also individualized**, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

Program Competencies for Substance Abuse Treatment (CD) and Mental Health Treatment (MH) Programs

Dual Diagnosis Capable: DDC-CD

- **Routinely welcomes individuals with dual disorders, provided:**
- **Low MH symptom acuity and/or disability, that do not seriously interfere with CD treatment**
- **Policies and procedures present re: dual assessment, treatment and discharge planning, meds**
- **Assessment includes integrated mh/sa history, mental illness symptom identification, phase-specific needs**
- **Treatment plan: 2 primary problems/goals**
- **Groups address comorbidity openly and are phase-specific**
- **Staff cross-training/competencies: dual assessment, motivational Enhancement, Treatment planning, stage of change id., Continuity of engagement**

- **Routine access to psychiatric/mental health consultation/coordination**
- **Continuous integrated care mgmt**
- **Standard addiction program staffing level/cost**

Dual Diagnosis Capable: DDC-MH

- **Routinely welcomes individuals with dual disorders, including those actively using**
- **Policies and procedures address dual assessment, treatment & discharge planning, meds**
- **Assessment includes integrated mh/sa history, substance use diagnosis, phase-specific needs**
- **Treatment plan: 2 primary problems/goals**
- **Groups address comorbidity openly and are phase-specific**
- **Discharge plan identifies substance specific skills**
- **Staff cross-training/competencies: dual disorder assessment, motivational enhancement, treatment planning, continuity of engagement**
- **Continuous integrated care management**
- **Standard mental health program staffing level/cost**

Dual Diagnosis Enhanced: DDE-CD

- **Meets criteria for DDC-CD, <u>plus</u>:**
  - **Welcomes individuals with moderate MH symptomatology or disability, that would affect usual treatment**
  - **Supervisors and staff: advanced competencies and cross-training**
  - **Higher staff/patient ratio; higher cost**
  - **Braided/blended funding needed**
  - **More flexible expectations in group work**
  - **Programming addresses mh as well as dual disorders**
  - **More consistent on site psychiatry/psych RN**
  - **More continuity if individual slips**

Dual Diagnosis Enhanced DDE-MH

- **Meets all criteria for DDC-MH, <u>plus:</u>**
  - **Supervisors and staff: advanced competencies and cross-training**
  - **Standard staffing; Specialized programming:**
    - **A. Intensive addiction programming in psychiatrically managed setting**
    - **B. Range of phase-specific treatment options in ongoing care setting**
    - **C. Intensive care mgt, outreach/motivational enhancement**
  - **May need braided/blended funding**

Appendix D: References

Substance Abuse and Mental Health Services Administration. (2004). *Results from the 2003 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-25, DHHS Publication No. SMA 04-3964). Rockville, MD.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04-3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

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Maryland Mental Health Coalition and Addiction Treatment Advocates of Maryland. *Co-occurring Disorders in Maryland: Status and Recommendations*. Mental Health Association of Maryland, 2004.