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Frederick County Health Department

Behavioral Health Services Division

Local Behavioral Health Authority Jurisdictional Plan SFY2024 – SFY2026

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1. INTRODUCTION

Executive Summary

The Frederick County Local Behavioral Health Authority is working to build a comprehensive, accessible, and culturally sensitive 24/7 system of behavioral healthcare. The LBHA falls under the Behavioral Health Services Division of the Frederick County Health Department. This structure leverages and enhances the relationship between public health and behavioral health. The intersection of the sciences of public health and behavioral health have never been more important than in today's world. Behavioral health *is* public health.

The mission of the Frederick County Health Department is to improve the health and well-being of the residents of Frederick County through programs to prevent disease and illness, promote wellness and safety and protect public health. Our vision that Frederick County leads as a community of health and wellness. Our values include:

Excellence - We strive to maintain the high quality of work as we continue to meet the standards set by our accredited status.

Integrity - We maintain consistency in what we say and what we do. We uphold ethical standards and maintain accountability to each other and the communities we serve.

Making a Difference - We believe the department's actions should assist our communities in addressing underlying factors that affect good health.

People - We value our employees as professional colleagues. We treat our customers, clients, partners, and those we serve with respect by listening, understanding, and responding to needs.

Quality - We actively work to maintain and improve our culture of quality, seeking opportunities to improve our daily work and looking for creative solutions to the challenges that face us.

The LBHA is the local arm of the State of Maryland's Behavioral Health Administration, charged with creating and overseeing the behavioral health system of care. The Local Behavioral Health Authority falls under the Frederick County Health Departments Behavioral Health Services Division. The Frederick County Health Officer serves as the Director of the Frederick County Health Department.

The Behavioral Health Services Division is one of ten Divisions within the Frederick County Health Department whose staff are charged with carrying out its mission, vision, and values. Of equal importance is the Division's designation of Local Behavioral Health Authority by the Maryland Department of Health's Behavioral Health Administration, as codified in Health General 10-1202. The LBHA is tasked with certain responsibilities that are essential to the local jurisdiction's public behavioral health system of care. These duties align with the essential

functions of public health and are carried out with those functions in mind. This marriage of public health and behavioral health allows for seamless interaction between the LBHA, the Frederick County Health Department and the programs and services of the Behavioral Health Services Division.

The LBHA Jurisdictional Plan for SFY 2024 - SFY 2026 is a three-year plan that outlines current areas of focus and existing needs for Frederick County's public behavioral health system, identified through data analysis and close collaboration with local stakeholders. This critical system of care benefits all residents of Frederick County. As we work to build a comprehensive accessible, 24/7, culturally sensitive continuum of care in Frederick County, we continue to utilize both universal and targeted interventions to meet the needs of our community. We will continue to work to meet the needs of those with inadequate access, specifically speakers of languages other than English and the child and adolescent population. We continue to move away from brick-and-mortar buildings and literally meet people where they are in the community. We have expanded mobile crisis services, embedded peers in community agencies, and opened our Harm Reduction *Street Safe* Program in a more accessible setting. Over the next three years, we plan to add full crisis stabilization services, expand our first responder behavioral health program, expand our mobile crisis teams to include Mobile Response and Stabilization Services (MRSS), advocate for Medicaid reimbursement for interpreting services, and expand access to child and adolescent mental health services.

Overview of Frederick County and the Local Behavioral Health Authority

Frederick County is the largest county geographically in the state of Maryland. The boundaries reach north to Pennsylvania, east to Carroll and Howard counties, south to Montgomery County and the Potomac River/Virginia, and west to Washington County. The City of Frederick, located in the south-central part of the county, is the county seat. The county has a total of 12 municipalities: Brunswick, Burkittsville, Emmitsburg, Frederick, Middletown, Mount Airy, Myersville, New Market, Rosemont, Thurmont, Walkersville, and Woodsboro. Emmitsburg and Thurmont in the northern area of the county make up the "Up County" region. Several municipalities have their own law enforcement agencies: Frederick, Brunswick, Thurmont, and Mount Airy.

The county has approximately 280,000 residents and is predicted to surpass 300,000 by 2030. Over 78,000 residents live in the City of Frederick. Currently, 29% of the county population is below age 18, and 15% is aged 65 and over. Females make up 50.5% of the residents. The racial makeup of the county is diverse: 69% identify as being non-Hispanic White, 11.6% identify as Black or African American alone, 11.3 % identify as Hispanic or Latino, 5.7% identify as Asian, and 3.3% identify as two or more races. There are over 16,700 veterans living in the county. Over 11% of the population is foreign born.

Frederick residents live in 97,615 households with an average of 2.69 people per household. As of July 1, 2021, there were 106,417 housing units in the county with a median value of $356,500 and median mortgage of $2,168. The median rent in the county is $1,503. Almost 93% of those aged 25 and over have graduated high school, and 42% have a bachelor's degree or higher. The median household income in 2021 dollars is $106,129 and the per capita income is $46,615. Sixty-nine percent of residents over age 16 are in the civilian workforce; they have a mean travel time to work of almost 35 minutes.

Just over 14% of Frederick County households speak a language other than English at home. Households with a computer totaled 95% and those with a broadband internet subscription totaled 91%. Of all residents under age 65, 7% have a disability and 4.9% are without health insurance. (Maryland At A Glance, 2023)

Between 6.2% (2020 data) and 6.6% (2021 estimate) of Frederick residents live in poverty. Of the children living in Frederick, 7.2% live in poverty. In addition to those who meet the definition of living below the Federal Poverty Line, 36.8% of households in 2018 qualified as "ALICE" households. ALICE stands for *Asset Limited, Income Constrained, Employed*. "ALICE households have income above the Federal Poverty Level (FPL) but not high enough to afford essentials in the communities where they live" (United for ALICE Research Center - Maryland, 2023). Areas of the county with over 50% of the households meeting ALICE criteria are Emmitsburg, Brunswick, the City of Frederick, and Thurmont. (ALICE Dashboard, 2023) There is more discussion of poverty in Frederick County in the Data section of this report.

Frederick County is home to some notable points of interest, including Fort Detrick and The Maryland School for the Deaf. The Maryland School for the Deaf is located in historic downtown Frederick and is one of two campuses in the state. The Frederick campus has over 500 students and 100 staff. About one-third of the students live in residences on campus during the week. Consequently, Frederick County has a large population of Deaf and Hard of Hearing residents, reaching into the thousands; a relatively new community resource for this population is the Deaf Community Center.

Fort Detrick, a U.S. Army Medical Research and Development Command (MRDC) installation, is in the outskirts of the City of Frederick. Fort Detrick is the county's largest employer with over 9,500 military (each branch is represented), federal employees, and contractors. The Frederick County Health Department is located in close proximity to Fort Detrick. (Military Installations, 2023)

On July 1, 2019, the Frederick County Local Addiction Authority (LAA) and the Core Service Agency (CSA) merged to form the Frederick County Local Behavioral Health Authority within the Behavioral Health Services Division of the Frederick County Health Department. The creation of a Local Behavioral Health Authority (LBHA) has allowed us the ability to develop a model for quality integrated care delivery throughout the public system by supporting providers in offering quality evidence-based care, connecting/educating/advocating for consumers, and

initiating public health outreach and education campaigns in collaboration with a variety of community partners. Our position as LBHA also allowed staff to quickly pivot staff duties with the emergence of the 2019 Novel Coronavirus (COVID-19) and ensure that community residents retained access to essential behavioral health services.

Persons with behavioral health diagnoses, including those with co-occurring substance use/mental health diagnoses, require a system of providers at the microlevel, systems managers at the mezzo level, and legislators and funders at the macro level. Stakeholders at each level must demonstrate an understanding that these disorders are most effectively treated simultaneously, with a variety of modalities that can be tailored. Frederick County providers and system managers work to address this need through integrations with provider councils, advisory councils, training, and ensuring that each population is represented when evaluating the system and strategizing to close gaps in services. Shortages at any of these levels impact services for those in need. This is most apparent in recent years by the behavioral health workforce shortage, apparent at all areas of staffing: prescribers, licensed clinicians, and peers either certified or working towards certification.

As behavioral health system managers, LBHA staff convene and/or participate in multiple councils and workgroups related to the services provided and populations served throughout the county. (See Attachment: *Frederick County LBHA Councils, Committees, and Workgroups*) These groups often lead to opportunities for LBHA staff to educate additional audiences about and promote behavioral health issues. This has been especially important as we navigate the changing local and state government leadership. Community and Law Enforcement Partners serve on councils, boards, and coalitions, and provide valuable feedback and guidance about behavioral health issues and needs of the community. This especially includes people with lived experiences and their families, who bring forth unique perspectives to ensure that the county can truly support all paths to recovery and support for those who need services now and in the future.

LBHA roles and responsibilities include overall management of the public behavioral health system, including quality assurance, compliance, and addressing grievances and complaints. In addition, the LBHA is responsible for planning and ensuring a full, accessible, and responsive continuum of behavioral health services in the jurisdiction. We are to develop and collaborate with the local provider network; engage with the public for education and information sharing; and collaborate with the ASO, local and state boards, councils, Maryland Association of Behavioral Health Authorities (MABHA) and other groups as needed to ensure coordination of activities. As we have integrated these roles to ensure adequate coverage of both mental health and substance related services, we have organized in a population-based structure. Staff are focused on populations across the lifespan: Adult Services, including adults involved in Criminal Justice; Children and Adolescents; and special populations within each age range. The merger has strengthened all of these teams. For example, an expanded Child and Adolescent unit has allowed staff to consult in the most challenging of child and adolescent cases and serve

on a number of multidisciplinary teams convened by the Office for Family and Children, the Frederick County Courts, and providers.

Highlight: Behavioral Health Needs for Children and Adolescents

The last few years have been particularly challenging due to the opioid epidemic and the pandemic. In February 2022, the LBHA started hearing from our community and agency partners that there was an increase in demand for child and adolescent mental health services at every level of care – including emergency department visits, inpatient admission, outpatient counseling, walk in crisis services, mobile crisis, school counseling and internally at the health department. Providers also reported seeing an increase in the severity of symptoms and negative behaviors. The LBHA convened a Child and Adolescent Crisis Workgroup of very dedicated subject matter experts from several local sectors that make up our continuum of crisis services in Frederick County. There are staff representing Frederick Health Hospital, Frederick County Public Schools, the Mental Health Association of Frederick County, Sheppard Pratt, the YMCA, the Local Care Team, and the Health Department. The group also consults with agencies outside of this list as needed. Most often that includes local law enforcement, fire and rescue or other relevant community providers. The workgroup goals include the following:

- Review local data to determine scope and prevalence of child and adolescent crisis needs;
- Surveille existing programs for access and capacity to serve;
- Plan public health education campaigns to targeted populations;
- Develop stronger coordination between agencies and programs to enhance outcomes for child and adolescent residents;
- Identify and plan training for community clinicians and programs to enhance competence among providers to address child and adolescent mental/behavioral health needs.

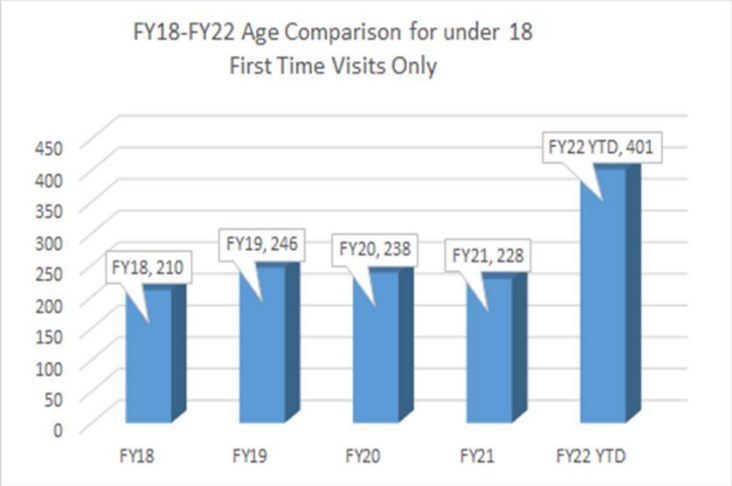
Collecting and analyzing local data points is key to determining stress on the system and the ability to serve our community appropriately. The group members understand the importance of determining whether a particular issue is an actual problem versus a perceived problem. A few challenging cases can feel overwhelming but do not necessarily mean there is a statistically significant difference in demand. Members of the workgroup gathered to present data from each sector for review and analysis.

The workgroup also contacted treatment providers to determine their confidence in the ability to serve the child and adolescent population. A brief sampling of existing providers shows a fair number of clinicians do not feel competent when treating the child and adolescent population. That percent decreases even further when adding suicidal ideation to the mix. The LBHA is working on providing this training for our existing providers. Providers have already

participated in a training on human trafficking, which often impacts youth. Additional, more in-depth, training and training with specific providers may be helpful to increase providers' competencies when treating children with behavioral health concerns.

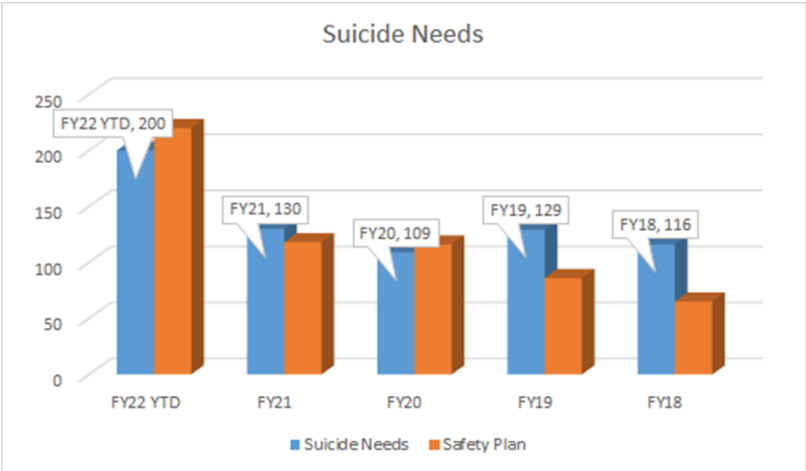
However, more providers are needed in Frederick County. There are simply not enough candidates in the job market to hire, a problem that is pervasive throughout the behavioral health field for all populations. There are not enough people studying social work or professional counseling. Frederick County has great infrastructure and a desire to make substantive change. But there is a lack of human capital.

In March 2022, the Frederick County Child and Adolescent Workgroup presented our findings to Senator Ben Cardin and the Federal Delegation. The following information was included in that presentation. The following slide shows the number of first-time visits for those under the age of 18 to the Walk-In Behavioral Health Crisis Center operated by the Mental Health Association.

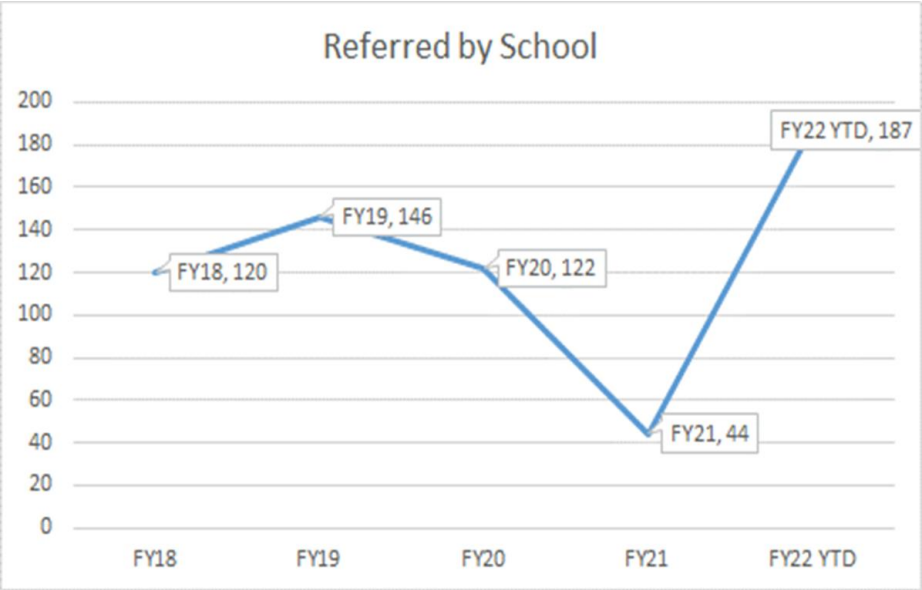


The number of new visitors in FY22 is significantly higher than previous years, already evident below by the end of Quarter 3 in March. The number of visitors during peak pandemic times in FY20 and 21 remained fairly high. The Crisis Center transitioned to providing virtual appointments during this time, and still offers both virtual and in person options.

When looking at the needs presented during the time of the visits, there is an increase of instances when suicide was mentioned during visits over time. Here, suicide needs are shown in blue; safety planning is shown in orange. The most recent year, FY22 is on the left. There is a dramatic increase in those with suicide needs and safety planning over prior years.



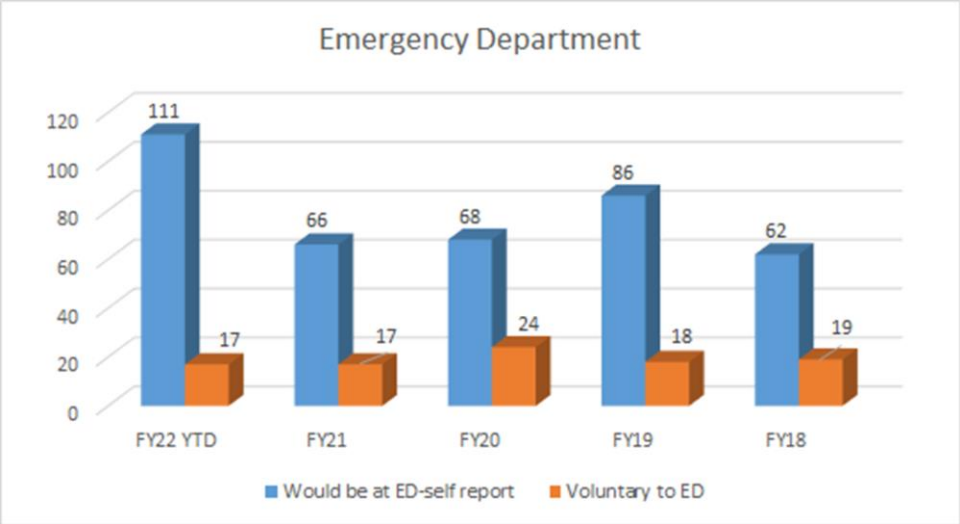
The data below shows the number of youths referred by FCPS to the crisis center between FY18 to YTD FY22. There has always been a strong relationship between crisis providers and the school system in terms of referrals. This chart also demonstrates decrease in referrals during times of virtual learning and the significant increase when students returned to onsite learning.



Other local data points for FY22, through March, for consideration include:

- Substance Use Screening Referrals from FCPS to FCHD - 68
- 31% of all calls for Mobile Crisis Services were for those under the age of 25.
    - 20 calls under the age of 10
    - 53 calls between age 11 – 17
    - 78 calls between age 18-25
- 74 adolescents and children seen in Emergency Department of Frederick Health Hospital
    - 21% - suicidal ideation or “took pills”
    - 22% - psychiatric evaluations

The data below shows the number of individuals who arrived at the MHA Walk In Crisis Center who stated they would be at the emergency department if it weren’t for the crisis center. The orange columns represent the number of individuals who were identified as needing a higher level of care and voluntarily went to the ED. Together, these numbers demonstrate the significant need for an alternative destination to the hospital, so that our sole emergency department does not become overwhelmed with mental health and behavioral health needs, especially during peak covid transmission times. Frederick County is planning to open a Crisis Stabilization Center that will serve both adults and child/adolescent populations.



Our system and jurisdiction are stressed by COVID-19, the lack of child psychiatrists, severely limited beds in in-state diagnostic and residential treatment settings, lack of specialty residential providers (severe trauma, substance use disorders, history of arson or sexual perpetrators) and lack of co-occurring competent child and adolescent providers. The integration of the mental health/substance use disorder teams at the systems level has become crucial to comprehensively map our jurisdictional resources and gaps and begin to build and ensure a continuum of care for child and adolescent consumers. Data confirms the assertion that we are in a crisis situation with child and adolescent services, in terms of both intensity and complexity.

Exposure to family members who are using substances is known to have a negative impact on children in a variety of ways. Whether the impact rises to the level of meeting the criteria for trauma or not, these youth often are in need of support to mitigate or minimize the impact of the exposure. The legalization of recreational marijuana use as of July 1, 2023 in Maryland, will likely see an accompanying increase in the number of Marylanders using marijuana. Regardless of whether this results in a corresponding increase in youth who are using marijuana, we should, at the least, expect an increase in the number of youths who are negatively impacted by family and household substance use. The need for resources such as the in-school *Kids Like Us* program will no doubt be magnified.

The Public Behavioral Health System in Frederick County

FCHD BHS provides and monitors a continuum of care that aims to reduce substance misuse and support treatment of mental health concerns among all Frederick County residents by ensuring access to quality behavioral health resources and through implementing innovative public health initiatives. Jurisdictional goals are accomplished with support from the Frederick County Government, Maryland Department of Health (MDH)'s Behavioral Health

Administration (BHA) and Public Health Services Administration (PHA), and the Maryland Opioid Operational Command Center (OOCC).

The services we currently provide directly include system navigation assistance and screening, including mandated screenings for those applying for TCA and connecting women with children and pregnant women with state-funded treatment services. Services for those involved with the criminal justice system include a Frederick County Detention Center substance use disorder treatment program, TAMAR, peer support, case management via MCCJTP, and a newly launched LEAD program. Our Recovery Support Services include Community Organized Recovery Efforts (*CORE*) Recovery Center and Community-Based Peer Support Services, State Care Coordination/Maryland Recovery Net and *On The Mark* Adolescent Recovery Clubhouse (OTM). Our Prevention Services include Smoking Cessation through the Cigarette Restitution Fund (CRF), *Kids Like Us* (KLU), Maryland Strategic Prevention Framework (MSPF), and the Opioid Misuse Prevention Program (OMPP), as well as many other collaborative efforts within treatment and recovery programs and in the community. Harm reduction initiatives through the FCHD BHS Division include overdose response and prevention training, distribution of Narcan and fentanyl test strips, infectious disease testing and case management, and a comprehensive syringe services program. Our FCHD BHS staff also provides management of the HUD Continuum of Care Permanent Supportive Housing program.

The LBHA also manages BHA grants for mental health and substance use disorder services by contracting with local providers through a competitive bid process that follows Frederick County procurement procedures. This ensures a complete continuum of high-quality services for residents of Frederick County.

Contracted Services include:

- 24/7 Mobile Crisis services (Sheppard Pratt/Way Station, Inc);
    - New in FY23:
        - Mobile Response and Stabilization Services (MRSS) for children and families
        - Pilot Crisis Response Team with Frederick Police Department and Fire and Rescue Services
        - Expansion of mobile crisis in partnership with the Frederick County Sheriff's Office. Together, the two agencies will assess the best way to respond to behavioral health crisis needs. The current research phase includes ride-alongs and shared office space to enhance relationships and efficiency.
    - Mobile Crisis services are possible through "braided" funding from BHA and Frederick County Government.
- Wellness and Recovery Center for those with lived experiences in mental health (On Our Own of Frederick County);
- Senior Mental Health in-home Outreach (FCHD OMHC);
- Respite Services for families with children and adolescents (Camp Journey at

Sheppard Pratt/Way Station, Inc., services ceased 6/30/2023);
- Specialized Residential Services for Individuals Dually Diagnosed with Mental Illnesses and Developmental Disabilities (Sojourn House at Sheppard Pratt/Way Station, Inc.);
- Crisis Intervention Team for behavioral health crisis training with law enforcement (Mental Health Association);
- Services for individuals experiencing homelessness including PATH and SOAR case management (Frederick Community Action Agency);
- Clinical case management for Adult Drug Treatment Court (Project Chesapeake);
- Services for the Deaf (funding to behavioral health providers for deaf interpreting services).
- Reimbursement to licensed substance use disorder and mental health service providers for language interpreting services;
- Targeted Case Management for adults (Potomac Case Management Services, Inc.) and Care Coordination for children oversight;
- Behavioral Health Crisis Walk-In Center (Mental Health Association);
    - Includes Peer Recovery Support Specialist expansion
    - FY24 opening of Behavioral Health Crisis Stabilization Center, co-located with Walk-In Center, and operated by MHA. Federal and county funding contribute to this project.

The Behavioral Health Services Division also directly operates several programs funded through the county government, Maryland Department of Health Public Health Administration, and the Opioid Operational Command Center (OOCC). These programs include:

- Community Peer Services - trained Peer Recovery staff embedded with various agencies
- Prevention Services
    - Tobacco Cessation
    - Tobacco Enforcement Program
    - Opioid Misuse Prevention Program (OMPP)
    - Kids Like Us
    - Alcohol Merchant Compliance Checks
- Harm Reduction Services
    - Comprehensive Syringe Services Program, *Street Safe*
    - Overdose Response Training and Narcan Distribution
    - Hepatitis C Testing and Linkage to Treatment
    - Other Infectious disease testing and linkage
    - COAST - The LBHA staffs the SUD outreach services of the COAST team 16 hours per week with Division of Fire and Rescue Services. The LBHA staffs the COAST team alone the remaining 24 hours. FCHD peer recovery specialists follow up with individuals with SUD and concerned others
- LEAD - Law Enforcement Assisted Diversion
- First Responder Wellness

LBHA support to service providers and local residents also extends to ensuring that all licensed programs have the resources they need to function and quality assurance measures in place. These LBHA duties include reimbursement for language interpreting services and funding to enable COVID-responsive service delivery such as PPE and provision of telehealth services. LBHA staff are also responsible for reviewing provider requests for residential crisis services and coverage for clients who are under- and uninsured. Residential Rehabilitation program (RRP) applications are routed through and managed by the LBHA. LBHA staff partner with the ASO on Medicaid audits and provide support and follow-up to any resulting Performance Improvement Plans required of the provider. Frequently, discussions in Provider Council, during audits, or site visits, lead to identification of clinical training needs that the LBHA can provide or sponsor to benefit the entire system of care.

Highlight: Crisis Stabilization Center

Support to Frederick County residents and providers also means ensuring a robust crisis continuum of services. People experiencing a behavioral health crisis require the same options available to us in a medical crisis: someone to call, someone to respond, and somewhere to go. The Mental Health Association of Frederick County (MHA) has long been "someone to call" in a behavioral health crisis via 211 or what is now the 988 Suicide Prevention Hotline. Frederick County is also home to Heartly House for needs related to interpersonal violence, and they also staff a 24/7 hotline. Way Station's Mobile Crisis teams, having expanded in staff and availability, provide residents with "someone to respond" along with COAST for needs specific to some substance-related crises. The Behavioral Health Walk-In Crisis Center at MHA and the Frederick Health Hospital Emergency Department have each partially provided "somewhere to go".

The Crisis Stabilization Center will complete the continuum by providing an alternative to the Emergency Department. A 2019 study conducted by the Maryland Dept of Health showed that 47% of all Frederick County 911 behavioral health calls were eligible for alternative destination transport. The Center, already under construction in FY23, will provide community based 24/7 crisis services in a home-like setting. It will be accessible through EMS, Police, Mobile Crisis, 988/211, the Walk-In Crisis Center and the hospital ED. The Center, staffed with both licensed and unlicensed personnel (such as Peer Recovery Specialists), will focus on a nonjudgmental client-focused harm reduction model. This facility will divert people who are in crisis and/or under the influence of a substance away from the emergency department to a welcoming environment that addresses crisis needs in a community-based setting. It will provide stronger links to community-based care for individuals who have not been engaged or retained by the behavioral health system.

2. KEY PRIORITIES / GOALS AND OBJECTIVES

Goal One: Increase access to behavioral health services and supports through the design and implementation of the local integrated crisis system, enhanced care coordination, and use of technology innovations.

Objective 1.1: Identify the number of children and adults who receive evidence informed mobile crisis and crisis stabilization services, increasing the number served by 10% compared to the previous year to be assessed annually.

Strategy:

1) Maintain adequate funding for mobile crisis and MRSS through braided state and county funding sources.
2) Maintain provider contract for the provision of mobile crisis and MRSS.
3) Analyze monthly program reports for mobile crisis and MRSS.

Obj 1.1 Performance Measure: Number of adults and children who receive MRSS and other Evidence informed crisis services in a fiscal year.

Target: Number of adults and children who receive MRSS and other Evidence informed crisis services will increase by 10% each fiscal year.

Objective 1.2: Complete the expansion of Behavioral Health Walk-In Center to include 24/7 Crisis Stabilization Center using a phased opening approach.

Strategy:

1) Continue working with County Finance office and subvendor to fulfill grant obligations.
2) Continue working with County Planning and subvendor to complete design and construction plans.
3) Maintain funding and fee for service billing as applicable to ensure continuity of services.

Obj 1.2 Performance Measure: Implementation of Phase I and Phase II services.

Target: Occupancy for Phase I operations will be completed by September 1, 2023.

Target: Completion of construction for Phase II operations will be completed by December 2024.

Objective 1.3: Assess the effectiveness of services for children and adults who receive crisis stabilization services at the Center by identifying relevant data and outcomes throughout the phased services.

Strategy:

1) Maintain adequate staffing.

2) Collect, report, and analyze data for number and type of visits, client demographics, outcomes, staffing and other relevant data elements.

Obj. 1.3 Performance Measure:

1) Number of complete reports submitted each fiscal year.
   Target: Submit reports each month by the tenth day of the following month.
2) Number of meetings with epidemiologist and subvendor to discuss data analysis.
   Target: Meet with subvendor and epidemiologist at least quarterly

Objective 1.4: Increase use of information technology innovations, such as telehealth applications, Care Traffic Control and bed registry/availability systems - to include regional collaboration - by inclusion of at least 2 crisis providers by June 30, 2026.

Strategy:

1) Identify key crisis providers.
2) Implement a collaborative approach to identifying technology solutions for crisis services across providers.
3) Ensure ability to serve all persons regardless of language needs through adoption of interpretation/translation app designed for Emergency Communications/911/988 through voice and text services.

Obj 1.4 Performance Measure:

1) Number of collaborating crisis providers identified in each fiscal year.
   Target: Identify two providers by June 30th 2025.
2) Acquire supporting technology.
   Target: Acquire technology by January 1st, 2026.
3) Collaboratively implement technology.
   Target: Implement by June 30th, 2026.

Goal Two: Improve quality of care in the public behavioral health system through increased availability and use of evidence-informed and promising practices, training and workforce development and quality assurance, and continuous performance improvement practices.

Objective 2. 1: Participate in the design and implementation of standardized assessment and data collection procedures in the local/regional/statewide crisis response system by June 30, 2026.

Strategy:

1) Ensure that all local crisis providers in the jurisdiction are trained and certified to use Crisis Assessment Tool (CAT) as this is implemented throughout the state.
2) Monitor data including the number of CAT tolls entered and submitted into the crisis data system.

Obj 2.1 Performance Measure:

1) Number of crisis providers in the jurisdiction trained and certified to use Crisis Assessment Tool (CAT) each fiscal year.

   Target: 100% of crisis providers in the jurisdiction are trained and certified to use CAT by 6/30/26.

2) Number of CAT tools entered and submitted into the crisis data system each fiscal year.

   Target: 100% of the CAT Tools completed are entered and submitted into the crisis data system by 6/30/26.

Objective 2.2: Expand the behavioral health workforce capacity by increasing the number of professionals and paraprofessionals from diverse backgrounds engaged in the behavioral health field as evidenced by increased provider capacity and number of staff. *See also: Cultural and Linguistic Competency Strategic Plan, Goal 5*

Strategy:

1) Lead and/or collaborate with the lead on the Local Health Improvement Plan (LHIP) Mental Health *Workforce Development* subgroup through the FY24 - FY26 cycle to carry out its Action Plan.
2) Increase the number of educational partnerships to promote behavioral health career paths with a particular focus on diversity, equity and inclusion - with a particular focus on relationships with the 4 HBCUs in Maryland who may have students and graduates in the Frederick area.
3) Assess the degree of diversity in the workforce of providers in the Public Behavioral Health System (PBHS) of care using an annual survey of PBHS of care providers regarding the race and ethnicity of their staff.

Obj 2.2 Performance Measure:

1) Partnerships with Frederick County Public Schools and local youth groups.

   Target: Complete outreach activities to establish partnerships with Frederick County Public Schools and/or 5 local youth groups by 6/30/24.

2) Partnerships with HBCUs in Maryland regarding internships or other identified workforce needs.

   Target: Meet with 4 HBCU field instruction or other relevant offices by 6/30/25.

3) Partnerships with other local institutions of higher learning regarding internships or other identified workforce needs.

   Target: Meet with 4 institutions by 6/30/25.

4) Number of individuals in the behavioral health workforce who identify as people of color.

   Target: Individuals in the behavioral health workforce (the number of clinicians, peer recovery specialists, and community health workers) who identify as people of color will increase 10% based on results of an annual provider survey by 6/30/26.

Objective 2.3: Expand first responder behavioral health wellness programming to include all first responder agencies by June 30, 2026.

Strategy:

1) Secure funding for additional behavioral health clinicians to provide services to all first responder agencies.
2) Hire, train and retain clinicians.
3) Ensure training and support for clinicians.

Obj 2.3 Performance Measure:

1) Number of behavioral health clinicians on staff to provide services to first responder agencies each fiscal year.
   Target: Hire one clinician each fiscal year.

Goal Three: Increase equity in behavioral health services for underserved groups in the public behavioral health system through the implementation of policies, practices and services that recognize and value all individuals.

Objective 3.1: Increase the number of PBHS stakeholders and community members who participate in training and community outreach events to promote awareness of health disparities and equity issues in behavioral health service delivery by 10% to be assessed annually.

Strategy:

1) Link to Goal 5 strategy in the Cultural and Linguistic Competency Strategic Plan:
   a) Collaborate with key stakeholders including Health Equity Office, Deaf and Hard of Hearing Community, Spanish Speaking Community and Asian American Center to identify and sponsor training to offer to PBHS providers and community members.
   b) Training topics may include health disparities, social determinants of health, the impact of systemic racism, and cultural humility.
2) Collaborate with key stakeholders (above) to identify promotion messaging and materials for participation in community outreach events.

Obj 3.1 Performance Measure:

1) Number of training and outreach events focused on increasing awareness of health disparities and racial equity issues in behavioral health service delivery completed each fiscal year.
   Target: 2 events each fiscal year.
2) Number of PBHS providers and stakeholders who receive training on health disparities and racial equity issues in behavioral health service delivery each fiscal year
   Target: 5 providers each fiscal year.
3) Number of PBHS jurisdictional staff and providers who receive training on CLAS principles and practices each fiscal year.

Target: 5 providers each fiscal year.

4) Number of PBHS providers who adopt CLAS principles each fiscal year.
   Target: 3 providers each fiscal year.

Objective 3.2: Increase the number of PBHS of care treatment providers able to serve CAYA and TAY clients in various levels of care and ensure that they are implementing best practices for working with this population.

Strategy:

1) Provide low barrier / no cost training for treatment providers in the PBHS of care regarding working with CAYA and TAY.
2) Seek additional providers and levels of care to provide services in Frederick County.

Obj 3.2 Performance Measure:

1) The number of licensed outpatient substance use disorder treatment centers in Frederick County with capacity to accept CAYA and TAY clients each year.
   Target: Capacity will increase from 1 provider to 3 providers by 6/30/26.
2) Number of providers represented at clinical trainings focused on the CAYA / TAY populations each year.
   Target: Increase the number of providers by 30% by 6/30/26.
3) Number of clinicians who attend clinical trainings focused on the CAYA / TAY populations each fiscal year.
   Target: Increase the number of clinicians 10% each year.

Goal Four: Increase behavioral health programs that promote mental health, reduce ACES and toxic stress, and prevent substance abuse, suicide, and related behaviors.

Objective 4.1: Increase the number of health and behavioral health professionals who receive suicide prevention training and lethal means counseling by 10% by June 2026 in order to enhance the PBHS of care's utilization of best practices when completing suicide risk screenings.

Strategy:

1) Hold a no cost, low barrier community wide training for stakeholders defining best practices for suicide risk screening in collaboration with the Frederick County Suicide Prevention Coalition (FCSPC).

Obj 4.1 Performance Measure:

1) Number of behavioral health professionals who complete suicide prevention training for best practices for suicide risk screening each fiscal year.
   Target: Reach 30 behavioral health professionals by 6/30/26.
2) Percentage of the behavioral health professionals attending the suicide prevention training for best practices for suicide risk screening who indicate increased confidence in

their ability to assess clients for suicide risk on an anonymous survey at the conclusion of the training.

Target: 80% of those who complete the training will indicate increased confidence in their ability to assess clients for suicide risk.

Objective 4.2: Increase the number of lay people (i.e., non-health/behavioral health professionals) who receive or view educational materials on suicide as a public health issue and reducing access to lethal means for people at risk for suicide by reaching 60,000 visits to the FCSPC website within 90 days of PSA being shared on social media.

Strategy:

1) LBHA staff will work in collaboration with Channel Communications and representatives from the FCSPC to create a Public Service Announcement that will be disseminated widely via a social media campaign.

Obj 4.2 Performance Measure:

1) Number of unique users who view the PSA during the course of the community awareness campaign via social media.

   Target: 600,000 unique users by the end of the campaign on social media.

2) The number of visits to the FCSPC website before and 90 days after the end of the campaign.

   Target: The number of visits will increase by 5% within 90 days after the end of the campaign.

Objective 4.3: Increase the number of PBHS funded organizations who have completed a Trauma informed Organizational Assessment (TIOA) of their organization by 10% by June 30, 2026.

Strategy:

1) Utilize Provider Council to disseminate TIOA to PBHS funded organizations annually.
2) Assist PBHS funded organizations with technical consultation on development of a TIC Quality Improvement Plan.
3) Organize timeline and efforts according to jurisdictional needs and readiness through participation in Trauma Informed practices Learning Community.

Obj 4.3 Performance Measures:

1) Number of PBHS funded organizations who complete and submit a Trauma Informed organizational Assessment Tool to BHA in each FY.

   Target: The number of organizations will increase by 10% each fiscal year.

2) Number of PBHS funded BH organizations who receive technical consultation on the development of a TIC Quality Improvement Plan in each FY.

   Target: Two organizations will receive technical consultation by FY26.

3) Number of PBHS funded BH organizations who develop a quality improvement plan to enhance trauma informed policy and practice in their organization in current FY.

Target: Two PBHS funded BH organizations will develop a quality improvement plan to enhance trauma informed policy and practice in their organization by FY26.

Objective 4.4: Increase the number of PBHS funded organizations that demonstrate an increase in trauma informed competencies (as measured by the TIOA tool) through work with Healing Systems Learning Community.

Strategy:

1) LBHA staff will utilize Provider Council to lead PBHS funded organizations in measuring trauma informed competencies using the TIOA tool annually.

2) Support BHA in engaging PBHS providers in UMD training for trauma informed care in order to increase trauma informed competencies.

Obj 4.4 Performance Measures:

1) Number of PBHS funded BH organizations who demonstrate an increase in trauma informed awareness and practice (as measured by the TIOA tool) each fiscal year.

Target: The number of PBHS funded BH organizations who demonstrate an increase in trauma informed awareness and practice (as measured by the TIOA tool) will increase by 10% by the end of FY26.

Objective 4.5: Increase the number of non-PBHS organizations (including local government and local branches of state government) that demonstrate an increase in trauma informed competencies.

Strategy:

1) Collaborate with members of Trauma Responsive Frederick, and Maryland Commission on Trauma Informed Care (Liza Guroff and Inga James, co-chairs) to determine the best approach to providing training to local government, local branches of state entities, and non-behavioral health organizations.
    a) Inga James is Executive Director of Heartly House, Inc. in Frederick and founder of Trauma Responsive Frederick.
    b) Liza Guroff is MABHA Executive Director and a nationally recognized Subject Matter Expert on numerous topics related to trauma, trauma-informed, resilience-oriented, equitable (TIROE) care, diversity, equity and engagement practices, organizational change management, TIROE leadership and TIROE supervision.

Obj 4.5 Performance Measure:

1) Implementation of a collaborative plan to engage non-PBHS organizations in trauma informed efforts.

Target: Implement plan by FY25.

2) Number of non-PBHS organizations trained in trauma informed practices each fiscal year.

Target: 5 non-PBHS organizations will be trained by FY26.

3. TARGETED CASE MANAGEMENT (TCM)

Number of Individuals Receiving TCM within the PBHS for FY 2021/22 by Age Groups:Statewide vs. County

	Fiscal Year 2021					Fiscal Year 2022			
	Age 0-17	Age 18+	Total	% of all TCM provided		Age 0-17	Age 18+	Total	% of all TCM provided
State	1,952	3,460	5,412		State	1,872	3,327	5,199	
WASHINGTON	341	739	1,080	20.0	WASHINGTON	359	672	1,031	19.8%
BALTIMORE CITY	227	825	1,052	19.4	BALTIMORE CITY	193	828	1,021	19.6%
FREDERICK	96	300	396	7.3	FREDERICK	89	266	355	6.8%
CARROLL	78	254	332	6.1	CARROLL	76	222	298	5.7%
WICOMICO	208	93	301	5.6	WICOMICO	174	91	265	5.1%
BALTIMORE COUNTY	96	129	225	4.2	BALTIMORE COUNTY	94	124	218	4.2%
ANNE ARUNDEL	107	115	222	4.1	ANNE ARUNDEL	97	120	217	4.2%
HARFORD	148	61	209	3.9	HARFORD	133	77	210	4.0%
WORCESTER	30	150	180	3.3	WORCESTER	41	126	167	3.2%
CHARLES	61	114	175	3.2	CHARLES	57	102	159	3.1%
ST. MARY'S	39	128	167	3.1	ST. MARY'S	45	110	155	3.0%
HOWARD	94	68	162	3.0	CALVERT	19	134	153	2.9%
CECIL	27	125	152	2.8	PRINCE GEORGE'S	38	91	129	2.5%
DORCHESTER	96	35	131	2.4	HOWARD	63	65	128	2.5%
CALVERT	17	110	127	2.3	DORCHESTER	88	31	119	2.3%
PRINCE GEORGE'S	44	58	102	1.9	CECIL	18	95	113	2.2%
CAROLINE	67	22	89	1.6	CAROLINE	79	31	110	2.1%
MONTGOMERY	24	60	84	1.6	SOMERSET	53	39	92	1.8%
SOMERSET	54	32	86	1.6	MONTGOMERY	33	53	86	1.7%
ALLEGANY	35	30	65	1.2	ALLEGANY	51	25	76	1.5%
TALBOT	49	15	64	1.2	TALBOT	48	13	61	1.2%
QUEEN ANNE'S	29	16	45	0.8	GARRETT	16	28	44	0.8%
GARRETT	11	26	37	0.7	QUEEN ANNE'S	29	13	42	0.8%
KENT	22	7	29	0.5	KENT	14	7	21	0.4%
				34.6					33.9%

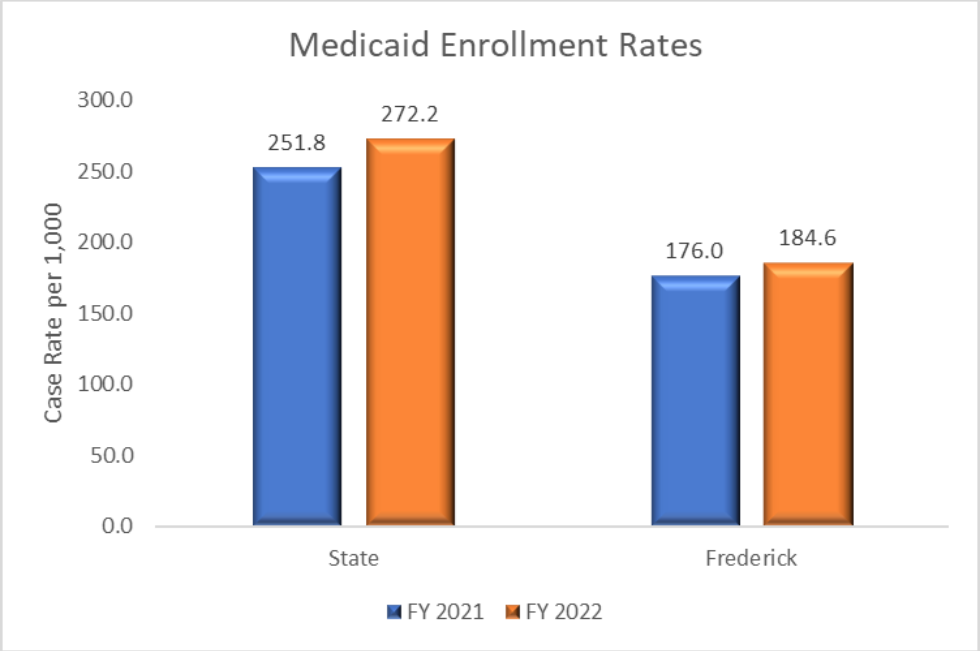
Data Source: Optum ASO claims data paid through 10/31/2022.
Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.
Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.
Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

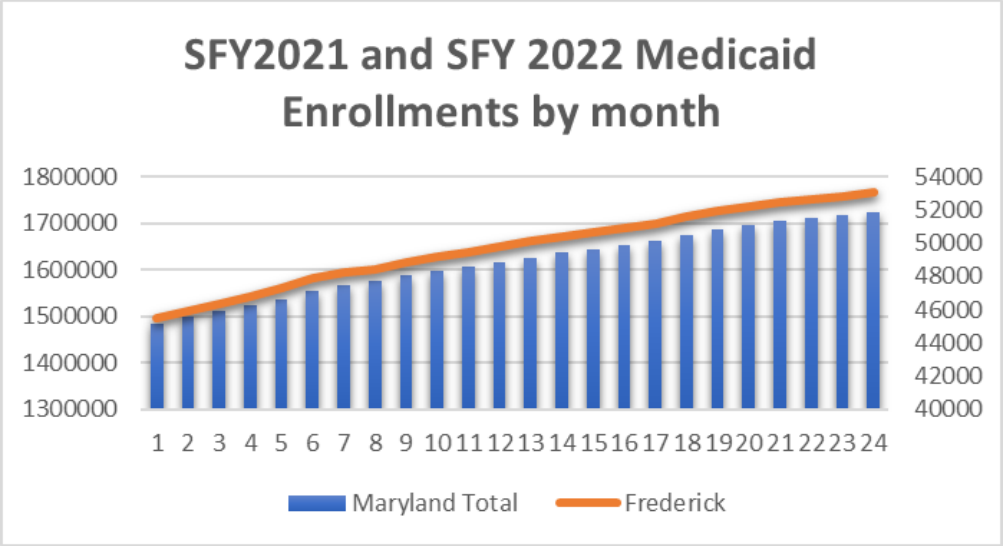
The cluster of west-central counties comprising Washington, Frederick and Carroll, together serve one-third of all the targeted case management clients in the state using a common provider, Potomac Case Management Services, Inc. Washington County has the highest utilization of case management services across the entire state (20%), even greater than that of Baltimore City. Potomac Case Management Services, Inc. is the provider of both adult and child case management services for Frederick. Frederick and Carroll Counties are the third and fourth highest utilizers of Targeted Case Management in the State behind Washington County and Baltimore City.

4. DATA AND PLANNING

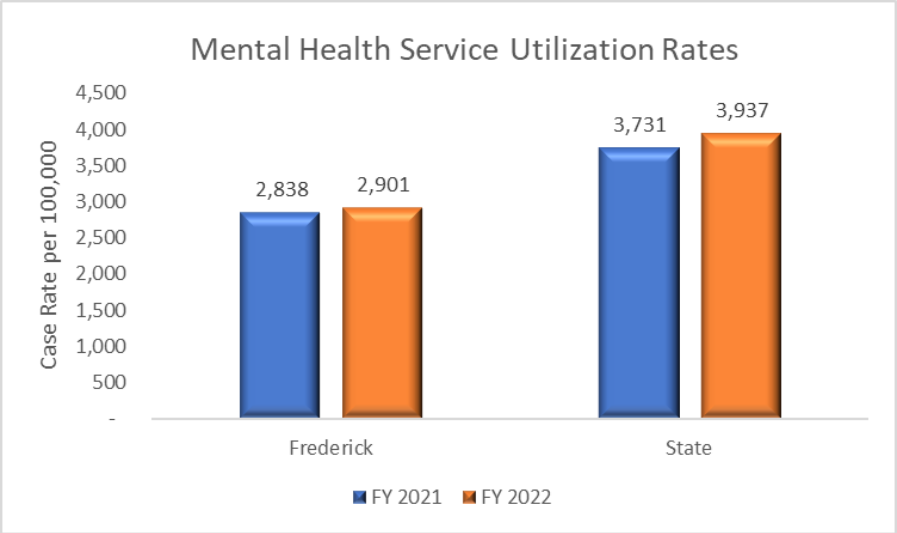
Medicaid Penetration Rates and Public Behavioral Health Services System Utilization

Source for data in this section: Optum ASO claims data paid through 10/31/2022. Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed. Consumer count totals are unduplicated and are not the sum of all services as an individual may receive more than one service or funding type throughout the fiscal year. Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".



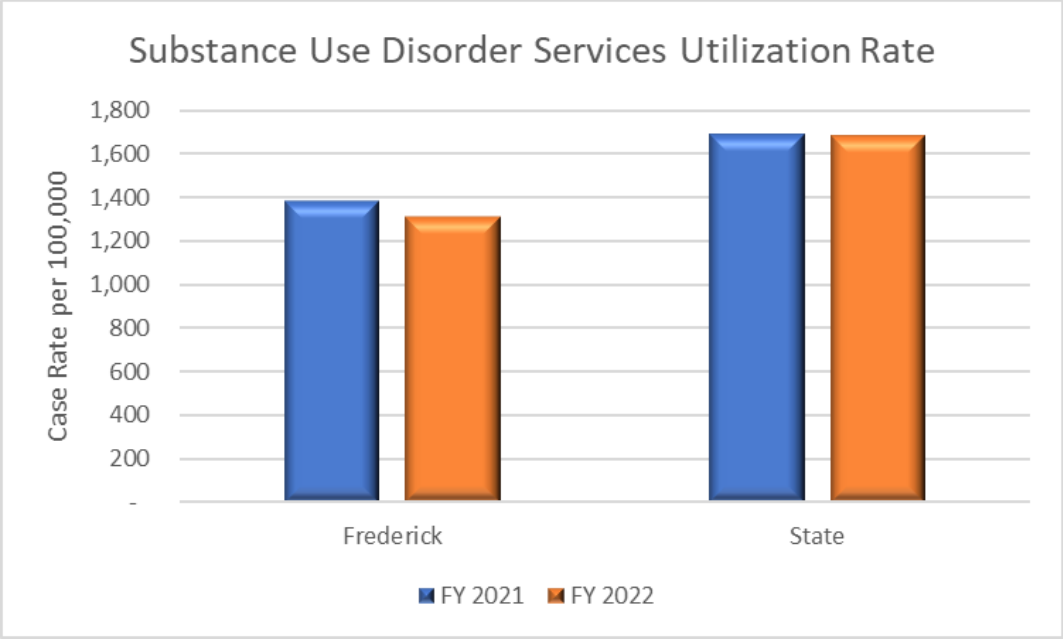


Residents of Frederick County are enrolling in Medicaid at higher rates than the state as a whole. This is likely a result of both an increasing number of Frederick residents meeting criteria for Medicaid over these past years and more people choosing to sign up for coverage. There are implications for behavioral health insofar as many types of program capacity have not kept pace with the increase. Consequently, there are more programs with waiting lists and more pressure on the walk-in and crisis services throughout the county. Additional access-related issues are also important to consider, such as access to transportation for reaching in person behavioral health services and access to adequate technology for telehealth services.



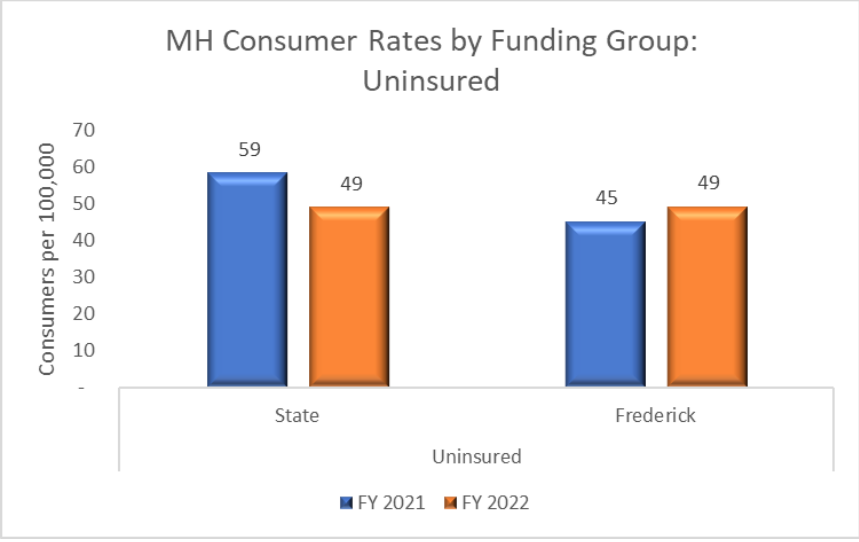
Note: Total count is unduplicated and includes individuals from Out of State

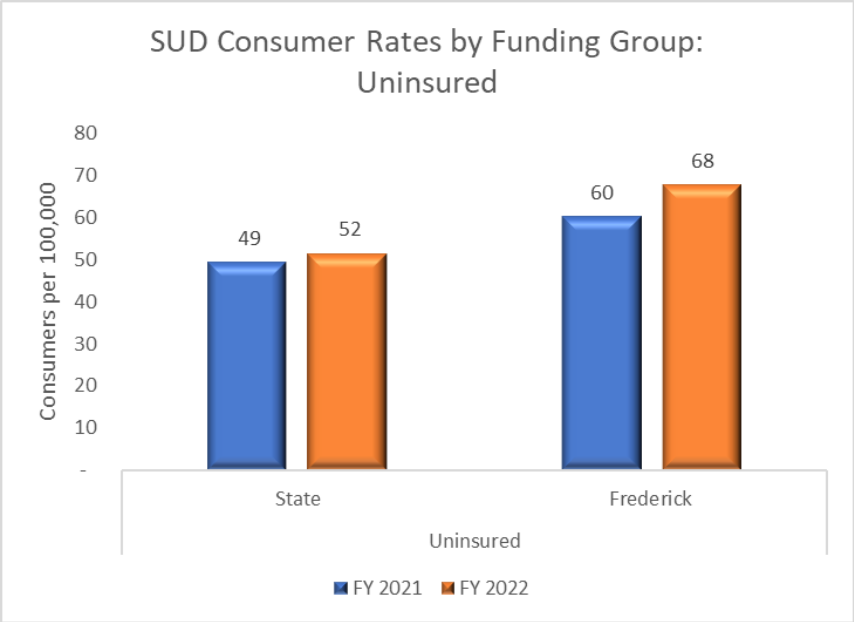
The rates of Medicaid enrollees utilizing mental health services has remained fairly steady. Frederick County enrollees use mental health services at a lower rate than those in the state as a whole.



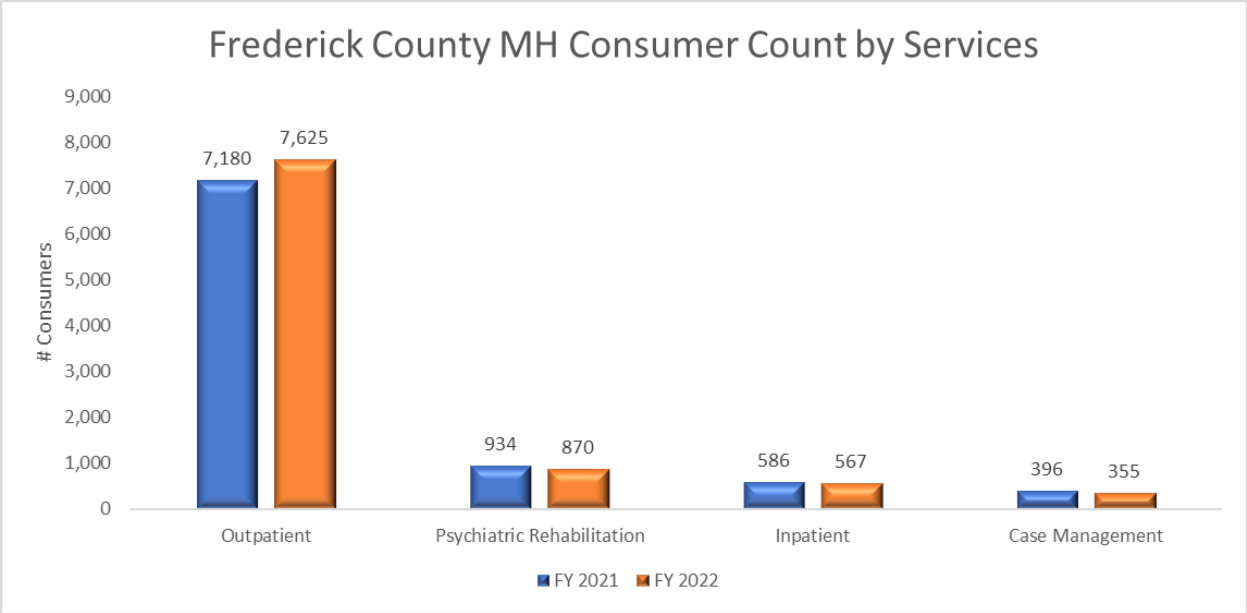
Note: Total count is unduplicated and includes individuals from Out of State

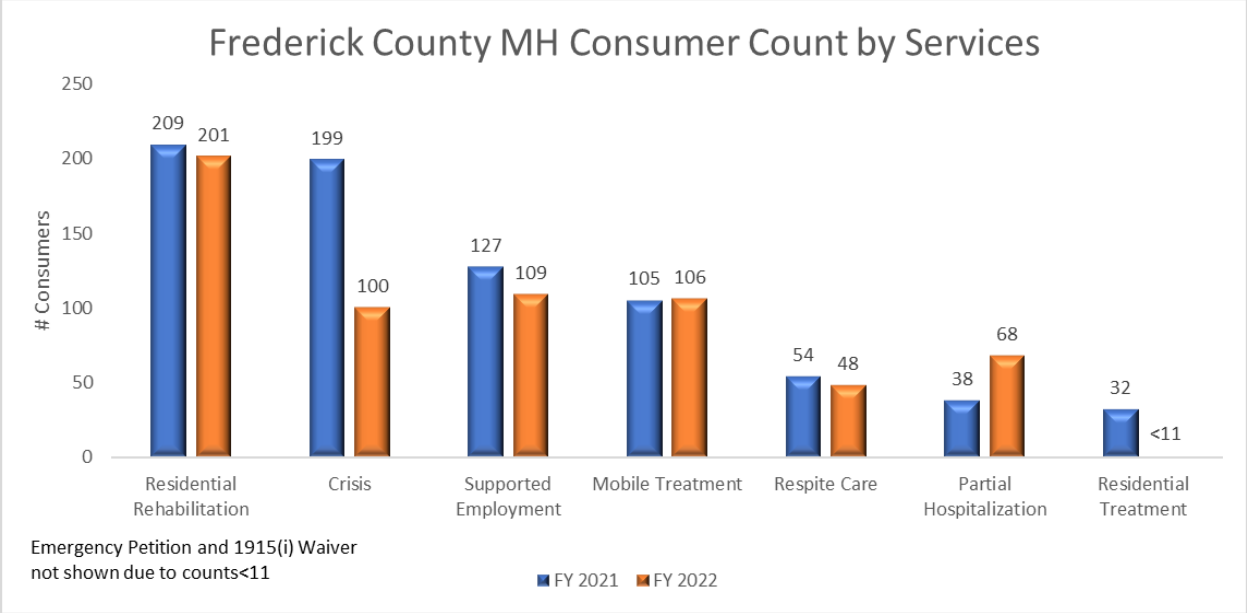
The rate of Medicaid enrollees who utilized substance use disorder services in Frederick County decreased slightly from 2021 to 2022. Frederick County has a lower utilization rate than the state of Maryland.





Individuals meeting certain criteria may qualify for coverage for both mental health and substance use disorder treatment. Providers may be approved through the Medicaid ASO system, upon application, to bill for services to these individuals. The hope for this payment source of last resort is to ensure that anyone in need of services has access to them. Providers are made aware of this process through monthly Provider Council meetings and from Optum ASO guidance documents. In Frederick, the number of residents who fall into this category has increased in FY22. Providers are still encouraged to ensure that all front-line staff are aware of the availability of this funding source for the appropriate situations. They are also given guidance about helping clients apply for all other potential funding sources that should be used whenever possible. Examples of individuals who may need to use this funding source include individuals in an undocumented status and those who have a pending application for Medicaid and need services immediately.

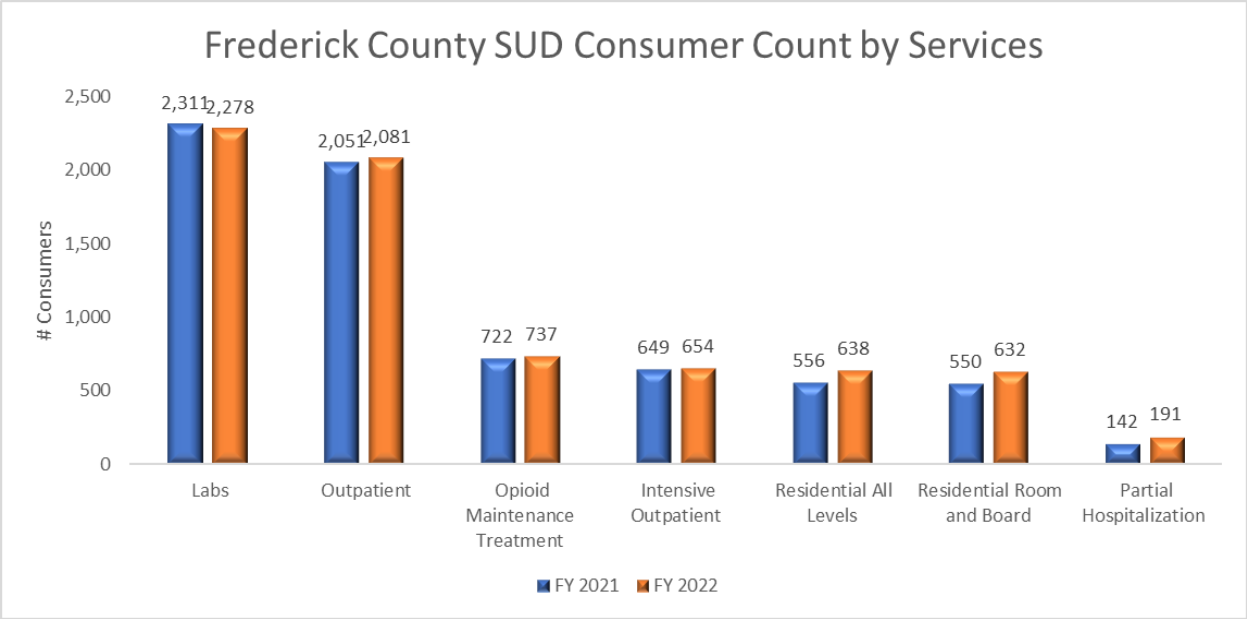


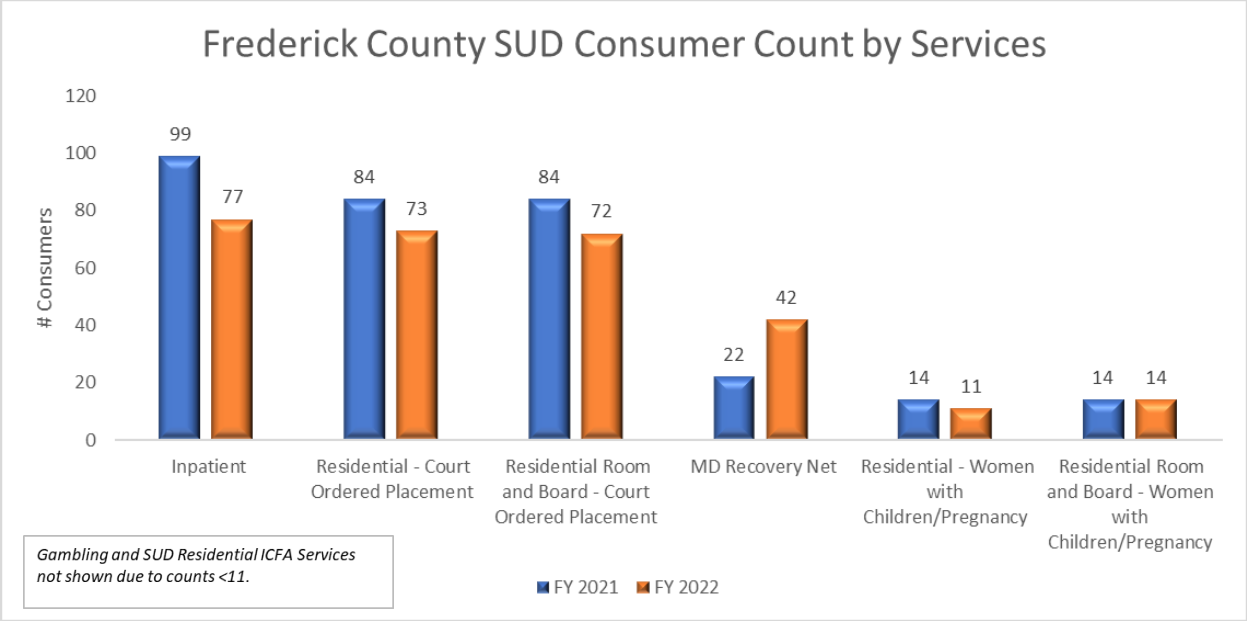


Of note here is what appears to be a decrease in the number of people accessing "Crisis" services. The service included in this data from Optum/ASO does not include some key crisis services provided by grant funding. For instance, the Behavioral Health Walk-In Center served over 1300 unduplicated individuals in FY2022, and Mobile Crisis Response Teams responded to over 400 individuals in crisis. Another crisis resource, Heartly House, has also seen significant increases in the demand for services specific to Interpersonal Violence. During FY22, there was a 72% increase in the average number of hotline contacts per month when compared to FY19, pre-pandemic. They served 65% more clients overall in FY22, including sheltering 113% more clients.

There are some slight increases in the number of people accessing Outpatient mental health services as well as the more intensive Partial Hospitalization. During the time period since the

pandemic, the population in general has experienced an increase in the severity and complexity of mental health needs. It is considered a success when those who are in need of behavioral health services reach out and engage with treatment and other support; however, without significant increases in program capacity to match, this may also result in longer wait times for individuals in need of services.



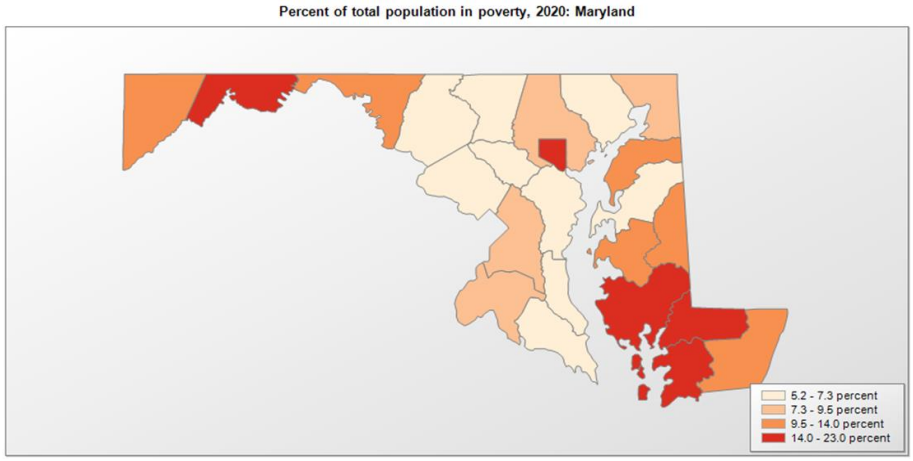


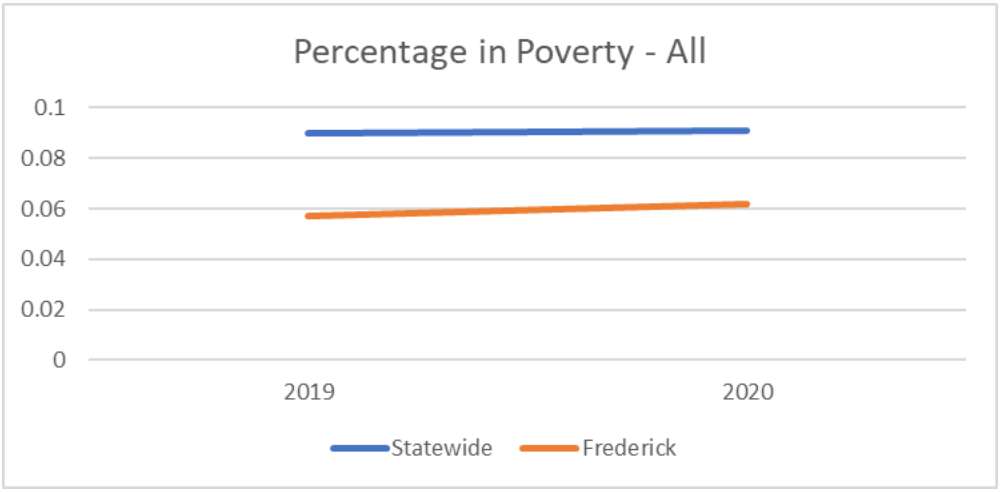
Substance related disorder services remained fairly steady through the last two fiscal years, with slight decreases in inpatient treatment services.

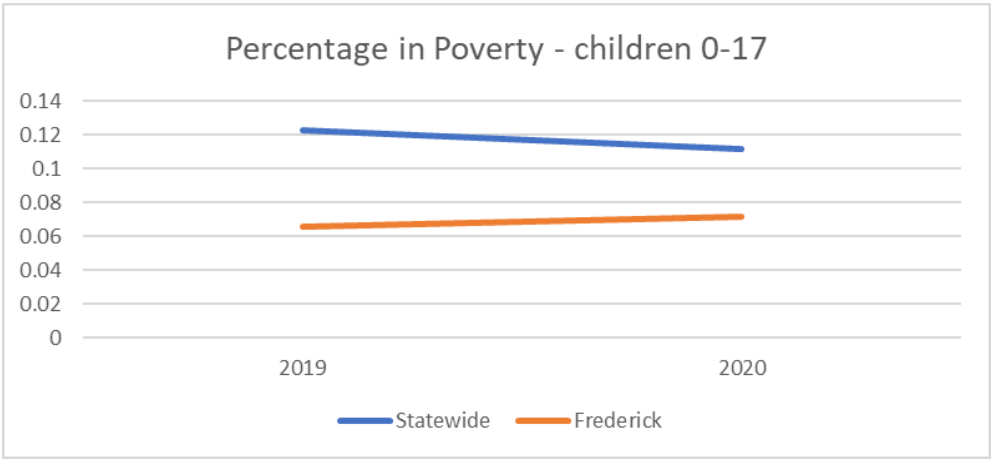
Poverty

Sources for data in this section: www.ers.usda.gov http://goccp.maryland.gov/data-dashboards/alice-dashboard/

Percent of Total Population in Poverty, Calendar Year 2020			
Jurisdiction	All people in poverty (2020) percentage	Children ages 0-17 in poverty (2020) percentage	Ranking (All people in poverty)
Statewide	9	11.2	
Allegany	14.7	18.6	4
Anne Arundel	5.2	6.3	23
Baltimore County	8.9	11.2	13
Calvert	5.3	5.3	22
Caroline	12.4	17.9	7
Carroll	5.2	5.6	24
Cecil	8.8	12.4	14
Charles	7.4	9.3	15
Dorchester	14.9	23.8	3
Frederick	6.2	7.2	19
Garrett	12.8	16.7	6
Harford	6.2	7.2	20
Howard	5.5	5.8	21
Kent	12	17.2	9
Montgomery	6.7	7.6	18
Prince George's	9.5	12.7	12
Queen Anne's	6.9	7.9	17
St. Mary's	7.3	9.2	16
Somerset	22.2	26.6	1
Talbot	9.6	14.7	11
Washington	12.3	16.9	8
Wicomico	14.2	19.2	5
Worcester	11.7	18.6	10
Baltimore City	20	26.8	2
Source: http://www.ers.usda.gov/data-products/county-level-data-sets/poverty.aspx			
2/13/2023			
See the county-level poverty rates from the 1990 and 2000 Census of Population. See important notes about intercensal model-based poverty estimates. The 2013 rural-urban continuum codes classify metropolitan counties (codes 1 through 3) by size of the Metropolitan Statistical Area (MSA), and nonmetropolitan counties (codes 4 through 9) by degree of urbanization and proximity to metro areas. See rural-urban continuum codes for precise definitions of each code. Source: Census Bureau, Small Area Income and Poverty Estimates.			
*See the Census Bureau web site for a description of FIPS codes.			







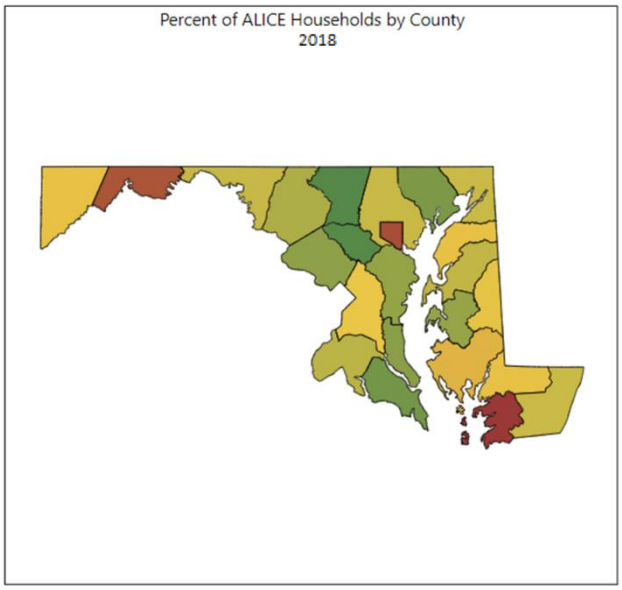
Frederick County ranks 19th out of Maryland's 24 jurisdictions for poverty among all residents. The initial impact of COVID may be seen when comparing calendar years 2019 and 2020 above. Statewide, there was a slight increase for the total population and a decrease in the percentage of children living in poverty. In Frederick, the slight increase overall was matched by a larger increase in the percentage of children living in poverty.

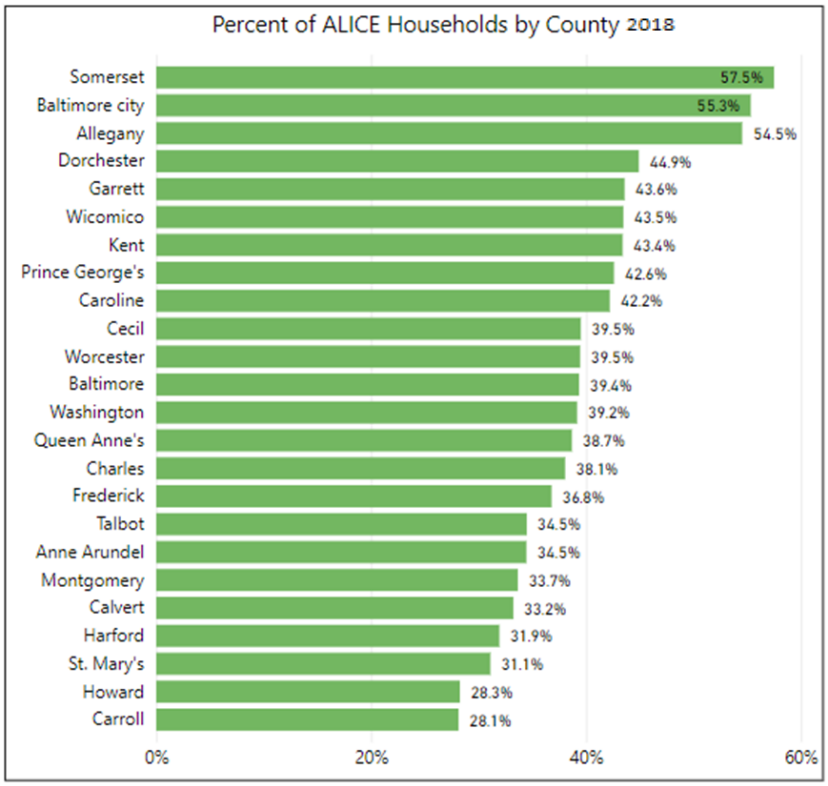
Another aspect of poverty that has great significance for the residents in Frederick County is what is commonly called the “working poor”. Better defined as “Asset Limited, Income Constrained, Employed”, or *ALICE*. These households have income above the Federal Poverty Level (FPL), but that income is not high enough to afford basic needs in the communities where they live (United for ALICE).

The most current ALICE data available is from 2018, detailed in the 2020 United Way report *ALICE in Frederick County: A Financial Hardship Study.* Despite data being captured prior to COVID, there is a great deal of value in examining it as a baseline for the later impact of the pandemic. As explained in their report:

"The release of this ALICE Report for Frederick County, Maryland comes during an unprecedented crisis— the COVID-19 pandemic. While our world changed significantly in March 2020 with the impact of this global, dual health and economic crisis, ALICE remains central to the story in every U.S. County and state. The pandemic has exposed exactly the issues of economic fragility and widespread hardship that *United for ALICE* and the ALICE data work to reveal. That exposure makes the ALICE data and analysis more important than ever. The ALICE Report for Frederick County presents the latest ALICE data available — a point-in-time snapshot of economic conditions across the county in 2018. By showing how many Frederick County households were struggling then, the ALICE Research provides the backstory for why the COVID-19 crisis is having such a devastating economic impact. The ALICE data is especially important now to help stakeholders identify the most vulnerable in their communities and direct programming and resources to assist them throughout the pandemic and the recovery that follows. And as Frederick County moves forward, this data can be used to estimate the impact of the crisis over time, providing an important baseline for changes to come." (United Way of Frederick County, 2023)

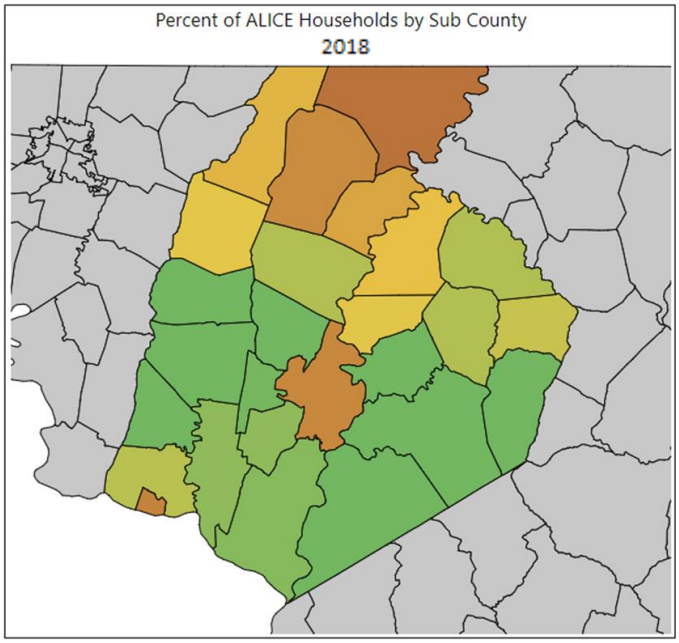
The counties with the highest number of ALICE households in Maryland are shown above in red, with the counties in dark green being the lowest.

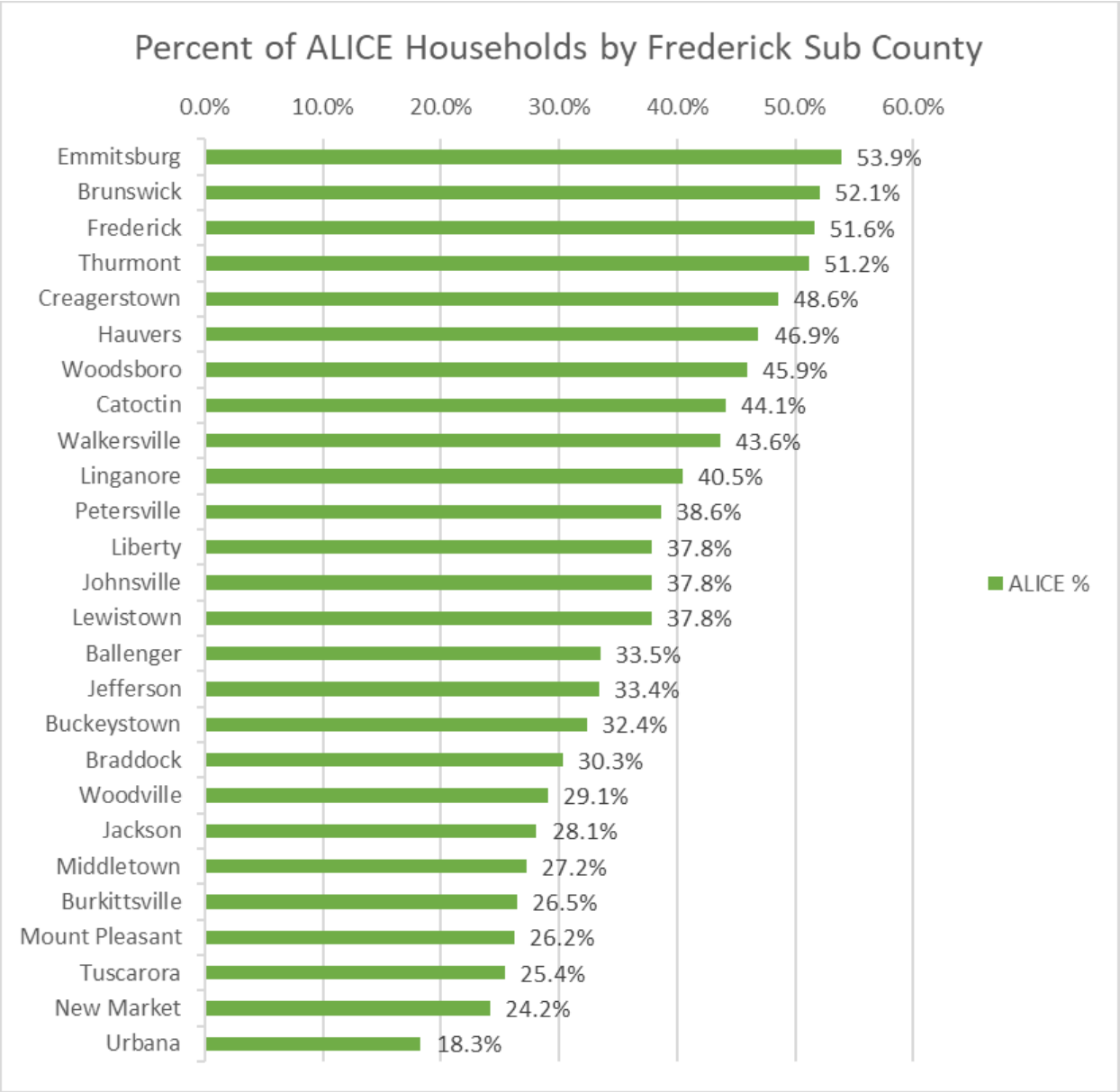




Frederick County ranks 16th of all Maryland counties, with 36.8% of residents meeting criteria as an ALICE household.

When looking at a breakdown of areas within the county, shown here and listed below, Frederick City, Brunswick, and several areas in the northern part of the county stand out as having higher numbers of ALICE households.



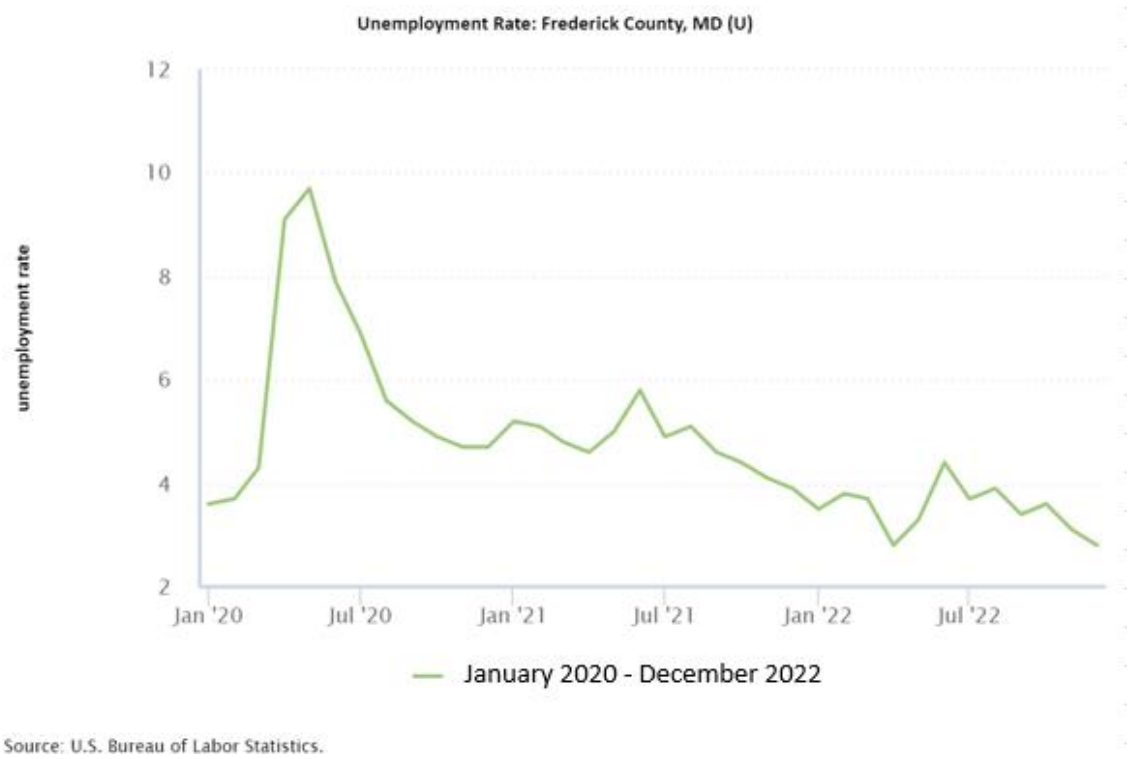


(ALICE Dashboard, 2023; data as of 2018)

An additional resource to consider when examining the picture of poverty in Frederick County is YouthReach survey results. SHIP of Frederick County staff administered many of the 134 most recent surveys in April 2022. Of all those surveyed, 46 youth met the YouthReach criteria for homelessness, which is broader than the definition used by HUD. (YouthReach Maryland, 2023) SHIP plans to follow up with the YouthReach group about the data, which may inform planning for local services.

Unemployment

Source for data in this section: Bureau of Labor Statistics (BLS)
https://beta.bls.gov/
Data extracted February 22, 2023



Latest Observation:
December 2022
2.8

Jan 2020 - Dec 2022
Minimum Value: December 2022
2.8

Maximum Value: May 2020
9.7

Data Availability:
1990 - 2022

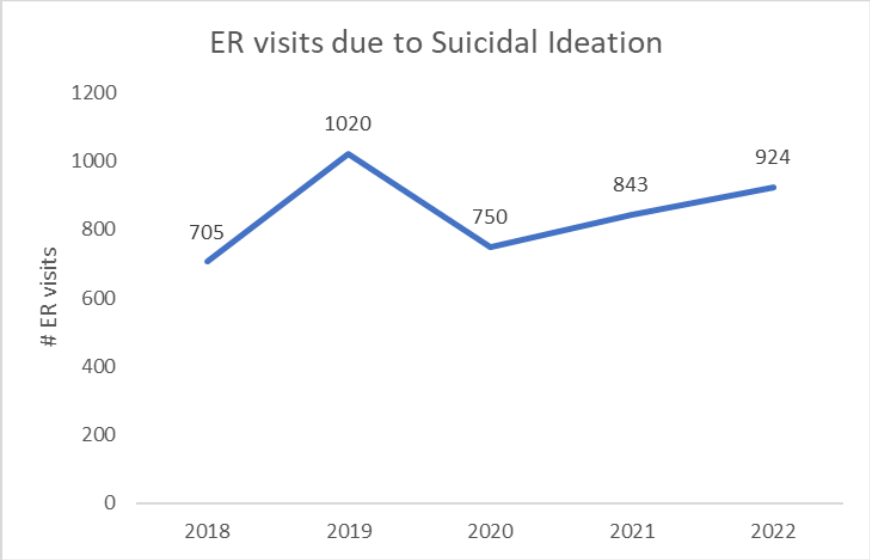
The unemployment rate for Frederick County hit its lowest point in December 2022 at 2.8, also the most recent month data was available at the time of this report. Predictably, the unemployment rate was at its peak of 9.7 in May 2020 due to the COVID pandemic. It will be important to continue looking at this data alongside poverty, ALICE, and wage data to see if wages are keeping pace with the cost of living and allowing households to afford basic needs.

Hospital Visits Related to Suicide Ideation

Source for data in this section: ESSENCE Maryland Data Query (Suicide, Suicidal, Injury to Self, Self-harm), (2018-2022). Maryland Department of Health. Accessed via ESSENCE. (2/24/2023).

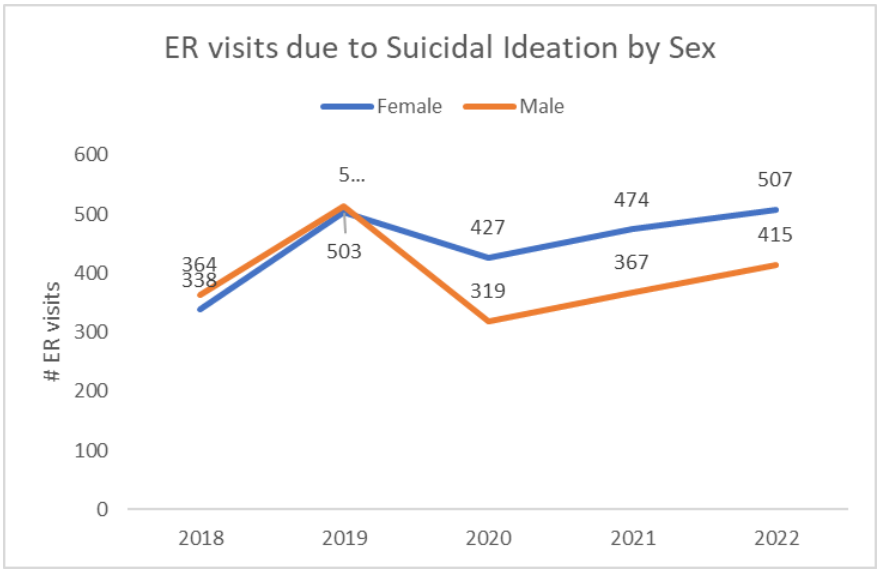
For the purpose of this analysis, data was pulled from CC and DD fields utilizing a keyword text query concerning: Suicide. The query returned results for all individuals in which a keyword of "suicide", "suicidal", "injury to self", "self harm", or "self-harm" was used.

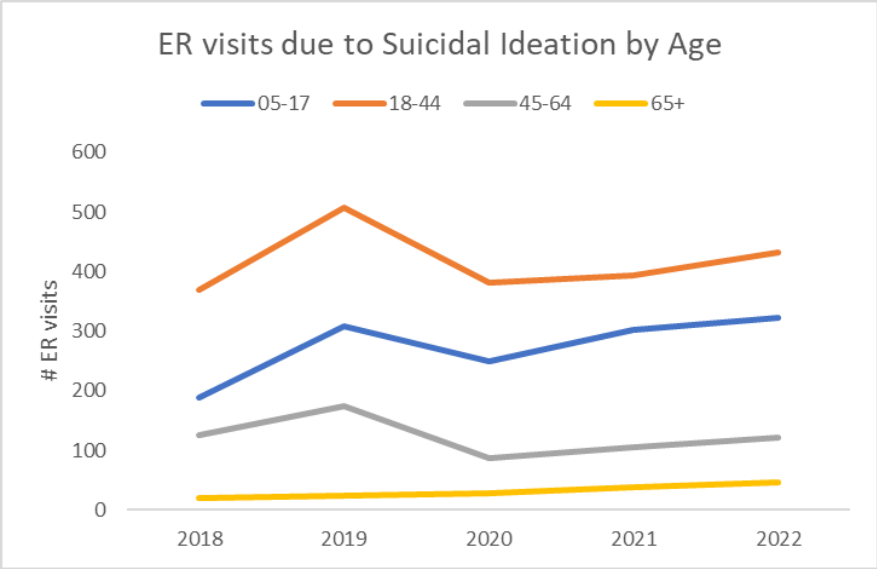
*ESSENCE Query: ^suicide^,or,^suicidal^,or,^injury to self^,or,^self-harm^,or,^self harm^*



Individuals seeking services at the hospital emergency department have been trending upwards for the past 3 years, after declining initially from 2019 to 2020. Starting in 2020 the instances have been steadily rising.

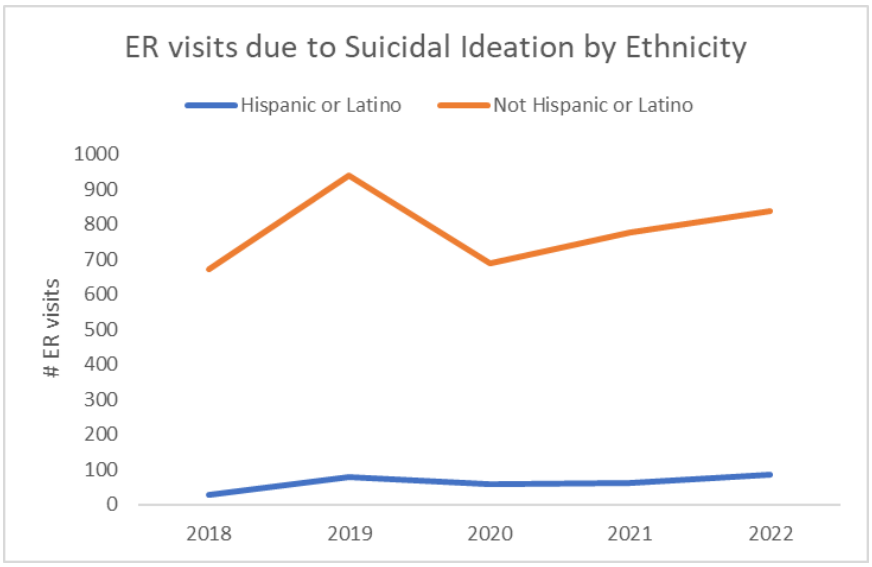
More females than males have been seen in the emergency department. The trend appears to be increasing at approximately the same rate for males and females since 2020.

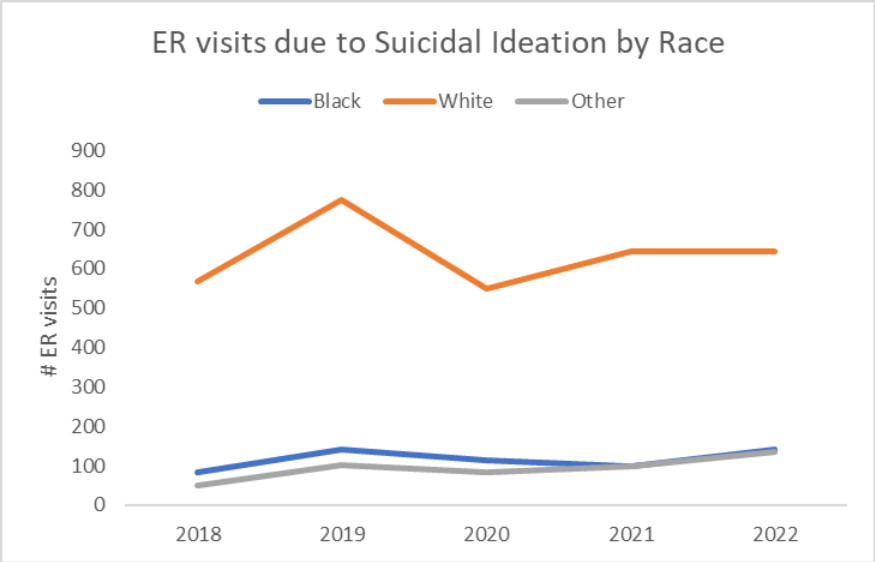




The highest number of people seen in the emergency department for suicidal ideation fall into the age range of 18-44. The next highest range is children aged 5-17. Both age groups appear to be contributing most to the increases over the past 3 years.

The majority of people seen in the emergency department for suicidal ideation are non-Hispanic or Latino.

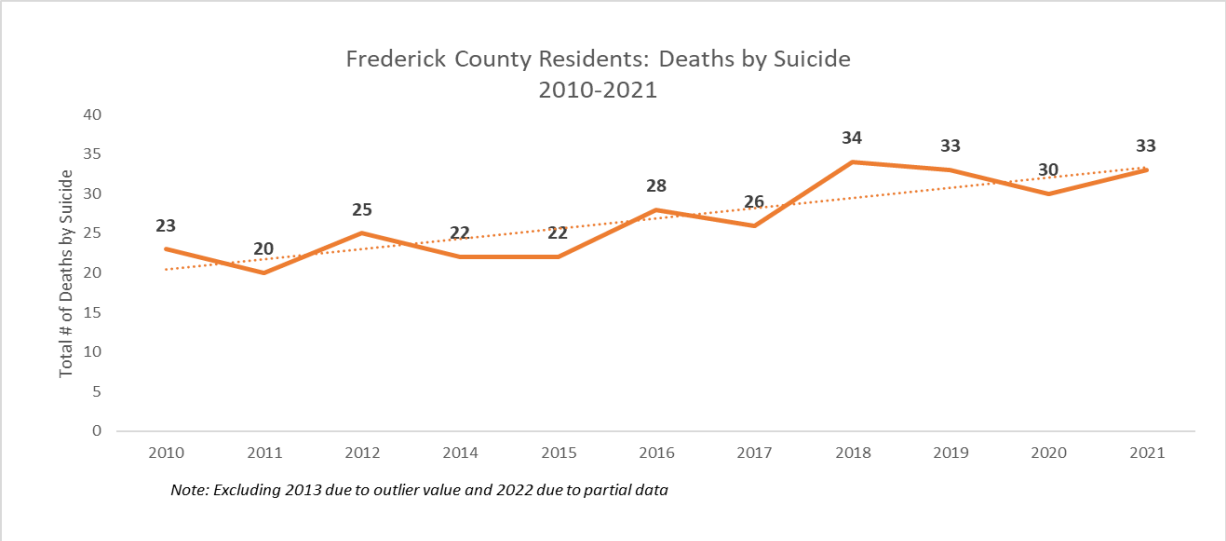




White individuals make up the majority of people seen in the emergency department due to suicidal ideation. There does appear to be a slight increase in the number of those identifying as black or other races. This should be monitored closely, especially when examining suicide death trends for younger Black and Asian/Pacific Islanders. The racial makeup of the county is as follows, according to the 2020 census data: 69% identify as being non-Hispanic White, 11.6% identify as Black or African American alone, 11.3 % identify as Hispanic or Latino, 5.7% identify as Asian, and 3.3% identify as two or more races.

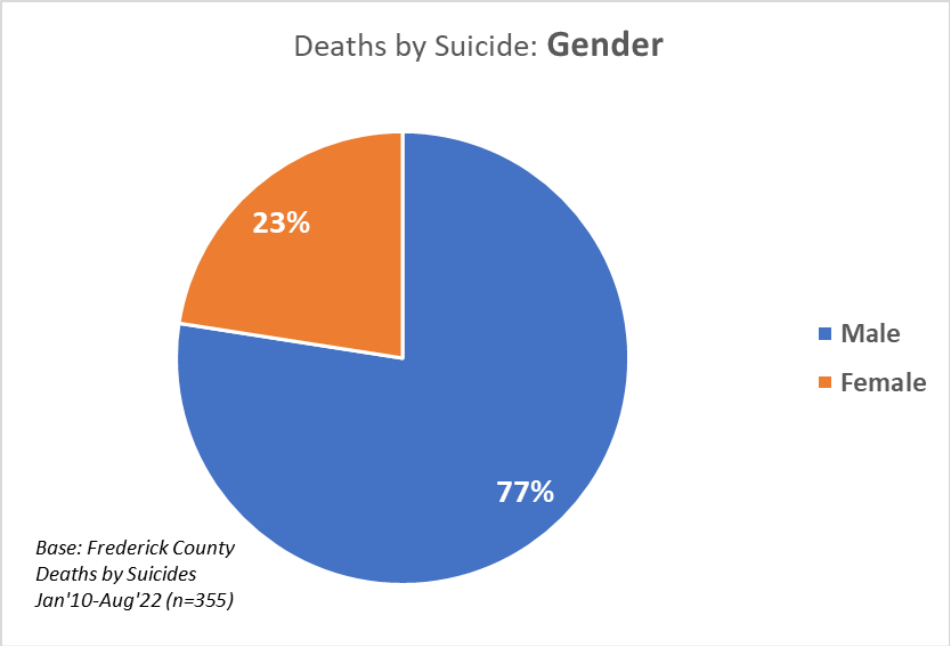
Suicide in Frederick County, 2010-2022

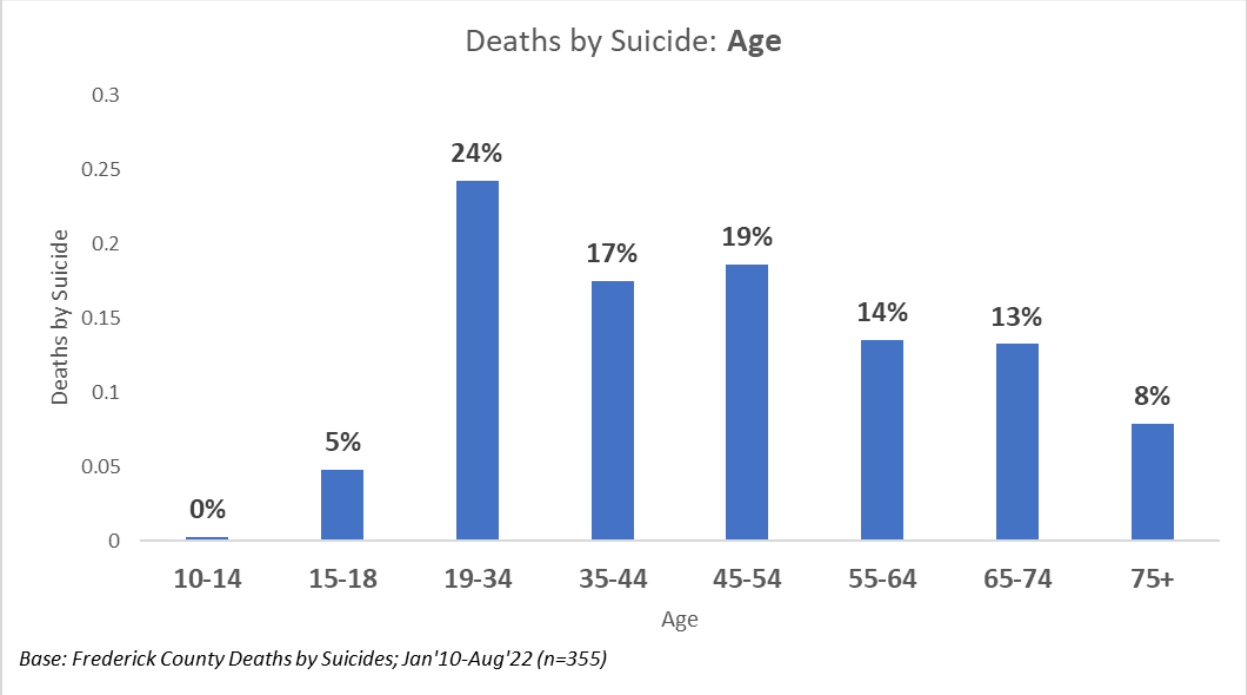
Source for data in this section: State of Maryland Vital Statistics, (2010-2022). Maryland Department of Health. Accessed via Electronic Vital Records Registration System (EVRS). (12/1/2022).



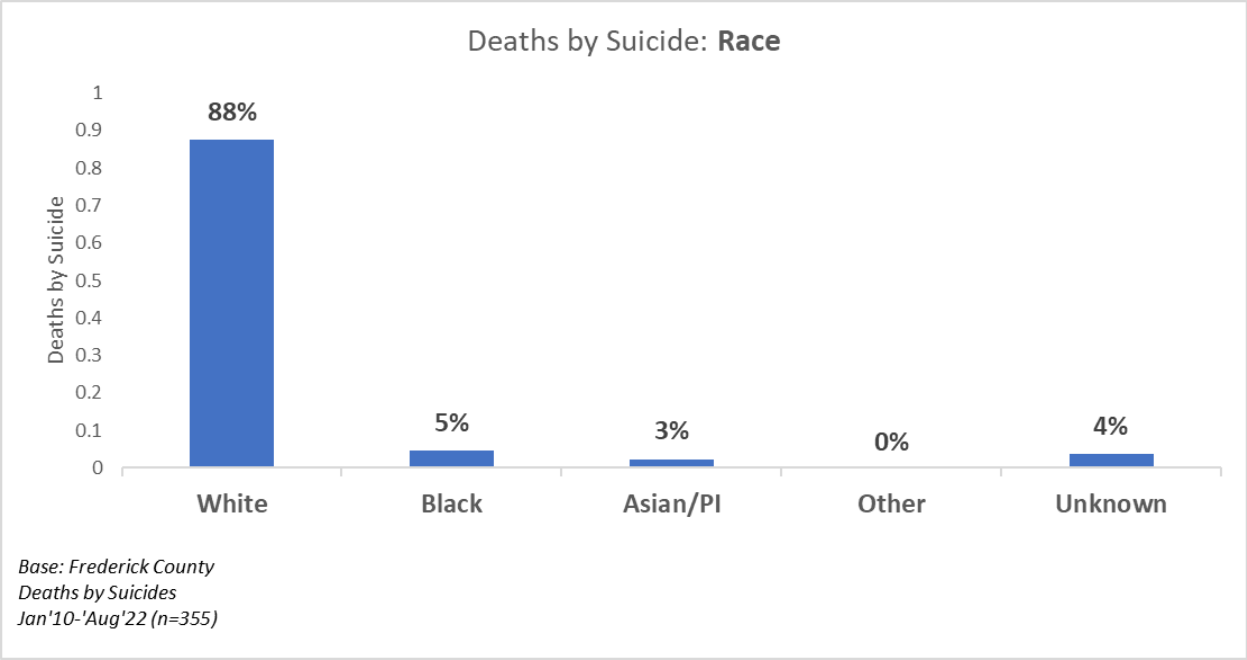
By examining suicide death data over 10 years, it is evident that suicide deaths have been trending upwards in Frederick County.

Men are more likely to complete a suicide than women. Women, however, may be more likely to seek help for suicide ideation at a hospital according to the data in the previous section.

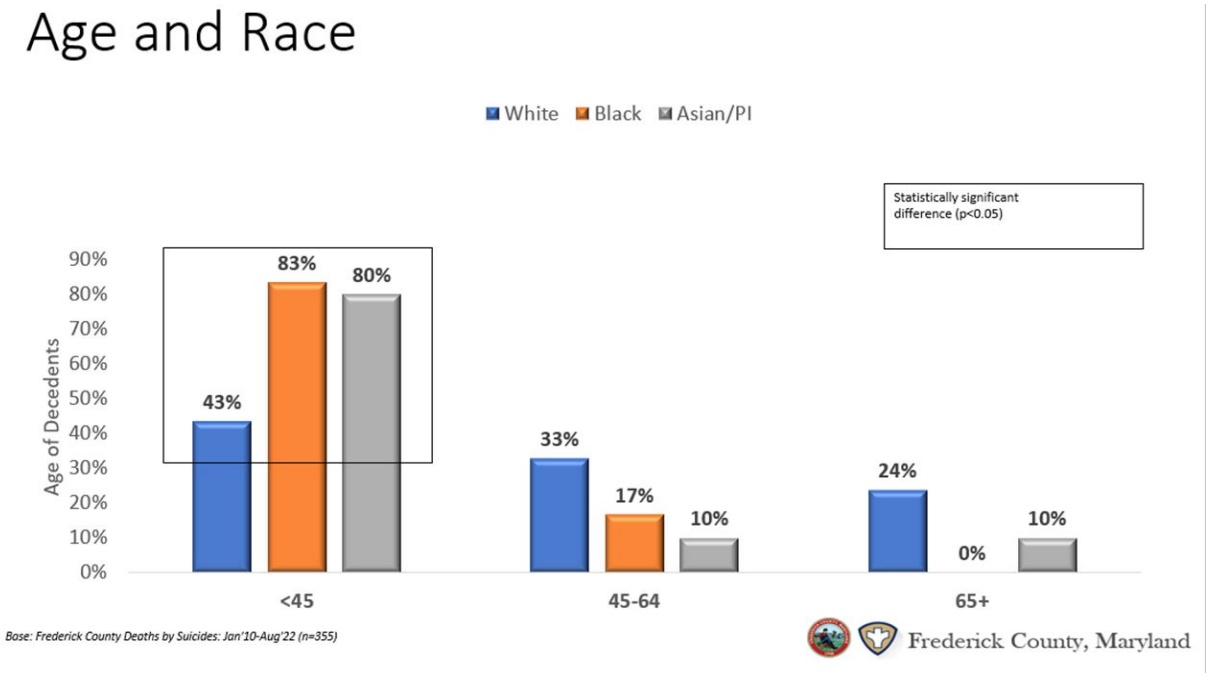




Individuals in the age range 19 to 34 comprise one quarter of deaths by suicide.

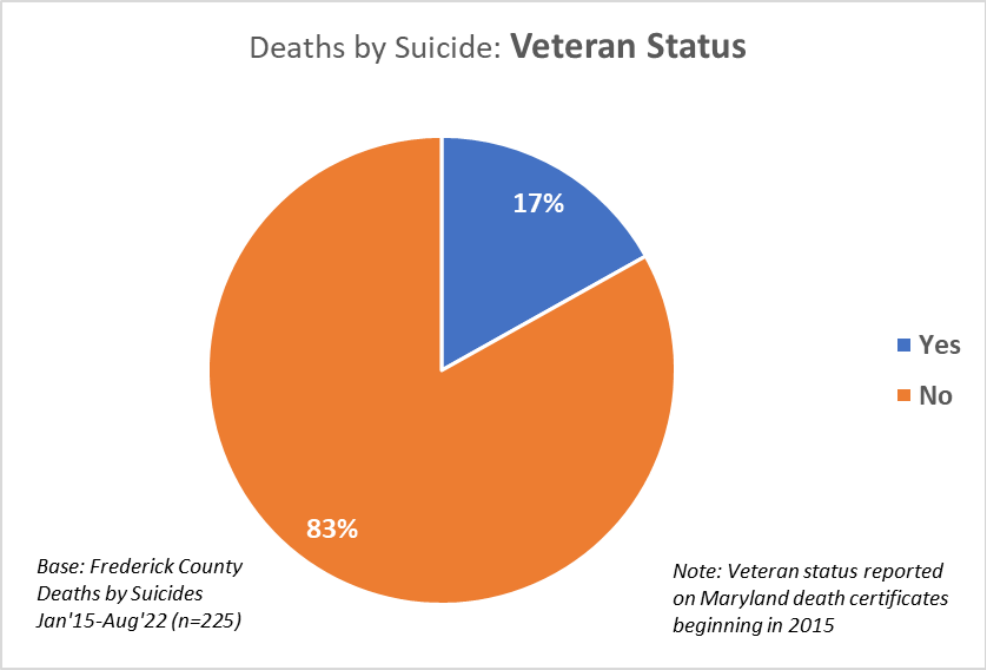


The majority of deaths by suicide are among those who are White. The racial makeup of the county is as follows, according to the 2020 census data: 69% identify as being non-Hispanic White, 11.6% identify as Black or African American alone, 11.3 % identify as Hispanic or Latino, 5.7% identify as Asian, and 3.3% identify as two or more races.



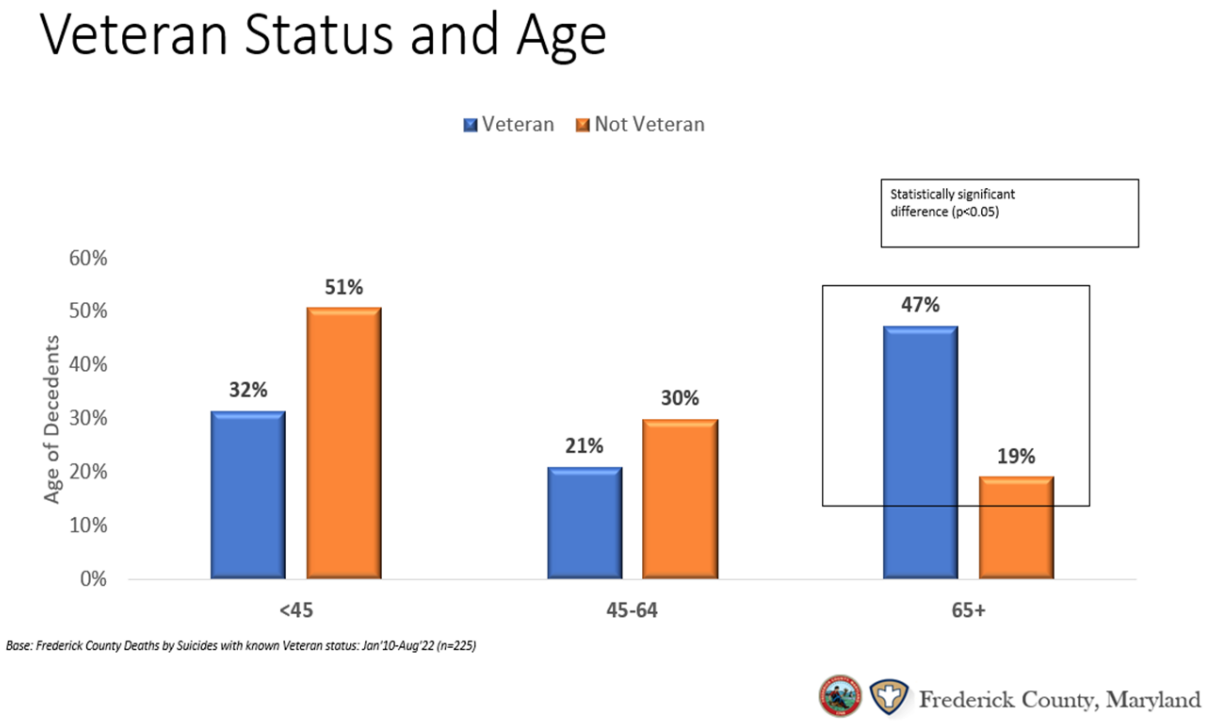
Of those who die by suicide, the number of nonwhite decedents is higher among those under the age of 45. This is of particular interest as we have seen trends across the state and nation that death by suicide is increasing among young persons of color. This may not specifically

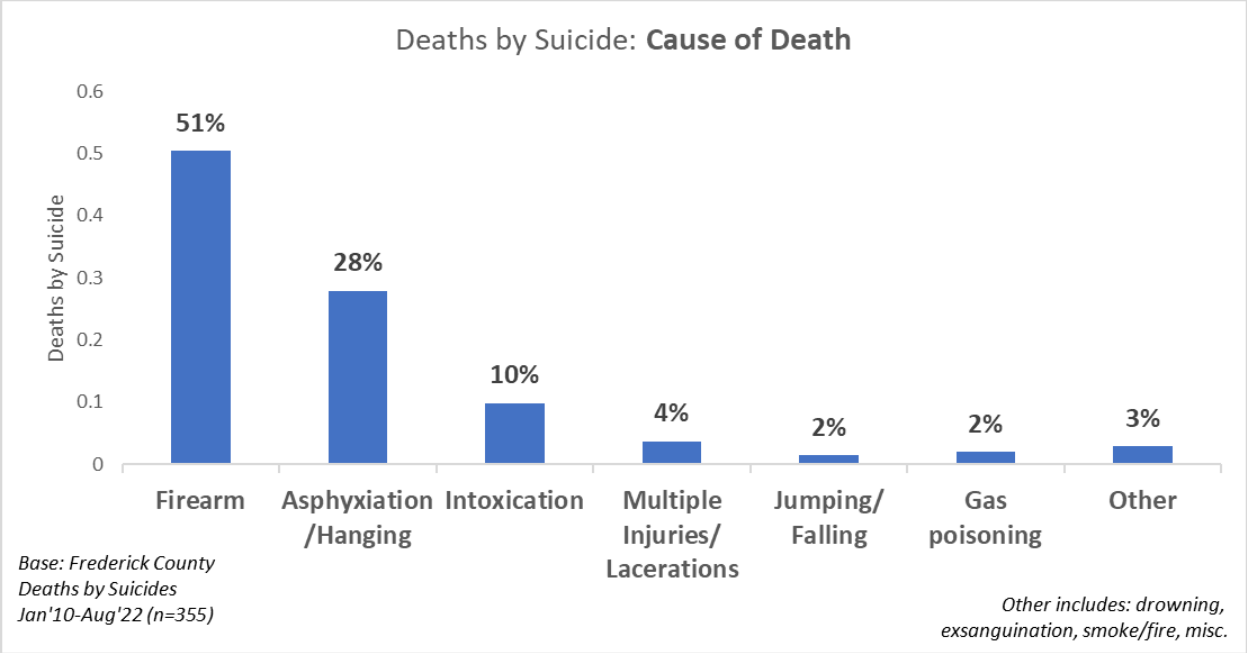
indicate that rates among Frederick County people of color are increasing, but it does show that black and Asian/Pacific Islanders who die by suicide in Frederick County tend to be younger. This is something to note as outreach and prevention strategies vary by age group, not just race and culture.



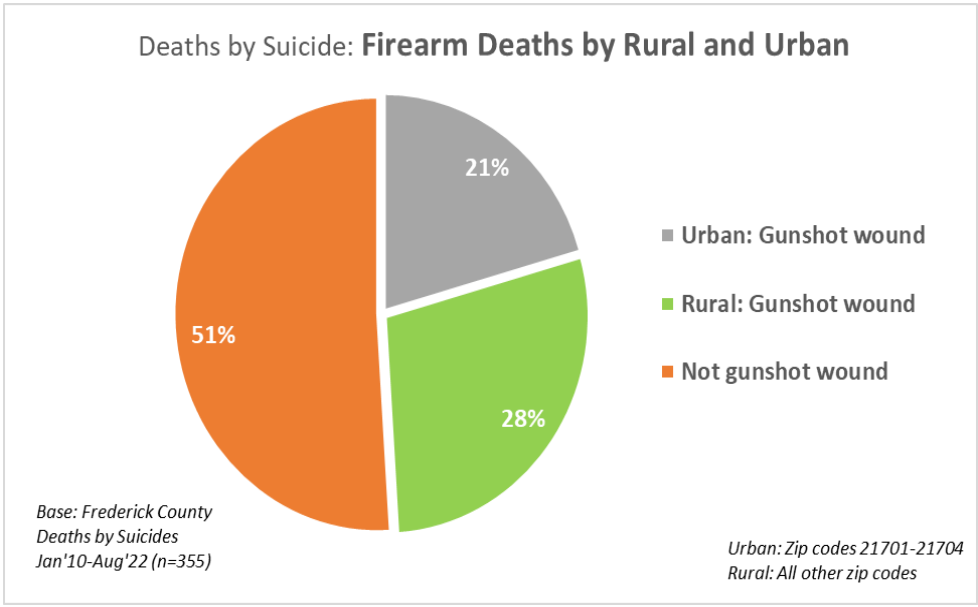
One in 6 deaths by suicide are veterans.

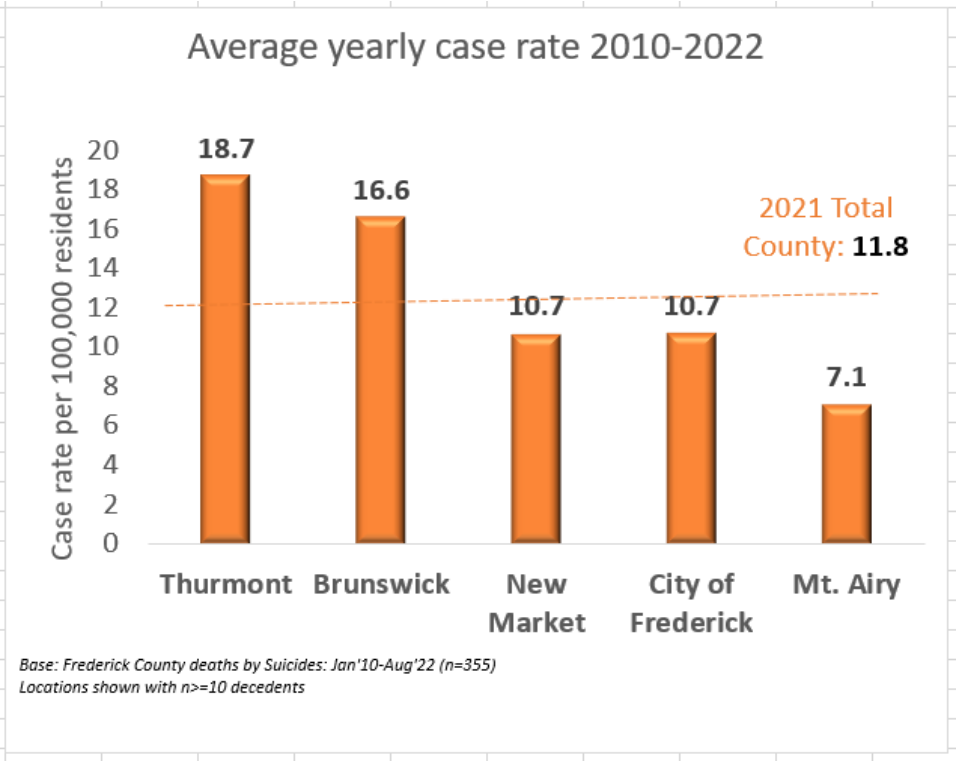
Among veterans who died by suicide, they were more likely to be over the age of 65. This tends to be Vietnam era veterans.





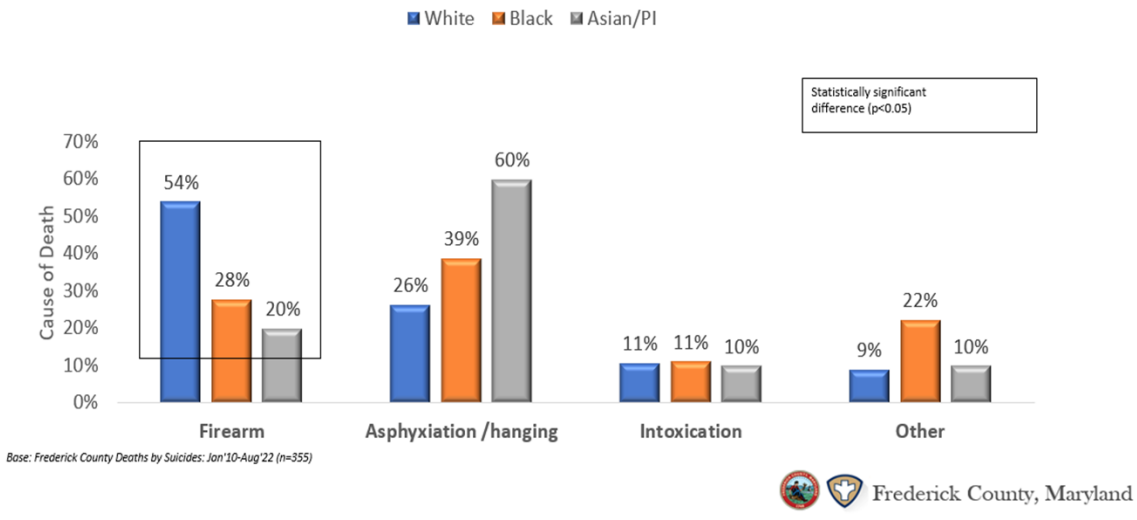
Half of all causes of death by suicide were gunshot wounds. Aside from firearms, asphyxiation/hanging and intoxication are the most frequent causes of death. Of the deaths by gunshot wound, over half were in rural areas.





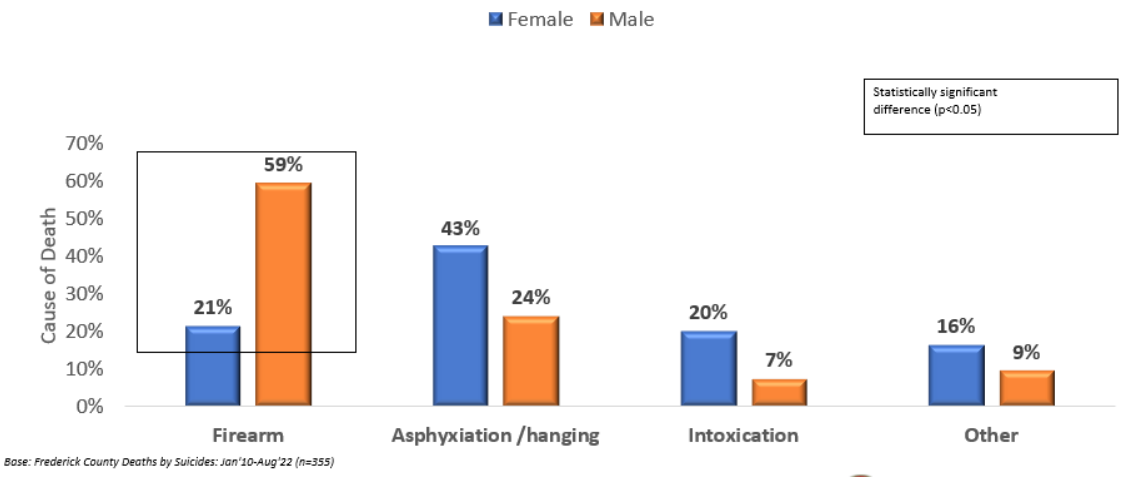
Slightly over half of decedents resided in more rural areas of the county. Notably, the up-county area may benefit from increased suicide prevention and mental health services outreach.

Cause of Death and Race

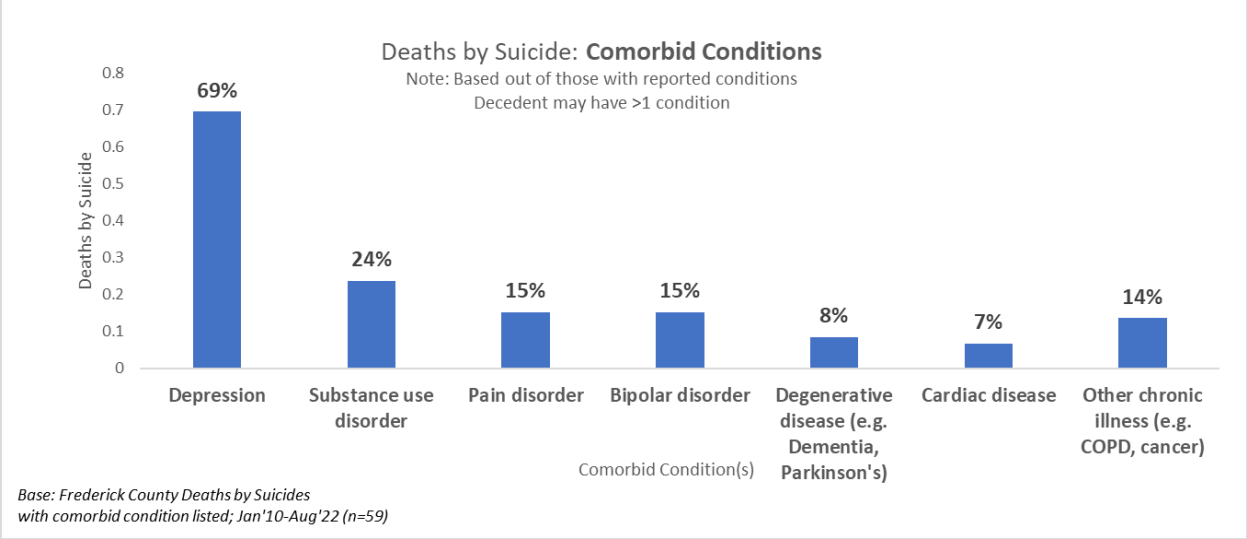


In looking at the intersection of cause of death and race, data shows that those who are white are more likely to use firearms as a means of death than their black and Asian counterparts.

Cause of Death and Sex

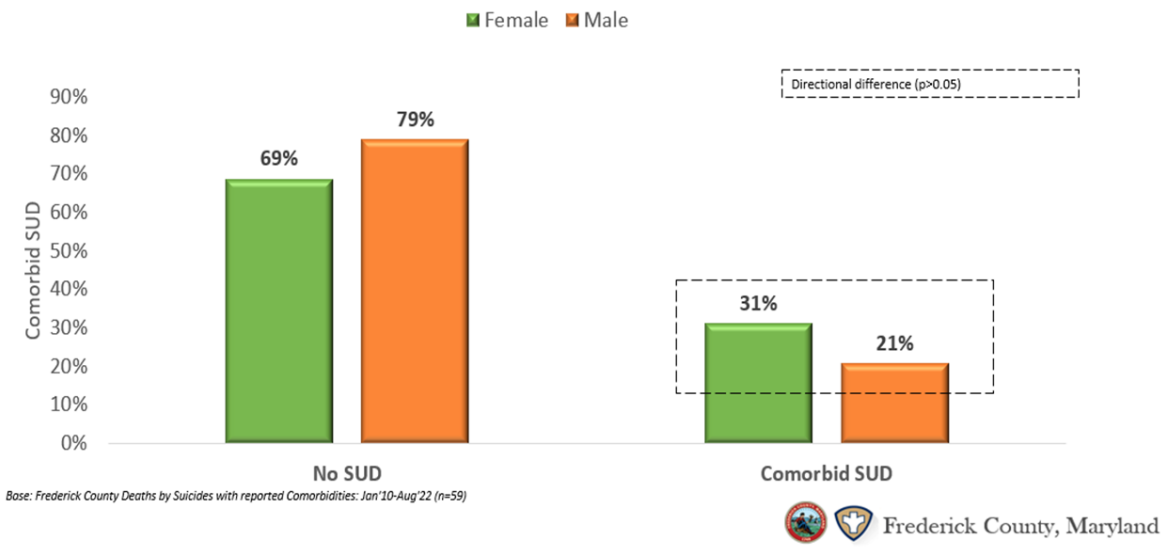


Upon examining cause of death and sex, it is noted that males were significantly more likely to die by firearm than females. This is expected, as it is a trend across the nation, as males tend to use more lethal means.



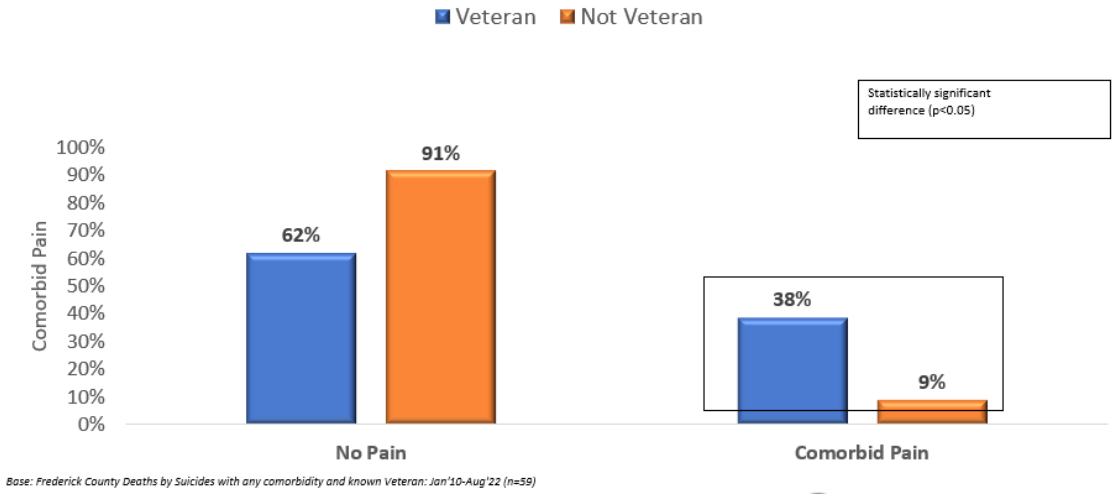
Out of everyone with a reported comorbid condition, many had depression and one quarter had a substance use disorder.

Comorbid Substance Use Disorder and Sex



The relationship between substance use disorder and sex does not rise to the level of statistical significance. Of interest, though, is that of those who died by suicide, females were more likely to have a documented diagnosis of substance use disorder. This could be for many reasons; for example, women tend to demonstrate help-seeking behaviors more often than men, which could account for the difference.

Veteran Status and Comorbid Pain

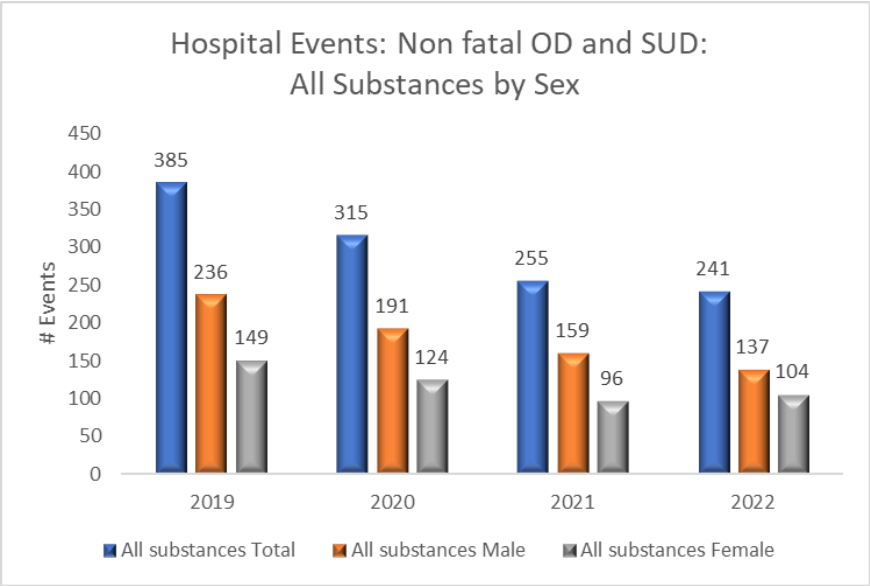


Veterans were significantly more likely to have a documented history of pain than their nonveteran counterparts. Report of pain was significant enough to be noted as a health issue

by the Office of the Chief Medical Examiner. The pain could be due to a number of causes related to illness or injury.

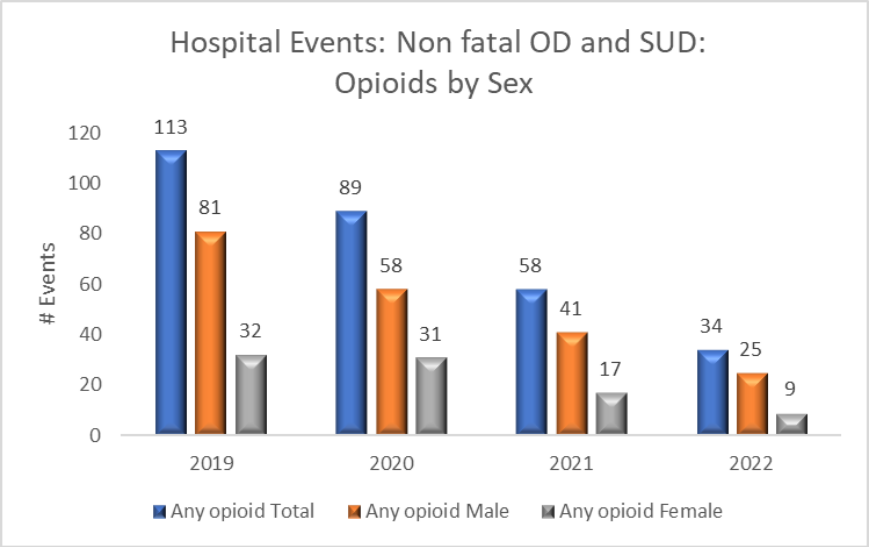
Hospital Visits Related to Non-Fatal Overdose

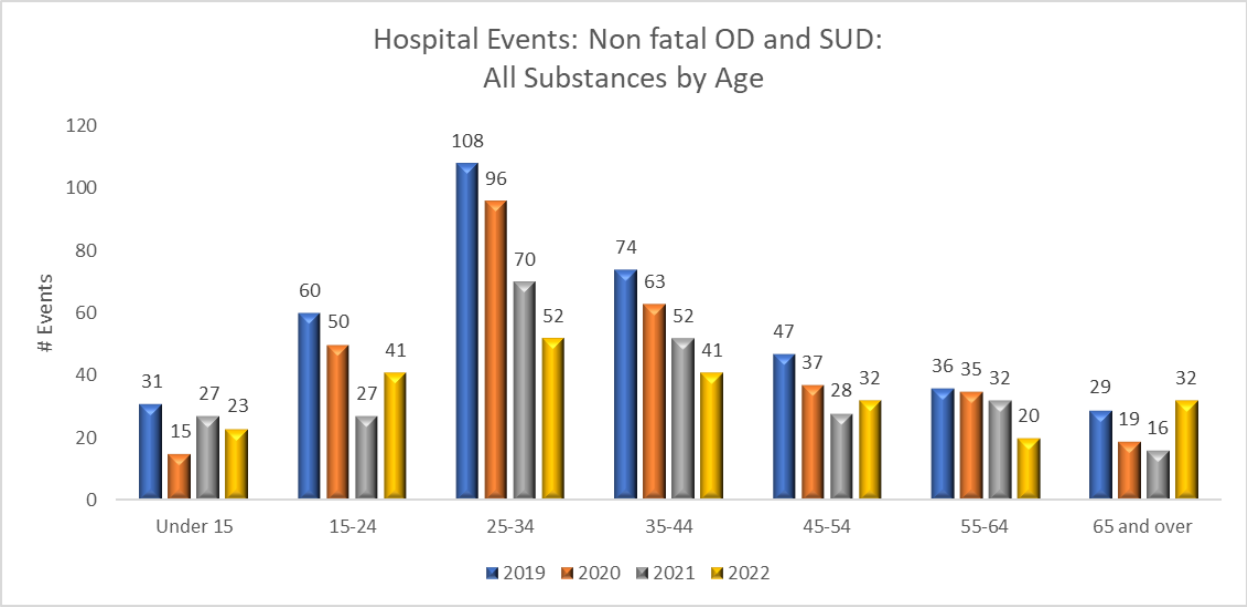
Source for data in this section: HSCRC Inpatient and Outpatient Case Mix Data with CRISP EID, (2020-2022). Maryland Department of Health. Accessed via CRISP Drug-Related Indicators Dashboards. (2/15/2023).



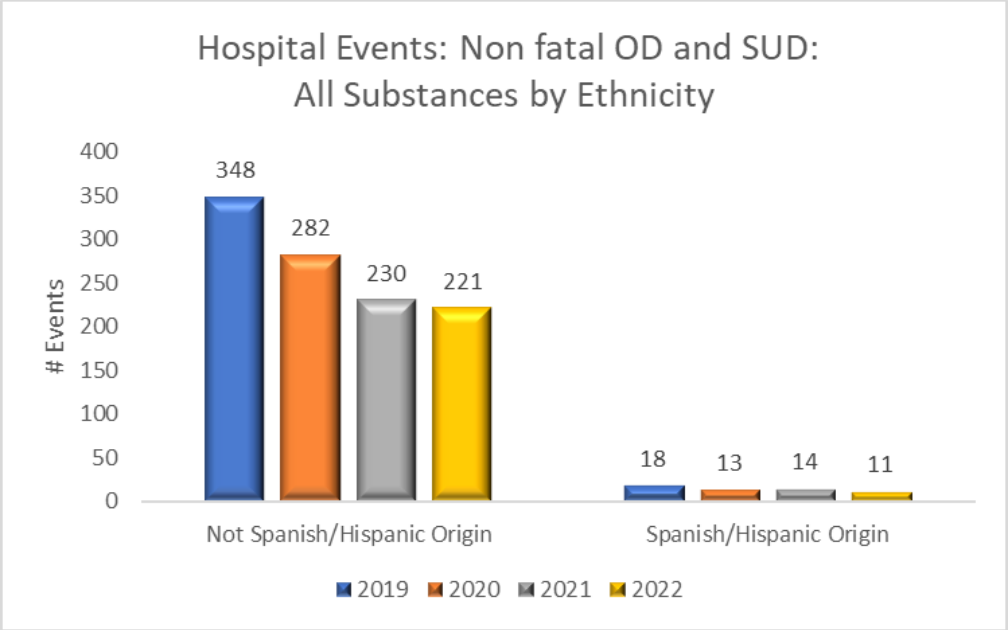
Over the previous four years, non-fatal overdose hospital events related to **any substance** have steadily declined. This is the case overall as well as for males and females. Males have a higher instance of being treated at the hospital for overdose.

For non-fatal overdoses involving **opioids**, there is a similar and slightly sharper decline overall. This is evident for both males and female, with males still receiving more services than females.

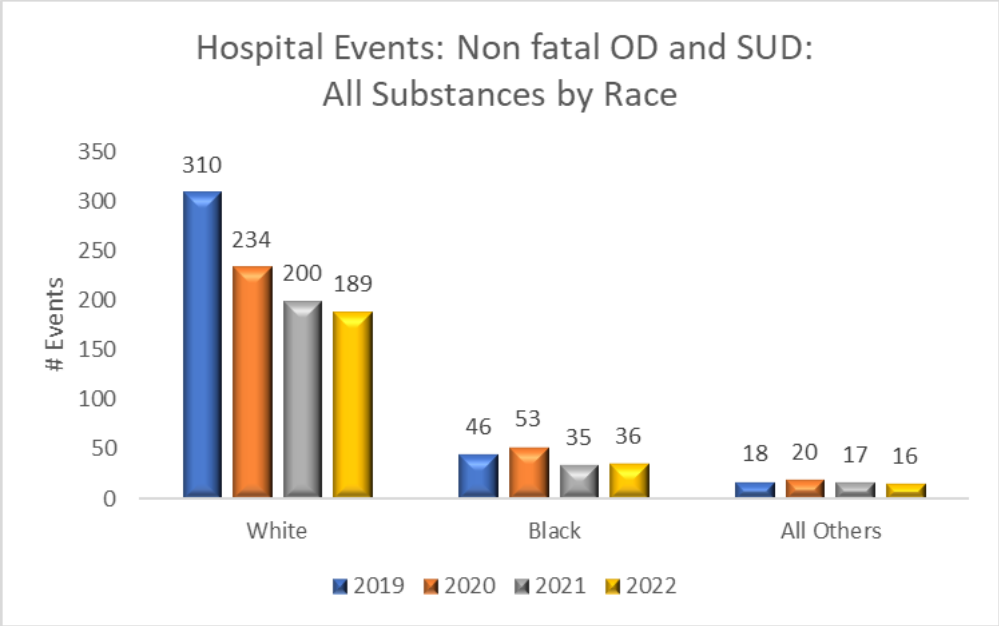




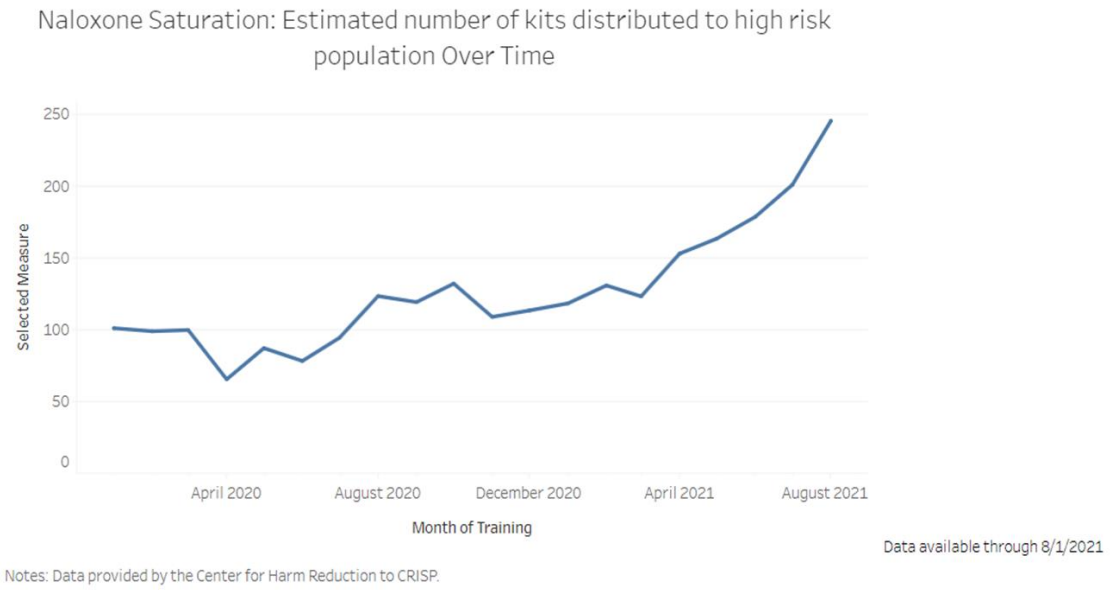
Of all non-fatal overdose hospital events, there was a spike for those between the ages of 25 and 34 during 2019 into 2020. Those aged 25 - 44 saw a steady decline in overdose events treated at the hospital from 2019 - 2022.



Persons identifying as not being of Spanish or Hispanic origin were treated most often at the hospital for non-fatal substance overdoses.



While the majority of patients seen for overdose are White, those who are Black and other races do not seem to show the same decrease as white counterparts. This is data to monitor.

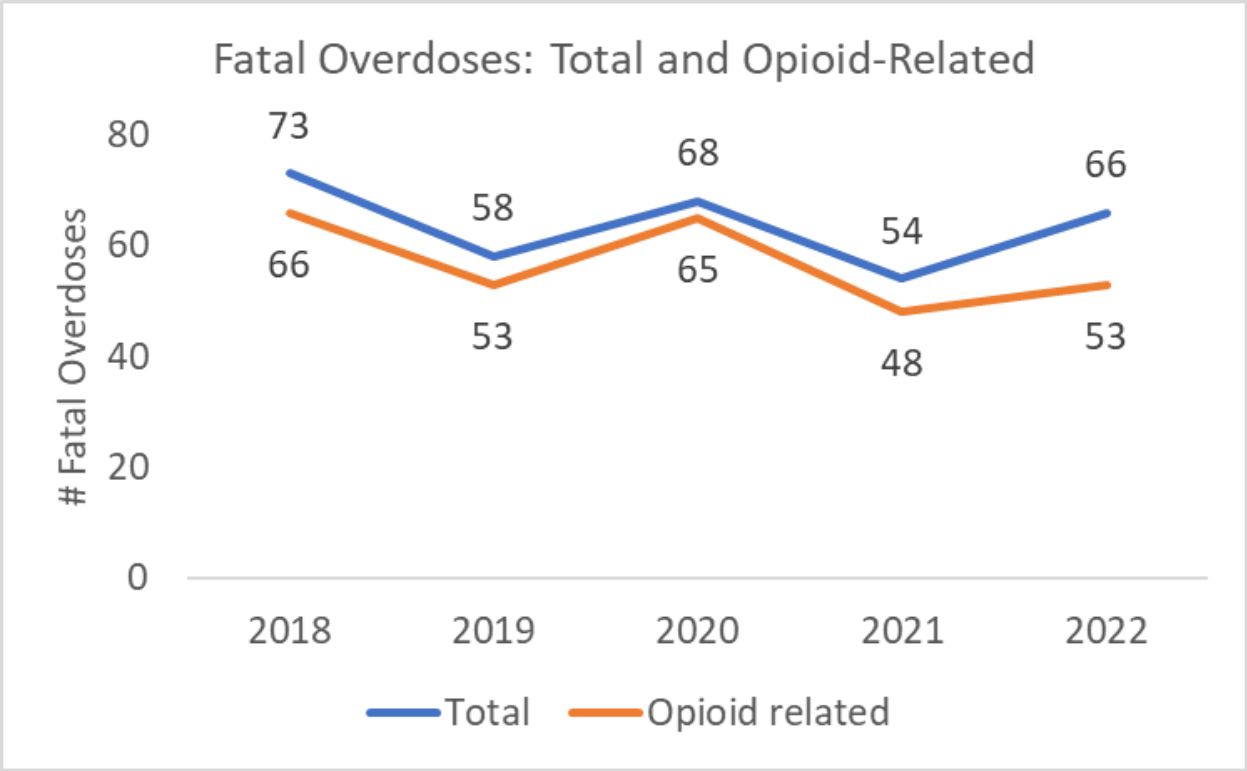


The sharp decrease in the number of people being seen at the hospital leads to several questions about what is occurring with substance use, especially opioids, in the community. In working with local EMS, it is known that a significant number of people decline transportation to the hospital after they have been revived from an overdose. Also, as illustrated above, naloxone/Narcan saturation among those considered to be high risk of overdose in Frederick County doubled between 2020 and 2021. Individuals may choose to not seek medical intervention after using Narcan to reverse an opioid overdose among their peers. Once the

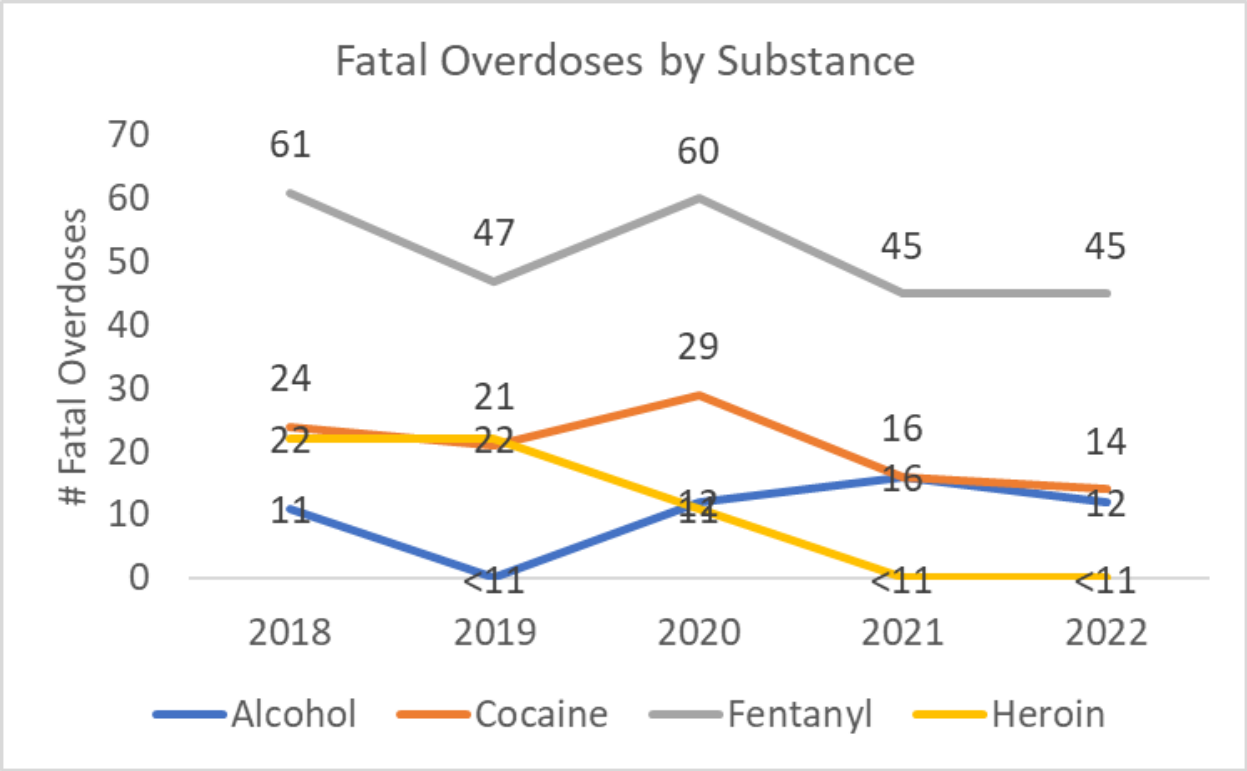
Crisis Stabilization Center is fully operational, this data should be revisited alongside the Center's data to see if people may be more likely to seek services there.

Overdose Deaths

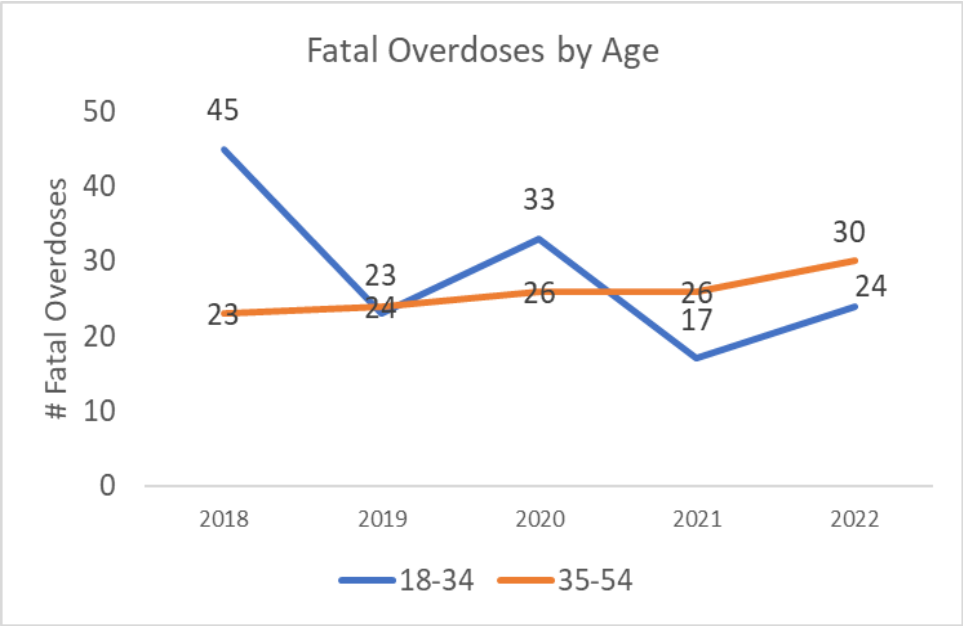
Source for data in this section: Office of the Chief Medical Examiner Data, (2007-2022). Maryland Department of Health. Accessed via CRISP Drug-Related Indicators Dashboards. (2/15/2023).



Fatal overdoses have seen increases and decreases over the past 5 years, with a very slight downward trend. Opioids have remained the substance involved in the majority of fatal overdoses.

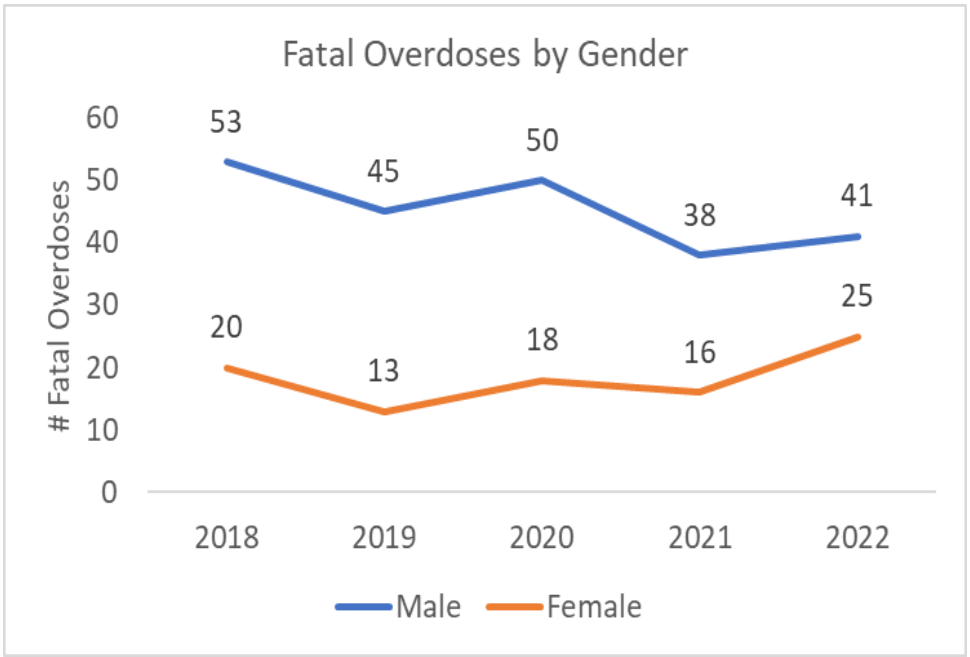


This further illustrates not only the prevalence of opioids in the drug supply, but also how fentanyl is specifically the cause of so many fatal overdoses. Fentanyl has almost completely taken over any presence of heroin in the community drug supply. These substances also show how combinations of substances can increase the likelihood of someone fatally overdosing when - either knowingly or unknowingly - ingesting more than one substance at a time. For instance, someone drinking alcohol and using cocaine or opioids, or using a substance believed to be a pressed benzodiazepines pill that is actually fentanyl, is at much higher risk of overdose.

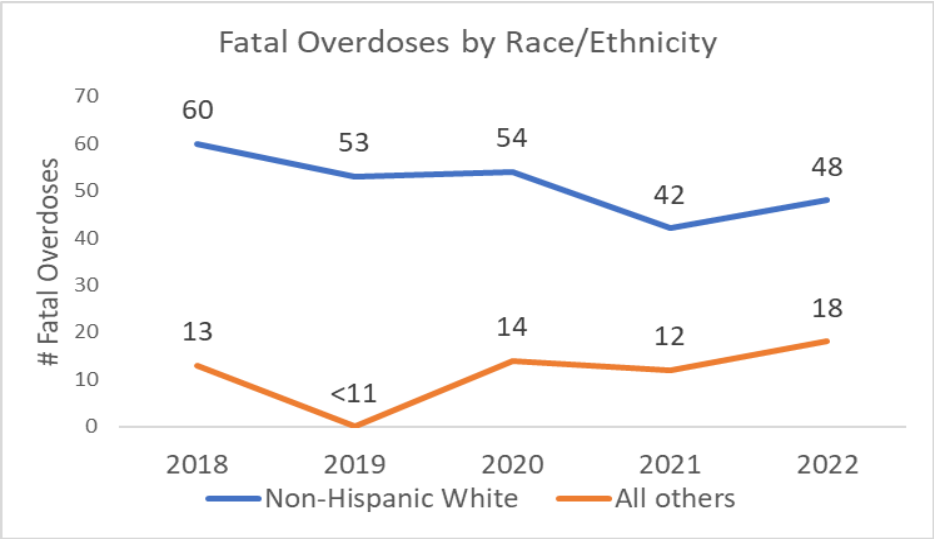


Both age groups appear to be trending upwards between 2021 and 2022, with those aged 35-54 experiencing fatal overdose in higher numbers than those aged 18-34.

Males typically fatally overdose more than females, which is also true for non-fatal overdoses according to the overdose-related hospital events. Here we see that the gap may be closing, with fatal overdoses by females increasing at a faster pace than their male counterparts.



Fatal overdoses tend to occur more frequently for those who identify as non-Hispanic White. Both groups are increasing at an even pace between 2021 and 2022.



Note: "All Others" here includes Hispanic, non-Hispanic, Black, and Asian/Pacific Islanders. These are grouped due to the separate ethnic and racial groups having sample sizes below 10.

5. SYSTEMS MANAGEMENT INTEGRATION

See Attachment

6. CULTURAL AND LINGUISTIC COMPETENCE (CTC)

See Attached Cultural and Linguistic Competency Self-Assessment, updated in 2023, and FY24-26 Cultural and Linguistic Competency Strategic Plan.

7. SUB-GRANTEE MONITORING

Sub-grantees are awarded funding through a competitive bid process that follows Frederick County procurement procedures. Awardees typically enter into a one-year contract with 4 additional one-year renewal options, dependent on performance and availability of funding. Each year of the award, LBHA staff monitor sub-grantees as required by the grant's specific Conditions of Award to ensure compliance and quality service provision. Sub-grantees are also expected to have regular representation at the Behavioral Health Provider Council meetings.

Monitoring consists of reviewing monthly or quarterly reports and invoices for sub-vendor performance and at least annual site visits. Provider reports are reviewed for overall compliance and progress towards the deliverables detailed in the Conditions of Award, MOU, and/or contract with the sub-grantee. Budgets and invoices are reviewed for allowable

expenses and documentation of line items. Sub-grantees with awards over $100,000 are required to provide a financial audit to the LBHA as well.

Should performance be unsatisfactory or should the sub-grantee demonstrate difficulty meeting performance measures, then LBHA staff will write a Corrective Action Plan outlining improvements that the sub-grantee must make. LBAH staff may develop a Corrective Action Plan when the sub-grantee, as a result of reports or site visits, demonstrates that they are out of compliance with the contract. LBHA staff will then follow up with the sub-grantee about progress towards, and completion of, the corrective actions. If a sub-grantee is consistently unable to fulfill the conditions of the grant award and has not demonstrated progress on a corrective action plan, the award may be re-bid prior to the end of the original contract period in accordance with county procurement policy.

ATTACHMENTS

Frederick County LBHA Councils, Committees, and Workgroups

Frederick County LBHA System Integration Self-Assessment

Frederick County LBHA Cultural and Linguistic Competency Self-Assessment and Strategic Plan

Local Advisory Council Letters of Approval – *pending*

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