Families Blossom Service Array Report: Substance Use Disorder Recommendations

Reporting Period: April 1, 2017-September 30, 2017

Provided to the Maryland Department of Human Services, Social Services Administration
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EXECUTIVE SUMMARY

Background

The Department of Human Services, Social Services Administration (DHS/SSA) identified substance use disorders (SUDs) as a priority area of focus for service array development as part of the Families Blossom initiative. DHS/SSA requested that The Institute for Innovation & Implementation (The Institute) at the University of Maryland, School of Social Work research and identify evidence-based or promising programs that address parental SUDs; assess jurisdiction-level need, interest and capacity; and then develop a set of recommendations for SUD model funding and implementation.

Process and Methods

The Institute developed an initial list of appropriate evidence-based and promising program models by reviewing various registries; contacting the model developers and purveyors; reviewing written materials; determining whether the intervention was manualized and whether training, tools and technical assistance were available to support implementation; gathering the requirements for implementation; and quantifying the costs associated with initial and ongoing implementation. Through an iterative and collaborative process with DHS/SSA, two evidence-based models, Adult Focused Family Behavior Therapy (FBT) and Sobriety Treatment and Recovery Team (START), were selected for implementation. The Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) model was also selected because of DHS/SSA's interest in identifying a cross-system collaborative framework.

In order to develop jurisdiction-level recommendations, The Institute collected and triangulated data from a number of sources, including administrative records and survey data that assessed LDSS interest and capacity to implement the models under consideration.

Findings

The following jurisdictions identified high interest, high need, and sufficient capacity to implement the identified SUD models:

Model	Jurisdictions
SAFERR	Allegany County Calvert County Cecil County Charles County Dorchester County Howard County

Model	Jurisdictions
	Kent County Prince George's County Talbot County
FBT	Charles County Frederick County Howard County Prince George's County Worcester County
START	Anne Arundel County Baltimore County Carroll County Cecil County Garrett County Harford County Prince George's County Washington County

These jurisdictions are considered priority in order to respond to the opportunity created by Families Blossom in a timely way. DHS/SSA should also consider additional strategies to support implementation of high need/low feasibility jurisdictions. See the table below titled *LDSS SUD Model Interest, Capacity and Resources for* additional detail on existing jurisdiction-level resources. Per request of DHS/SSA, a key aspect of capacity unique to each model is highlighted: multi-disciplinary workgroups (SAFERR), treatment providers (FBT), and peer mentors/recovery specialists (START). In addition, the table provides information regarding other jurisdiction-level EBPs funded through Families Blossom. Note that cells color-coded in dark green represent jurisdictions with high need and high capacity to implement the SUD model while light green cells represent jurisdictions with high need but low capacity to implement. This table provides a snapshot of key indicators relevant for consideration during implementation planning.

The three models recommended for implementation are only a portion of the necessary SUD service array in Maryland. These models do not address adolescent substance use nor do they address capacity for interventions such as medication-assisted treatment or prevention initiatives. As DHS/SSA works with the LDSS to implement these models, there remains work to be done with the Maryland Department of Health and other partners to support increased access to and availability of effective home- and community-based interventions for SUDs.

Recommended Next Steps

The Institute recommends DHS/SSA consider the following steps to move forward. Model-specific next steps are provided in the table below titled *SUD Model Implementation Requirements, Costs, and Recommended Model-Specific Next Steps*.

1. Make final decisions on which jurisdictions are best suited to implement which of the three models.
2. Share next steps of selected jurisdictions and implementation plans at upcoming SUDs Workgroup.
3. The Institute contacts the three model developers to request specific proposals and scopes of work to implement models in select jurisdictions.
4. The Institute facilitates meetings with the selected LDSS and Core Service Agencies/ Local Addiction Authorities to discuss local plans to implement the selected models.
5. DHS/SSA identifies an individual with knowledge of SUD interventions who can provide on-site technical assistance and implementation support, to support implementation, coordination, and sustainability. This individual could be employed by DHS or a partner agency.
6. The Institute drafts a Request for Information or Request for Proposals for DHS/SSA to solicit interest from providers on the FBT model in selected jurisdictions.

LDSS SUD Model Interest, Capacity, and Resources

Jurisdiction	SAFERR		FBT		START		Existing FB-funded EBPs
	Juris. Request	Multi-discipinary workgroup	Juris. Request	Community MH or SUD provider	Juris. Request	Peer mentor or recovery specialist	
Allegany	**Yes**	✓	**Yes**		**Yes**		• IY; IY Dina • Seeking Safety • FFT
Anne Arundel	No		No		**Yes**		• FFT • PCIT
Balt. City	No	✓	No		No		• SBC
Balt. Co.	No	✓	No		**Yes**	✓	• PfS FFT
Calvert	**Yes**	✓	No		No		• TF-CBT
Caroline	**Yes**	✓	No		No		• Families in Recovery
Carroll	No		No	✓	**Yes**		• FFT
Cecil	**Yes**		No		**Yes**		• TF-CBT
Charles	**Yes**		**Yes**	✓	No		• SBIRT • Healthy Familes • TREM
Dorchester	**Yes**		No		No		
Frederick	No		**Yes**		No		• MST • ZTT/Safe Babies Court
Garrett	No		No		**Yes**		• IY • FFT
Harford	No	✓	No		**Yes**		• FFT • NPP • Healthy Families America
Howard	**Yes**		**Yes**		No		• FFT
Kent	**Yes**		No		No		• NPP
Montgomery	**Yes**		No		**Yes**	✓	
Prince George's	**Yes**		**Yes**	✓	**Yes**		• Strengthening Families • MST
Queen Anne's	No		No	✓	**Yes**		• NPP
Somerset	No		No	✓	**Yes**		• Strengthening Families
St. Mary's	No		**Yes**		**Yes**		• Nurturing Heart • Strengthening Families
Talbot	**Yes**		No		No		• NPP
Washington	No		**Yes**	✓	**Yes**		• Bester COH • MST • Restorative Parenting • STEPS • TF-CBT
Wicomico	No		No		No		
Worcester	No		**Yes**	✓	No		

Note: BHA has funding for recovery support coordinators in the following jurisdictions: Worcester, Baltimore City, Baltimore County, Washington, Prince George's. Additionally, multi-disciplinary teams are present in every jurisdiction but the focus is typically on child abuse investigations, rather than SUDs exclusively.

SUD Model Implementation Requirements, Costs, and Recommended Model-Specific Next Steps

SUD Model	Implementation Requirements	Implementation Costs	Next Steps
Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)	**Training/TA** • No formal training • Technical assistance available from the National Center on Substance Abuse and Child Welfare **Staffing** • Child welfare staff • Alcohol and drug providers • Courts	None identified: materials and TA are provided free of charge through the National Center on Substance Abuse and Child Welfare.	• Identify jurisdictions that have a need to develop or strengthen cross-system collaboration. • Work with LDSS to identify key stakeholders to participate in the workgroup. • Work with the National Center on Substance Abuse and Child Welfare to procure materials and develop a plan for ongoing TA.
Adult Focused Family Behavior Therapy (Adult-Focused FBT)	**Training/TA** • 3-day initial training plus weekly/biweekly follow-up calls • 2 booster trainings between 2-6 months later • Certification in FBT • Cohort of 4-8 therapists **Staffing** • Therapist (State licensed mental health professional) • Supervisor (State licensed mental health professional)	• Training costs o Trainer fee: $175-200/hr. o Manual: $33 • Payment to providers for time spent on training/certification and reporting data • Medicaid billable services • Additional costs o Drug screening/testing o Travel time/expenses to home or community setting o Supplemental rate for in-home based setting	• Identify local providers who are interested in and have capacity to provide FBT. • Utilize the existing contract between DHS/SSA and The Institute to have The Institute contract with the FBT developer and pay providers to go through the training and certification process. • Ensure FBT providers are enrolled in Medicaid and have the necessary information and capacity to submit claims for services provided. • Identify the necessary procurement method to provide supplemental rates to

SUD Model	Implementation Requirements	Implementation Costs	Next Steps
			FBT providers for providing services in-home and for maintaining certification and collecting and reporting data to DHS/SSA.
Sobriety Treatment and Recovery Teams (START)	**Training/TA** • 1-2 day initial "nuts and bolts" training plus monthly follow-up calls • On-site needs assessment • TA includes: model coaching, program evaluation support; integrating with peer support staff, child welfare workforce training; engagement with community partners **Staffing** • Child welfare staff • Peer mentor	• Training costs vary depending on number of LDSS and implementation strategies chosen (Consultation fee: $100/hr.) • Peer mentor salary • Child welfare staff salary • START coordinator for Maryland salary • Additional costs o Drug screening/testing o Travel time/expenses to home or appointments	• Confirm which LDSS are interested in this model, based on need for LDSS staff to be trained (versus community provider). • Identify if there are existing and funded peer mentors in the community (i.e. through local addiction authorities, health departments, family and consumer-run organizations, and core service agencies). If not, identify procurement necessary to contract for and support peer mentors. • Identify and implement procurement necessary to contract with the developer for training and TA.

INTRODUCTION AND BACKGROUND

The Department of Human Services, Social Services Administration (DHS/SSA) identified substance use disorders (SUDs) as a priority area of focus for service array development as part of the Families Blossom initiative. The 2015 Families Blossom readiness assessment of local departments of social services (LDSS) showed that parental SUDs was the most commonly cited need, with approximately one-third of LDSS identifying a need for improved SUD prevention and/or treatment services. Additionally, CHESSIE data indicate that one of the most commonly identified factors at the time of a young child's entry into out-of-home care is the presence of a parental SUD.

With technical assistance from The Institute for Innovation & Implementation (The Institute) at the University of Maryland, School of Social Work, DHS/SSA developed the following 3-prong approach to address parental SUDs in Maryland:

1. Create workforce development opportunities to:
    - Understand addiction and recovery
    - Impact maternal health and children and families
    - Increase effective engagement in services
    - Care for drug exposed infants and children
    - Address role of spouses, significant others, and fathers

2. Increase access to existing service systems via learning collaboratives and multi-disciplinary teams.

3. Enhance the current service array by creating a continuum of services, beginning with the prioritization of services for parents of children ages 0-8.

SUDs are also a priority in the work outlined as part of Maryland's Three Branches Institute (3BI) Strategic Plan. The specific goal under 3BI is to *improve early identification of high-risk populations and provide appropriate services to decrease the impact of substance-exposed newborns*. As such, DHS/SSA requested that The Institute research and identify evidence-based or promising programs that address parental SUDs, with a primary focus on parents with children ages 0 to 8. Additionally, The Institute was tasked with providing jurisdiction-level SUD service array recommendations.

PROCESS & METHODS

MODEL IDENTIFICATION

The Institute researched appropriate models that fit the population of focus by searching registries of evidence-based and promising programs, including the National Registry of Evidence-based Programs and Practices (NREPP) and the California Evidence Based

Clearinghouse for Child Welfare (CEBC), and through review of the National Academy of Sciences report, *Parenting Matters: Supporting Parents of Children Ages 0-8* (2016). In addition to the evidence-based interventions that have demonstrated impact, the SAFERR model was included because of DHS/SSA's interest in identifying an intervention that utilizes a cross-system framework.

After interventions were identified, The Institute contacted the model developers and purveyors; reviewed written materials; determined whether the intervention was manualized and whether training, tools and technical assistance were available to support implementation; gathered the requirements for implementation; and quantified the costs associated with initial and ongoing implementation.

The selections initially included two of each of the following types of models outlined in Table 1. The models represent a continuum of services and supports that differ in type and intensity. Models in **bold** are those that were selected for final recommendation.

Table 1. Parental SUD models considered for implementation

MODEL TYPE	***MODEL NAME***
Assessment/Cross-system collaboration	✓ SBIRT ✓ **SAFERR**
Parenting training	✓ Strengthening Families Program ✓ Nurturing Program for Families in Substance Abuse Treatment and Recovery
SUD treatment	✓ **FBT** ✓ MST-BSF
Peer Support/Home visiting	✓ Parent-Child Assistance Program ✓ **START**

Interventions were removed from consideration if they lacked manualization, training, technical assistance, and/or other materials to support implementation. In addition, models were removed from the list if the time commitment or delivery characteristics did not align with DHS/SSA's preferences.

The eight models and the process selection criteria were presented to the LDSS at regional meetings in March 2017. Twenty-two of the 24 LDSS attended the meetings. The Institute then worked with the Families Blossom SUD Workgroup to review feedback from the LDSS on model interest and suitability, conducted additional feasibility research, and obtained input from SSA Executive Leadership. As a result of that iterative process, the SUD interventions under consideration reduced from eight to three, including: Adult-Focused Family Behavior Therapy (FBT), a SUD treatment model; Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR), an assessment/cross-system collaboration model; and Sobriety Treatment and Recovery Teams (START), a peer support/care coordination model (see *Appendix A. Summaries of SUD Interventions under Consideration* for more detail).

DATA UTILIZED

In order to develop jurisdiction-level recommendations, The Institute collected and triangulated data from a number of sources, including administrative and survey data.

Administrative Data. DHS/SSA provided administrative data on 1) child welfare referrals due to a substance exposed newborn (SEN) and 2) out-of-home placements where parental SUDs were identified at the time of removal. Live birth data came from the Maryland Vital Statistics Administration. Data on neonatal abstinence syndrome (NAS) births came from the Maryland Health Services Cost Review Commission.

Survey Data. Webinars featuring each of the three proposed models were held from May-July 2017. The model developers presented overviews and provided an opportunity for questions and answers. Representatives from all 24 LDSS were invited to attend. Additionally, The Institute held a conference call with representatives from KVC Kentucky, an organization that has implemented FBT broadly in Kentucky, and shared lessons learned on contracting, training, referrals, and sustainability using Medicaid.

Participants in the webinars received links to complete online surveys using the Qualtrics platform in order to assess interest and capacity to implement the three SUD models under consideration (see *Appendix B. Substance Use Disorder Intervention Survey* for more detail). Fewer than one-fourth of LDSS participated in the webinars and related survey. In response, The Institute worked with DHS/SSA to send an email to all LDSS containing information on the three models; this email was followed up with an email from the Technical Assistance (TA) Lead for each LDSS that provided model overviews, links to the Qualtrics surveys, and an offer of assistance if there were any questions. The TA Leads provided additional outreach prior to the close of the survey offering assistance offering assistance with survey completion and reminders regarding completion due dates. **A total of 19 of 24 jurisdictions submitted survey responses and 16 completed the NIRN Hexagon Tool ratings.** The jurisdictions that did not respond to the survey (i.e., Calvert, Caroline, Dorchester, Somerset, and Worcester) were contacted once more by the TA Leads to receive input on whether they had interest and capacity to implement any of the models under consideration. **While information for non-survey respondents is limited, The Institute was ultimately able to reach all 24 jurisdictions.**

The Hexagon Tool was developed by the National Implementation Research Network (NIRN) to help sites identify appropriate evidence-based instructional, behavioral, and social-emotional practices to implement with their respective populations. The Hexagon Tool comprises the following six factors for consideration when selecting a practice or innovation to implement[1]:

- **Needs** of individuals;

[1] Blase, Kiser, & Van Dyke, 2013, based on Kiser, Zabel, Zachik, & Smith, 2007 and The National Implementation Research Network (NIRN).

- **Fit** with current initiatives, priorities, structures and supports, and parent/community values;
- **Resource Availability** for training, staffing, technology supports, data systems and administration;
- **Evidence** indicating the outcomes that might be expected if the program or practices are implemented well;
- **Readiness for Replication** of the program, including expert assistance available, number of replications accomplished, exemplars available for observation, and how well the program is operationalized; and
- **Capacity to Implement** as intended and to sustain and improve implementation over time

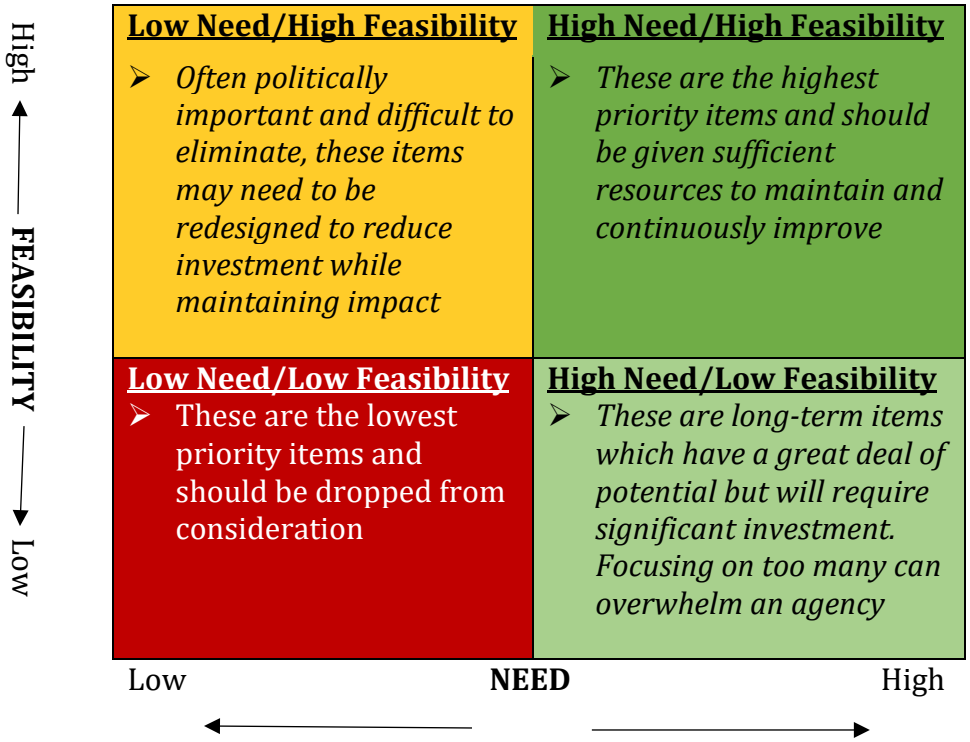
Respondents rate each of the six factors as High, Medium, or Low, as they pertain to implementing a particular practice at a particular site. The High, Medium, and Low ratings yield scores of 5, 3, and 1, respectively, for each factor. The Total Score is computed by taking the mean of the six individual factor scores. Thus, **Total Scores can range from 1-5, with higher scores indicating greater propensity to implement.**

CRITERIA AND STRATEGY FOR DEVELOPING PROGRAM RECOMMENDATIONS

Criteria. The Families Blossom SUD Workgroup determined that **program need and implementation feasibility** should be the criteria used to prioritize LDSS for implementation of the identified SUD interventions. Program need was determined using the LDSS' identified interest in a program as a starting point. If the LDSS expressed interest, then the NIRN Need item was also considered. Implementation feasibility was determined using the NIRN Capacity item. As SUD model implementation preparation begins, additional data sources included within this report will be referred to in order to tailor and guide jurisdiction-level rollout.

Strategy. Recommendations were derived using strategy grids, an approach often used by state and local agencies to make resource decisions. Strategy grids provide a decision making mechanism that considers how to best maximize results given limited resources. The tool is typically used when organizations are transitioning from brainstorming to a more focused plan of action (Duttweiler, 2007). Strategy grids involve setting up two broad criteria that are currently relevant to the agency – in this case, program need and implementation feasibility – and evaluating how well this set of criteria is met across jurisdictions. Using a two by two grid, jurisdictions are placed in the appropriate category based on the quadrant labels. Figure 1 below briefly outlines a set of decision-making recommendations based on this four-quadrant approach. For the purposes of this report, **jurisdictions were placed in the strategy grid if they were within the two actionable quadrants: high need/high feasibility and high need/low feasibility.**

Figure 1. Strategy Grid and Associated Decision Making Recommendations[2]



[2] Figure adapted from National Association of County and City Health Officials. "First Things First: Prioritizing Health Problems." Available at http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf. Accessed September 1, 2017.

ADMINISTRATIVE SUD DATA BY JURISDICTION

Table 2 provides FY15 DHS data on the number and percent of out-of-home placements in which a parental SUD was identified as a factor that was present at the time of placement. The FY15 placement data are broken down by the ages of children in the home and by jurisdiction. The table also provides the number of substance exposed newborn referrals to DHS and the rate per 100 live births by jurisdiction.

Table 2. Maryland out-of-home placements and substance exposed newborns (SENs)

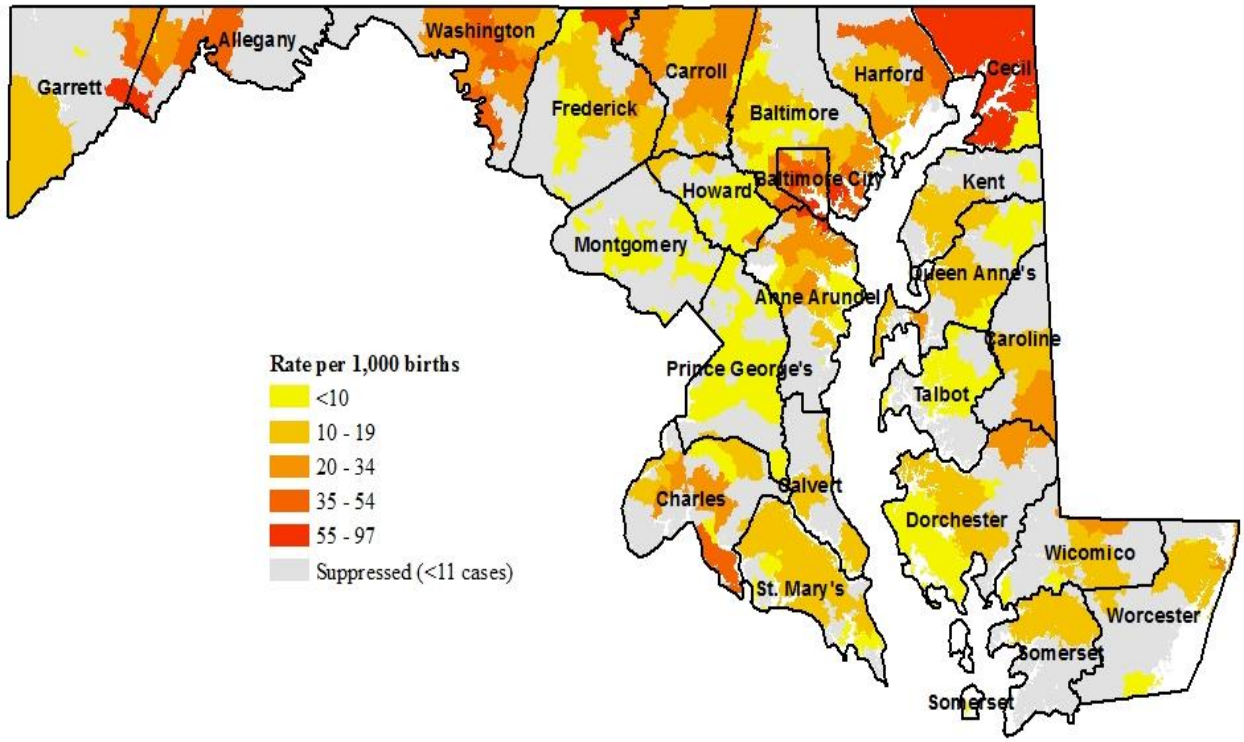
	FY15 Placements				FY16 SENs	
	Ages 0-8		*All Ages*			
Jurisdiction	*Total Placed*	*N (%) with Parental SUD* [1]	*Total Placed*	*N (%) with Parental SUD* [1]	*Total*	*Rate per 100 Live Births* [2]
Allegany	40	36 (90%)	54	46 (85%)	96	14
Anne Arundel	31	26 (84%)	59	40 (68%)	197	2.8
Baltimore City	505	324 (64%)	860	494 (57%)	484	5.6
Baltimore Co.	106	85 (80%)	207	116 (56%)	287	2.9
Calvert	7	7 (100%)	24	19 (79%)	44	4.8
Caroline	5	5 (100%)	8	8 (100%)	10	2.6
Carroll	9	9 (100%)	31	20 (65%)	53	3.1
Cecil	31	26 (84%)	57	37 (65%)	77	6.6
Charles	39	35 (90%)	53	38 (72%)	33	1.8
Dorchester	2	2 (100%)	13	9 (69%)	32	8.4
Frederick	51	37 (73%)	66	43 (65%)	51	1.8
Garrett	24	22 (92%)	35	29 (83%)	33	11.2
Harford	60	48 (80%)	102	66 (65%)	117	4.3
Howard	3	2 (67%)	24	4 (17%)	37	1
Kent	2	0 (0%)	3	1 (33%)	8	**
Montgomery	88	70 (80%)	153	95 (62%)	42	0.3
Prince George's	58	22 (38%)	153	39 (26%)	100	0.8
Queen Anne's	0	NA	1	0 (0%)	15	3.2
Somerset	13	9 (69%)	15	11 (73%)	18	7.5
St. Mary's	37	24 (65%)	48	31 (65%)	40	2.8
Talbot	2	1 (50%)	5	2 (40%)	7	**
Washington	49	47 (96%)	84	69 (82%)	102	6
Wicomico	7	6 (86%)	8	7 (88%)	89	7.2
Worcester	11	10 (91%)	20	14 (70%)	29	6.7
State Total	*1,180*	*853 (72%)*	*2,083*	*1,238 (59%)*	*2,001*	2.7

[1]Parental substance abuse identified by removal factor, CANS, MFRA, or SAFE-C assessment.

[2]Rates based on 2015 MDH Vital Statistics data, which represents the most recent live birth data available by jurisdiction. Rates are suppressed for counts under 10 as the estimates can become unreliable.

Figure 2 provides data from the Maryland Health Services Cost Review Commission regarding the rate of NAS births per 1,000 live births by zip code of residence in Maryland from 2007-2015.

Figure 2. Rate of NAS births per 1,000 births by zip code of residence, Maryland, 2007-2015.



SURVEY FINDINGS BY JURISDICTION

Table 3 provides an overview of the LDSS' expressed interest in the SUD models currently under DHS consideration. The table includes data only for the LDSS that completed the survey. Additionally, the table includes information regarding other interventions or practices the LDSS indicated they would like to see implemented in their respective jurisdictions. Appendix C. *SFY 2018 IV-E Waiver Funded EBPs* includes additional detail on other Families Blossom-funded EBPs by jurisdiction.

Table 3. LDSS-recommended SUD interventions for their respective jurisdictions

Jurisdiction	SAFERR
Allegany	✓
Anne Arundel	
Baltimore City[1]	
Baltimore Co.	
Carroll	
Cecil	✓
Charles	✓
Frederick	
Garrett	
Harford	
Howard	✓
Kent	✓
Montgomery	✓
Prince George's	✓
Queen Anne's	
St. Mary's	
Talbot	✓
Washington	
Wicomico	

[1]Responded to the survey but did not indicate interest in the SUD models under DHS consideration and did not offer other SUD interventions or practices.

Table 4 provides detail regarding the LDSS' existing resources with regard to SUDs, including an existing multidisciplinary workgroupthat meets regularly regarding parent and/or youth SUDs, peer mentors or recovery specialists, potential providers for FBT, and dedicated work force available to implement the SAFERR and START models.

Table 4. LDSS-identified implementation resources

Jurisdiction	Multidisciplinary SUD Workgroup	Peer Mentor or Recovery Specialist	Potential FBT Provider Identified	Dedicated Work Force to Deliver SAFERR	Dedicated Work Force to Deliver START
Allegany	Yes	--	--	No	--
Anne Arundel	No	No	No	No	No
Baltimore City	Yes	No	No	No	No
Baltimore Co.	Yes	Yes	No	Unsure	Yes
Carroll	No	No	Yes	Unsure	Unsure
Cecil	No	No	No	Yes	Yes
Charles	No	No	Yes	No	No
Frederick	No	No	Yes	Yes	Unsure
Garrett	Unsure	No	No	No	No
Harford	Yes	No	No	Unsure	Unsure
Howard	Yes	No	No	Yes	No
Kent	No	No	No	Unsure	No
Montgomery	No	Yes	No	No	Unsure
Prince George's	No	No	Yes	Yes	No
Queen Anne's	No	Unsure	Yes	--	Unsure
St. Mary's	Yes	No	No	No	No
Talbot	No	No	No	No	No
Washington	No	No	Yes	Unsure	Unsure
Wicomico	No	No	No	No	No

Note: BHA has funding for recovery support coordinators in the following jurisdictions: Worcester, Baltimore City, Baltimore County, Washington, Prince George's. Additionally, multi-disciplinary teams are present in every jurisdiction but the focus is typically on child abuse investigations, rather than SUDs exclusively.

SAFERR

Table 5 provides LDSS responses regarding SAFERR using the NIRN Hexagon ratings. A total NIRN composite score is also included.

Table 5. Perceived need and readiness to implement SAFERR

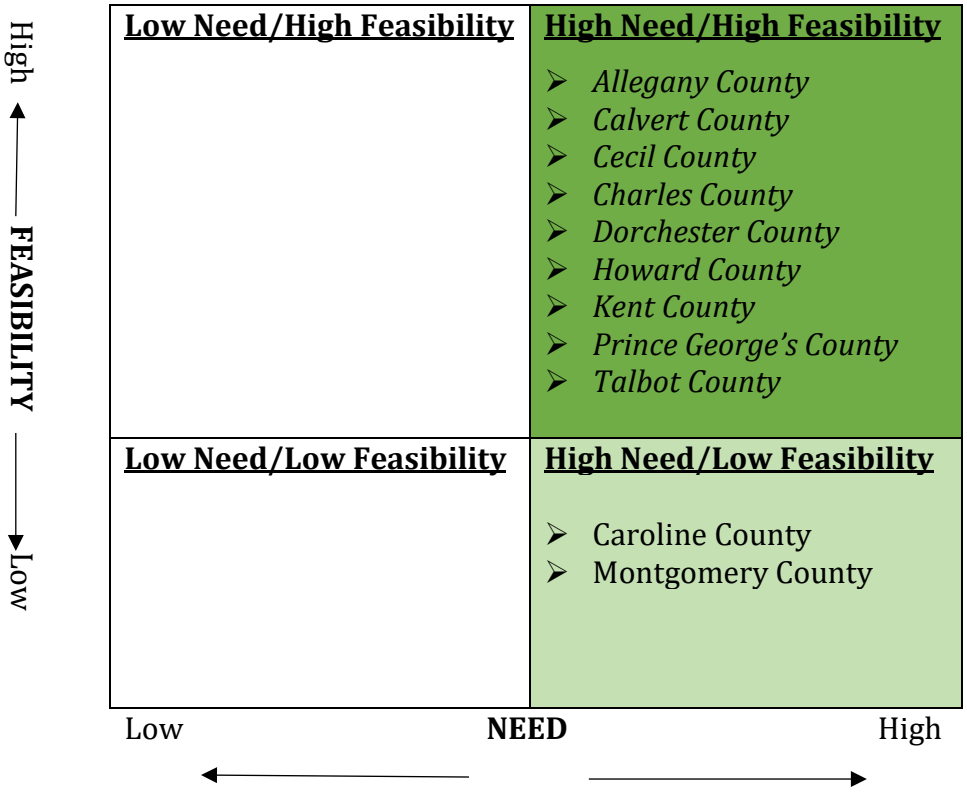
Jurisdiction	NIRN Item Ratings						
	Need	**Fit**	**Resource Availability**	**Evidence**	**Ready to Replicate**	**Capacity**	***NIRN Score (1-5)***
Allegany	--	--	--	--	--	--	
Anne Arundel	High	Low	Med	Low	Low	Med	*2.3*
Baltimore City	Med	Med	Low	Low	Low	Low	*1.7*
Baltimore Co.	High	Med	Low	Low	Low	Low	*2.0*
Carroll	High	High	Med	Med	Med	Med	*3.7*
Cecil	High	Med	Med	Low	Low	High	*3.0*
Charles	High	High	Med	High	Med	High	*4.3*
Frederick	High	High	High	Med	Med	High	*4.3*
Garrett	Med	Low	Low	Med	Med	Low	*2.0*
Harford	High	High	Med	High	Low	Low	*3.3*
Howard	Med	High	Med	Med	Med	Med	*3.3*
Kent	High	High	Med	Med	Med	High	*4.0*
Montgomery	Med	High	Low	Low	Med	Low	*2.3*
Prince George's	High	High	Med	High	High	High	*4.7*
St. Mary's	High	High	Low	High	Low	Low	*3.0*
Talbot	High	Med	Med	Med	Med	Med	*3.3*
Washington	Med	High	Low	Med	Low	Med	*2.7*
Wicomico	--	--	--	--	--	--	--

The LDSS were asked to describe what they hoped to achieve by implementing SAFERR in their jurisdiction. Thirteen jurisdictions provided a response to this item on the survey. Common themes for what they hoped to achieve included:

- Increase cross-system communication and collaboration
- Workforce development for child welfare staff and SUD treatment professionals
- Improve SUD-related client outcomes
- Improve child welfare-related outcomes (e.g., fewer entries and re-entries, permanency for children)

Figure 3 provides a strategy grid representing those jurisdictions who indicated both interest and need for SAFERR. The jurisdictions are broken into quadrants for those with high and low capacity to implement the model. *Note that for this report, data for jurisdictions with low interest and/or need are not captured in the strategy grid, as the focus is on actionable jurisdictions.*

Figure 3. SAFERR Strategy Grid



ADULT-FOCUSED FBT

Table 6 provides LDSS responses regarding FBT using the NIRN Hexagon ratings. A total NIRN composite score is also included.

Table 6. Perceived need and readiness to implement FBT

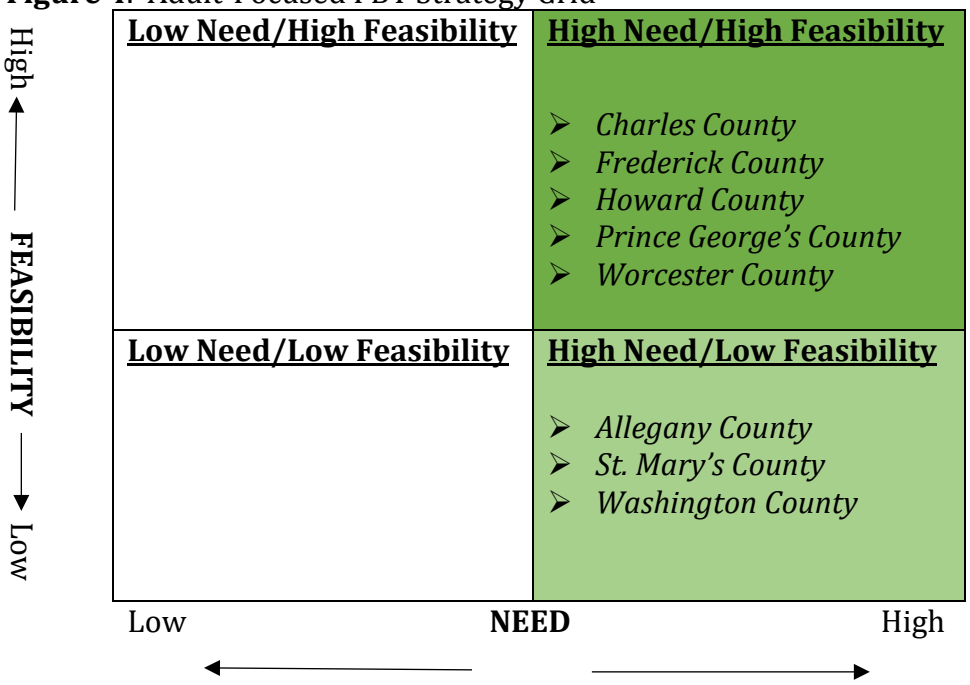
Jurisdiction	NIRN Item Ratings						
	Need	**Fit**	**Resource Availability**	**Evidence**	**Ready to Replicate**	**Capacity**	***NIRN Score (1-5)***
Allegany	--	--	--	--	--	--	--
Anne Arundel	High	Med	Med	Low	Low	Med	*2.7*
Baltimore City	Med	Med	Low	Low	Low	Low	*1.7*
Baltimore Co.	High	Med	Low	Med	Low	Low	*2.3*
Carroll	High	High	Low	Med	Med	Med	*3.3*
Cecil	High	Low	Low	Low	Low	Low	*1.7*
Charles	High	High	High	High	Med	High	*4.7*
Frederick	High	High	High	Med	Med	High	*4.3*
Garrett	Med	Med	Low	Med	Med	Low	*2.3*
Harford	Med	Med	Med	Med	Med	Med	*3.0*
Howard	Med	Med	Med	Med	Med	Med	*3.0*
Kent	Med	Med	Low	Low	Low	Low	*1.7*
Montgomery	Low	Low	Low	Low	Low	Low	*1.0*
Prince George's	High	High	Med	High	Med	Med	*4.0*
Queen Anne's	High	Med	Low	Med	Low	Low	*2.3*
St. Mary's	High	High	Low	High	Low	Low	*3.0*
Talbot	High	Low	Low	Med	Low	Low	*2.0*
Washington	High	High	Med	Med	Low	Low	*3.0*
Wicomico	--	--	--	--	--	--	--

The LDSS were asked to describe what they hoped to achieve by implementing FBT in their jurisdiction. Fourteen jurisdictions provided a response to this item on the survey. Common themes for what they hoped to achieve included:

- Expand treatment services, particularly for clients with co-occurring disorders
- Improve SUD-related client outcomes
- Improve family stability
- Improve child welfare outcomes (e.g., fewer entries and re-entries, timely reunification, reduce foster care placement)
- Identify community providers

Figure 4 provides a strategy grid representing those jurisdictions who indicated both interest and need for FBT. The jurisdictions are broken into quadrants for those with high and low capacity to implement the model. *Note that for this report, data for jurisdictions with low interest and/or need are not captured in the strategy grid, as the focus is on actionable jurisdictions.*

Figure 4. Adult-Focused FBT Strategy Grid



START

Table 7 provides LDSS responses regarding START using the NIRN Hexagon ratings. A total NIRN composite score is also included.

Table 7. Perceived need and readiness to implement START

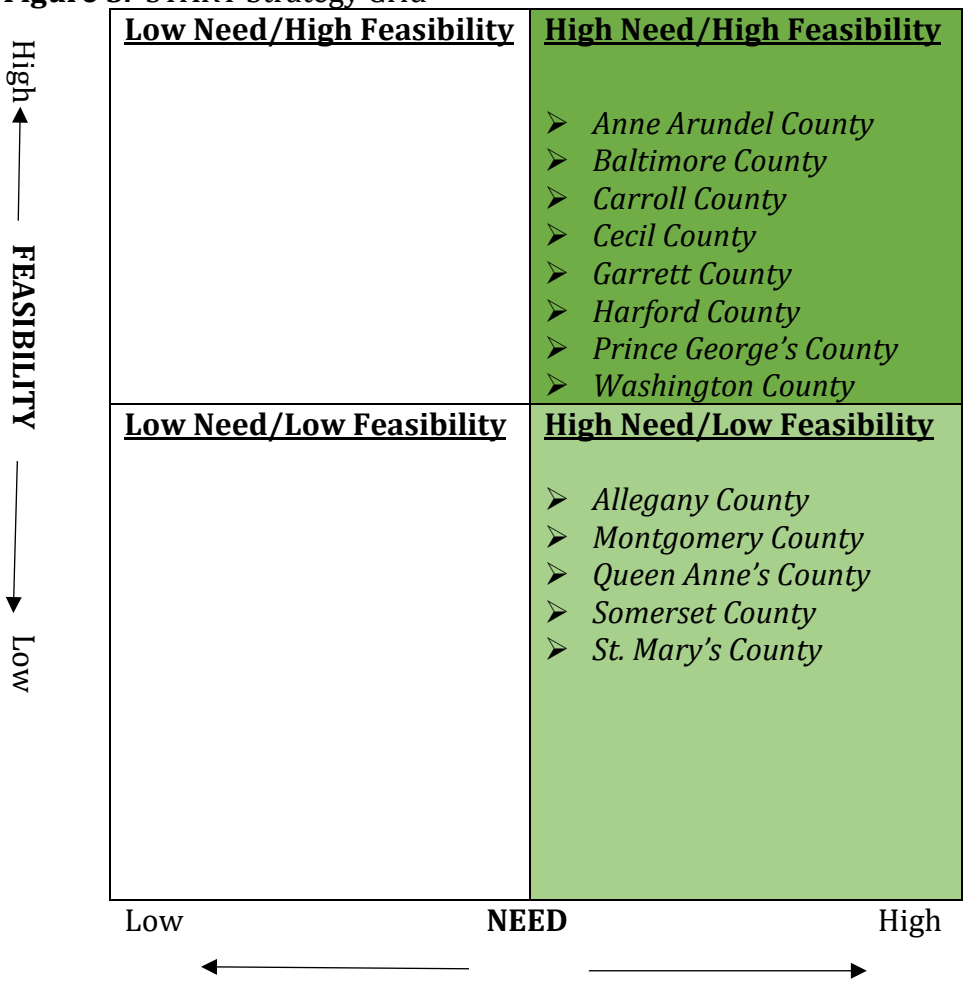
Jurisdiction	NIRN Item Ratings						
	Need	Fit	Resource Availability	Evidence	Ready to Replicate	Capacity	NIRN Score (1-5)
Allegany	--	--	--	--	--	--	--
Anne Arundel	High	Med	Low	Med	Low	Med	2.7
Baltimore City	Low	Low	Low	Low	Low	Low	1.0
Baltimore Co.	High	High	Low	High	High	Med	4.0
Carroll	High	High	Med	Med	Med	Med	3.7
Cecil	High	High	High	Low	Med	Med	3.7
Charles	Med	Low	Low	Low	Low	Low	1.3
Frederick	High	High	High	High	High	High	5.0
Garrett	Med	Med	Low	Med	Med	Med	3.7
Harford	High	High	Med	Med	Med	Med	3.7
Howard	High	High	Med	High	Med	Low	3.7
Kent	Med	Med	Low	Low	Low	Low	1.7
Montgomery	High	High	Med	Low	Med	Low	3.0
Prince George's	High	High	Med	High	Med	Med	4.0
Queen Anne's	High	Med	Med	Med	Low	Low	2.7
St. Mary's	High	High	Low	High	Low	Low	3.0
Talbot	High	Med	Low	Low	Low	Low	2.0
Washington	High	High	Med	Med	Med	Med	3.7
Wicomico	--	--	--	--	--	--	--

The LDSS were asked to describe what they hoped to achieve by implementing START in their jurisdiction. Seventeen jurisdictions provided a response to this item on the survey. Common themes for what they hoped to achieve included:

- Provide quick access to SUD services
- Workforce development for child welfare staff
- Increase collaboration with behavioral health providers and the health department
- Improve SUD-related client outcomes
- Improve child welfare-related outcomes (e.g., decrease out-of-home placements, reduce re-entries, improve well-being)

Figure 5 provides a strategy grid representing those jurisdictions who indicated both interest and need for START. The jurisdictions are broken into quadrants for those with high and low capacity to implement the model. *Note that for this report, data for jurisdictions with low interest and/or need are not captured in the strategy grid, as the focus is on actionable jurisdictions.*

Figure 5. START Strategy Grid



RECOMMENDATIONS

The recommendations presented below are based on the responses provided by the LDSS as well as the limited data available on out-of-home placements and NAS present in live births. **These recommendations are intended to serve as a starting point for decision-making; The Institute strongly encourages DHS/SSA to explore these recommendations with the LDSS and consider other factors when making a final decision, including**:

- whether larger jurisdictions should be prioritized in order to see greater impact;
- whether interventions should be implemented in a range of urban, suburban, and rural environments; and
- whether there are regional economies of scale with regard to implementation of some models.

SAFERR

The SAFERR model was developed by the National Center on Substance Abuse and Child Welfare and technical assistance is provided through them as well. This model is a guide for states and communities serving families with substance abuse disorders in child welfare and court systems. The overarching purpose of this model is to form a collaborative approach between child welfare, alcohol and drug providers, and courts to make collective and informed decisions about parents who use substances and maltreat their children.

As DHS works to address the increased SENS cases and prevalence of addictions issues in Maryland, this model and its structure could serve as a means (by jurisdiction) to create or enhance cross-system collaboration to establish individual and cross-system roles and responsibilities; identify front-line collaborative practice; and, establish and monitor individual and cross-system outcomes.

Training & Cost:

The materials are available at no cost as is limited technical assistance. Additional technical assistance to support implementation at scale may be necessary depending on the needs of each LDSS. There are in-kind costs from the participating agencies, and there may be costs to recommendations that come from these workgroups.

Recommended Next Steps:

- Identify jurisdictions that have a need to develop or strengthen cross-system collaboration.
- Work with LDSS to identify key stakeholders to participate in the workgroup, including families.
- Work with the National Center on Substance Abuse and Child Welfare to procure materials and develop a plan for ongoing TA.

Based on the survey results and qualitative input, the following jurisdictions appear well suited to implement SAFERR based on their high need and high feasibility ratings:

- *Allegany County*
- *Calvert County*
- *Cecil County*
- *Charles County*
- *Dorchester County*
- *Howard County*
- *Kent County*
- *Prince George's County*
- *Talbot County*

ADULT-FOCUSED FBT

FBT is implemented as an outpatient SUD treatment approach that can be delivered in a home- or community-based setting by providers. FBT addresses substance use and co-occurring problems and has demonstrated impact on child and family well-being and reduces parental substance use disorders.

Training:

The developer typically trains 4-6 therapists in one cohort (but will go up to 8 therapists if necessary). The training process includes a 3-day training with weekly, and transitioning to biweekly, follow-up phone calls. Two follow-up booster training are offered between 2 and 6 months. Therapists are expected to record their initial treatment sessions and review these recordings with the trainer. There are 16-18 protocols that therapists must pass at 80% score in order to be certified in FBT.

Start-Up and Ongoing Costs:

Training costs include the trainer fee ($175-$200/hour; est. $4,800 per cohort for initial training, not including coaching) and the cost of the manual ($33/manual). Non-Medicaid reimbursable start-up costs for this service could include:

- Training and follow-up coaching/consultation to the therapist paid to the developer
- The therapist's lost billing hours while training

Providers of FBT can bill Medicaid for the intervention once they are certified. Ongoing expenses that are not Medicaid-reimbursable and which the provider may need to be compensated for include:

- Drug screenings/testing
- Travel time and expenses, if model is done in a home or community setting

Maryland Medicaid's community-based SUD fee schedule[3] limits many of the services to SUD treatment programs, with the place of service limited to the office. FBT may be able to be billed with procedure code H0004 ($20.40 per 15 minute increment) for Individual Outpatient Therapy. Mental Health providers may be able to provide this service under the Maryland Medicaid community-based mental health fee schedule.[4] Licensed mental health professionals may use these codes as appropriate under their scope of practice to provide SUD treatment in mental health clinics or in private practices as long as clients have a SUD diagnosis. This information about financing FBT should be confirmed with Maryland Medicaid.

DHS may want to provide a supplemental rate to the providers who have the capacity to deliver this model in home-based settings since Medicaid does not allow billing in non-office settings for the SUD billing codes.

Recommended Next Steps:

1. **Identify local providers** who are interested in and have capacity to provide FBT within the prioritized jurisdictions as well as across the state, in partnership with the LDSS, Core Service Agencies, and Local Addiction Authorities. Providers should have experience in implementing evidence-based or evidence-informed services, be interested in working with the child welfare population, and be comfortable with providing the intervention in the families' homes, in an office, or in a different community-based setting.

2. **Contract with the FBT developer to train and deliver technical assistance to providers** as they go through the training and certification process. While providers are being trained and certified, **ensure FBT providers are enrolled in Medicaid** and have the necessary information and capacity to submit claims for services provided. [Note: This could be done by DHS/SSA or by a contracted partner.]

3. While providers are being trained and certified, identify the necessary **procurement method to provide supplemental rates** to FBT providers for providing services in-home and for maintaining certification and collecting and reporting data to DHS/SSA and develop and implement a plan for these rates and ongoing data collection.

Based on the survey results and qualitative input, the following jurisdictions appear well suited to implement FBT based on their high need and high feasibility ratings:

- Charles County
- Frederick County
- Howard County

[3] http://maryland.beaconhealthoptions.com/provider/alerts/2016/Copy-of-SUD-Fee-Schedule-09-30-16.pdf
[4] http://maryland.beaconhealthoptions.com/provider/alerts/2016/New-PMHS-Reimbursement-Schedule-EM-Update-10-19-16.pdf

- Prince George's County
- Worcester County

START

The START model is intended to create child welfare system transformation over time, which is aligned with the Families Blossom vision. START is a model that can be implemented in its entirety or by using certain strategies only. The model has a flexible training curriculum once child welfare agencies decide on their priorities and goals. The developer will complete an on-site needs assessment to help the jurisdictions determine where to focus their implementation efforts. The strategies to choose from include the following:

1. System of Identifying Families Affected by Substance Use Disorders
2. Timely Access to Assessment and Treatment Services
3. Increased Management of Recovery Service and Compliance with Treatment
4. Focus on Family Centered Services and Parent-Child Relationships
5. Increased Administrative and/or Judicial Oversight
6. Systematic Response for Participants – Contingency Management
7. Collaborative Approach across Service Systems and the Courts

All of the above strategies are intended to achieve improved outcomes for families in these areas:

1. Recovery – parents accessing treatment faster
2. Children remaining at home
3. Reunification efforts – fewer days in foster care and faster reunification, as appropriate
4. Reduction in repeat maltreatment
5. Reduction in re-entries into foster care

Implementation of the START model will vary significantly by jurisdiction based on the strategies chosen, resources available, and volume and flow of SUD child welfare cases within the LDSS. START is an integrative model that combines best practices among child welfare, behavioral health and family preservation and helps parents achieve recovery while keeping children in their homes and safe. One of the fundamental purposes of this model is to assist with rapid access to substance use disorder treatment while also creating a partnership between child welfare agencies and peer mentors to address presenting addiction issues impacting families.

START is a systems reform initiative and therefore not quickly implemented. Sustainability plans should be discussed up front at the beginning of the planning process. This model helps support good practice and change in local child welfare departments, supported by the availability of formal substance abuse treatment in the community.

Training & Associated Costs
The training is provided by a START consultation team from Kentucky, along with independent consultants from the Center for Children and Family Futures, Inc. Training costs vary by site. The START 101 "nuts and bolts" training costs approximately $1,300 for an initial on-site training and approximately an additional $2,400 to receive consultation over a 6-month period. *It takes 2-4 years to reach full implementation and realize outcomes data with rigorous program evaluation.* Specific pricing for the model will ultimately depend on how many LDSS implement and which strategies they choose to implement. There are different levels of training and therefore different costs that will have to be established after the counties are chosen and needs assessments are completed. The cost will include TA calls, on-site trainings and a site visit. *Discussions with the developer indicated that effective implementation would require a dedicated staff or technical assistance person, available to be onsite locally and who is knowledgeable in SUDS initiatives to support coordination and sustainability.*

Recommended Next Steps
1. Confirm which **LDSS are interested in this model**, including the extent to which the jurisdictions are able to implement this program with fidelity. Child welfare staff will need to be identified and paired with the peer mentors. **Committed leadership and resourced buy-in** and support for systems change is critical.
2. **Identify if there are existing and funded peer mentors** in the community (e.g. those funded through the Health Department or other agencies). If not, identify procurement necessary to contract for and support peer mentors.
3. **Identify and implement procurement** necessary to contract with the developer for the training and TA.

Based on the survey results and qualitative input, the following jurisdictions appear well suited to implement START due to their high need and high feasibility ratings:
- Anne Arundel County
- Baltimore County
- Carroll County
- Cecil County
- Garrett County
- Harford County
- Prince George's County
- Washington County

CONCLUSION & NEXT STEPS

Current recommendations focus on high need/high feasibility jurisdictions in order to respond to the opportunity created by Families Blossom. The prioritization of high feasibility jurisdictions reflects urgency to implement and begin to demonstrate

effectiveness of interventions over the course of the final two years of Maryland's IV-E Funding Waiver. DHS/SSA should also consider additional strategies to support implementation of high need/low feasibility jurisdictions.

The three models recommended for implementation are only a portion of the necessary SUD service array in Maryland. These models do not address adolescent substance use nor do they address capacity for interventions such as medication-assisted treatment or prevention initiatives. As DHS/SSA works with the LDSS to implement these models, there remains work to be done with the Maryland Department of Health and other partners to support increased access to and availability of effective home- and community-based interventions for SUDs.

DHS/SSA and the LDSS should consider the availability, accessibility, quality and effectiveness of prevention; early intervention; individual, family, and group therapies; medication-assisted treatment; recovery support services; and peer services available within each jurisdiction in order to prioritize additional interventions for implementation or expansion.

APPENDICES

APPENDIX A. SUMMARIES OF SUD INTERVENTIONS UNDER CONSIDERATION

Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)
SAFERR is a collaborative model that brings together multiple systems – child welfare, substance abuse treatment, and the courts – to address substance use disorder and child maltreatment. The model focuses on building collaborative structures, establishing individual and cross-system roles and responsibilities, and identifying frontline collaborative practices (Young 2006). Some specific strategies from the model include creating an oversight committee, understanding the work of each system, and creating joint policies for information sharing.

There are no current studies reporting the effectiveness of this model and it is not rated by any evidence-based registries. The model was developed by the National Center on Substance Abuse and Child Welfare (NCSACW), as a training and technical assistance resource. Some of the intended outcomes of this model include substance use disorders being identified more accurately and earlier, higher rates of families entering and completing treatment, and increased family stability, reunification, and well-being.

Family Behavior Therapy (FBT)
FBT is a comprehensive outpatient treatment that addresses substance use disorder within a family context. The intervention has been implemented with various populations including adolescents, adults, and adults involved with child welfare (Donohue, 2009). Treatment usually lasts 6 months to 1 year and consists of 12 to 16 sessions that are 60 to 90 minutes long. Sessions can be conducted in an outpatient setting, in the client's home, or in a group setting. The treatment is skill-oriented and includes topics such as goals and rewards, communication, child behavior management, financial management, self-control, and environmental control.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated FBT as a Level 2 Program, "Supported by Research Evidence," on a 1 to 5 scale, with relevance to child welfare as "High." This categorization is generally considered to indicate a promising program. A few studies have reported that FBT participants showed improvements in drug use, employment/school attendance, family relationships, depression, institutionalization, alcohol use, and child maltreatment potential (Azrin, 1994; Donohue, 2014). A benefit-cost analysis of FBT conducted by the Washington State Institute for Public Policy found that the benefits outweigh the costs for Washington State with a benefit to cost ratio of $4.93 (WSIPP 2017), so that for every dollar the program costs the returned benefit to society is valued at $4.93.

Sobriety Treatment and Recovery Teams (START)
START is a child welfare program for families with parents with substance use disorder and child abuse/neglect. The model pairs a child protective services (CPS) social worker and a family mentor to work with families in providing peer support, quick access to

intensive treatment, and child welfare services. Family mentors have personal experience with the child welfare system and are in long-term recovery from addiction. The pair work intensively with families making several visits each month and engaging them in individualized services.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated START as a Level 3 Program, "Promising Research Evidence," on a 1 to 5 scale, with relevance to child welfare as "High". One study reported that START participants achieved higher rates of sobriety and a lower rate of children placed in state custody (Huebner 2012). In the same study, a cost avoidance analysis showed that for every $1 spent on START, the state of Kentucky avoided $2.22 in out-of-home care costs.

APPENDIX B. SUBSTANCE USE DISORDERS INTERVENTIONS SURVEY
Maryland Title IV-E Waiver

Substance Use Disorders Interventions Survey (Note: Numbers were used for coding purposes only and do not reflect any weighted responses)

Which LDSS jurisdiction do you represent?

- O Allegany County (1)
- O Anne Arundel County (2)
- O Baltimore City (3)
- O Baltimore County (4)
- O Calvert County (5)
- O Caroline County (6)
- O Carroll County (7)
- O Cecil County (8)
- O Charles County (9)
- O Dorchester County (10)
- O Frederick County (11)
- O Garrett County (12)
- O Harford County (13)
- O Howard County (14)
- O Kent County (15)
- O Montgomery County (16)
- O Prince George's County (17)
- O Queen Anne's (18)
- O St. Mary's (19)
- O Somerset County (20)
- O Talbot County (21)
- O Washington County (22)
- O Wicomico County (23)
- O Worcester County (24)

Does your LDSS currently have an interdisciplinary work group that meets regularly regarding parent and/or youth substance use disorders?

- O Yes (1)
- O No (2)
- O Unsure (3)

Did you attend the START webinar, facilitated by the model developers, on 5/24/2017?

- O Yes (1)
- O No (2)

If yes, how helpful was the webinar in relaying information about the model and how it is implemented?

- O Very helpful (1)
- O Somewhat helpful (2)
- O Not at all helpful (3)

What additional information about the model would be helpful for making a decision about whether to implement it in your jurisdiction?

Does your LDSS have a workforce unit that can be dedicated to delivering the START model?

- O Yes (1)
- O No (2)
- O Unsure (3)

Does your LDSS workforce include a recovery specialist or peer mentor?

- O Yes (1)
- O No (2)
- O Unsure (3)

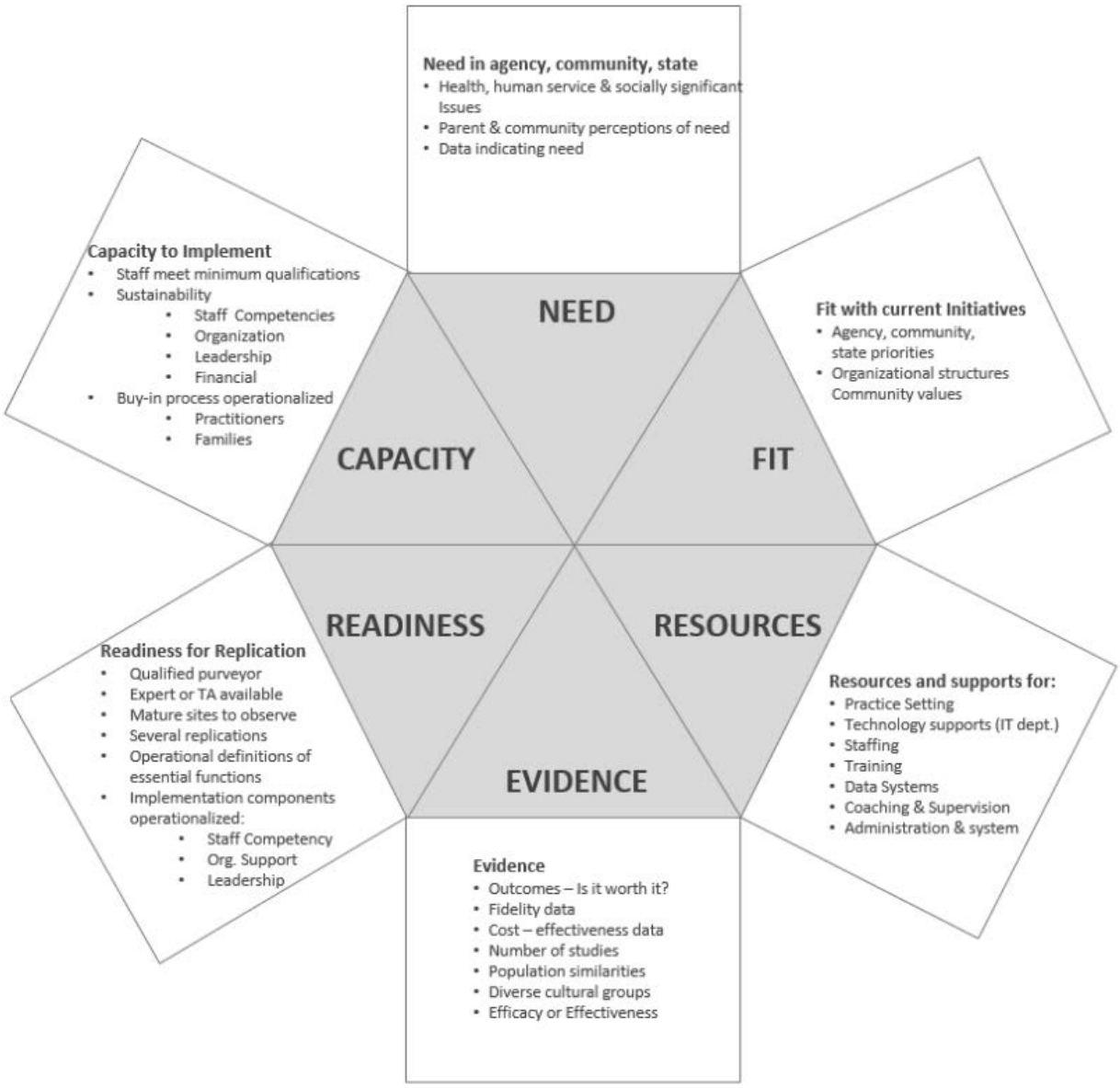
Based on the cases that are served in your jurisdiction, what do you perceive is the level of need to implement the START model in your LDSS?

- O High need (1)
- O Moderate need (2)
- O Low need (3)

Please describe what you might hope to achieve by implementing START in your jurisdiction? (e.g., client outcomes, workforce development, agency responsiveness to client needs, etc.)

Please review the National Implementation Research Network (NIRN) Hexagon Tool below, and rate each of the six factors as they pertain to implementing the START model in your jurisdiction.

	High (1)	Medium (2)	Low (3)
Need	O	O	O
Fit	O	O	O
Resource Availability	O	O	O
Evidence	O	O	O
Readiness for Replication	O	O	O
Capacity to Implement	O	O	O



Did you attend the Adult-Focused Family Behavior Therapy (AF-FBT) webinar, facilitated by the model developer, on 5/31/2017?

- O Yes (1)
- O No (2)

If yes, how helpful was the webinar in relaying information about the model and how it is implemented?

- O Very helpful (1)
- O Somewhat helpful (2)
- O Not at all helpful (3)

What additional information about the model would be helpful for making a decision about whether to implement it in your jurisdiction?

_____

_____

Can you identify a community provider that could potentially deliver the AF-FBT intervention in your jurisdiction?

- O Yes (1)
- O No (2)

If yes, please name this provider:

_____

Is this a mental/behavioral health provider or a substance abuse treatment provider?

- O Mental/behavioral health (1)
- O Substance abuse (2)

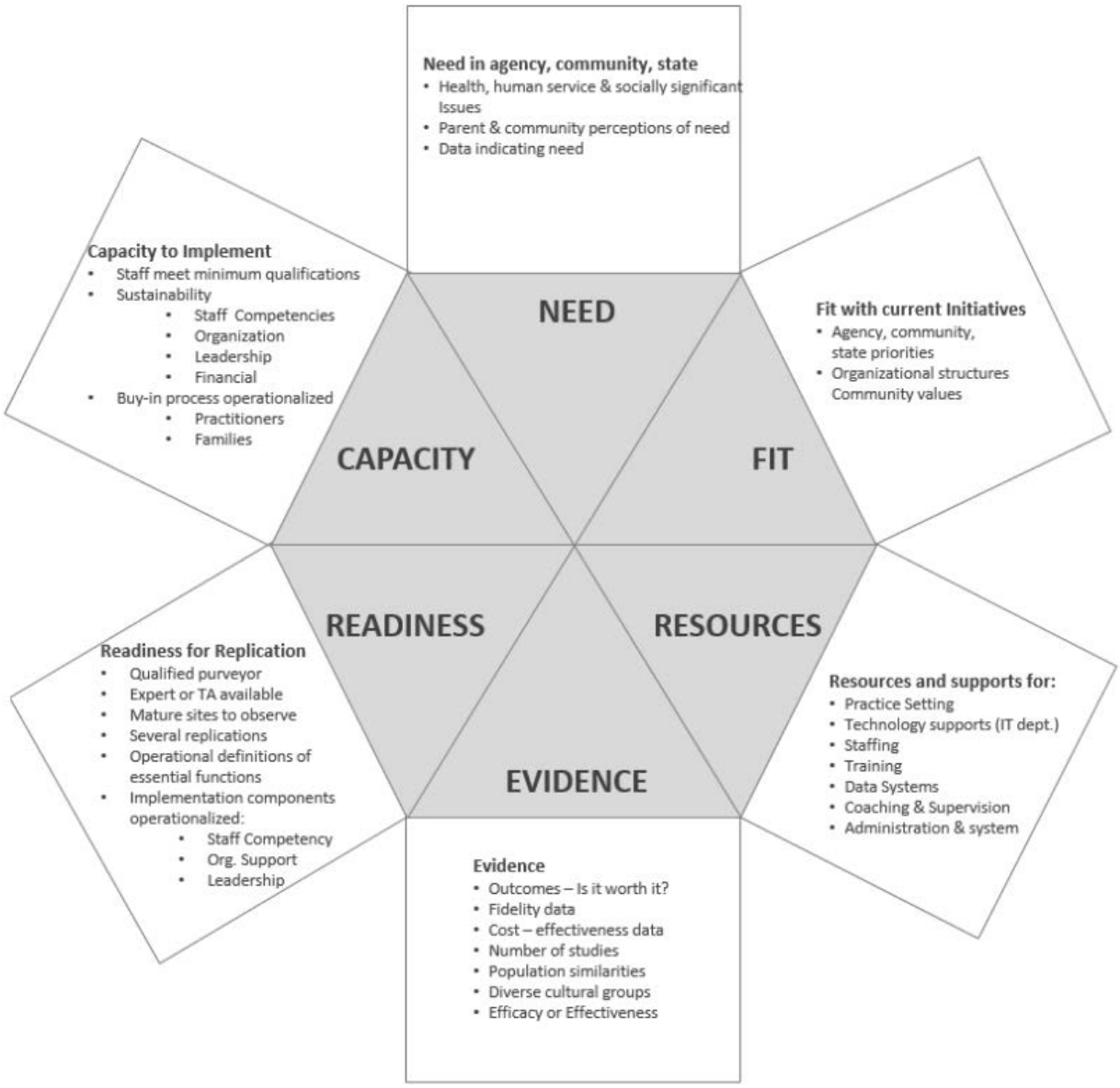
Based on the cases that are served in your jurisdiction, what do you perceive is the level of need to implement the AF-FBT model in your LDSS?

- O High need (1)
- O Moderate need (2)
- O Low need (3)

Please describe what you might hope to achieve by implementing AF-FBT in your jurisdiction? (e.g., client outcomes, workforce development, agency responsiveness to client needs, etc.)

Q21 Please review the National Implementation Research Network (NIRN) Hexagon Tool below, and rate each of the six factors as they pertain to implementing the AF-FBT model in your jurisdiction.

	High (1)	Medium (2)	Low (3)
Need	O	O	O
Fit	O	O	O
Resource Availability	O	O	O
Evidence	O	O	O
Readiness for Replication	O	O	O
Capacity to Implement	O	O	O



Did you attend the Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) webinar, presented by the National Center on Substance Abuse and Child Welfare, on 7/6/2017?

- O Yes (1)
- O No (2)

If yes, how helpful was the webinar in relaying information about the model and how it is implemented?

- O Very helpful (1)
- O Somewhat helpful (2)
- O Not at all helpful (3)

What additional information about the model would be helpful for making a decision about whether to implement it in your jurisdiction?

_____

_____

_____

_____

Does your LDSS have a workforce unit that can be dedicated to delivering the SAFERR model?

- O Yes (1)
- O No (2)
- O Unsure (3)

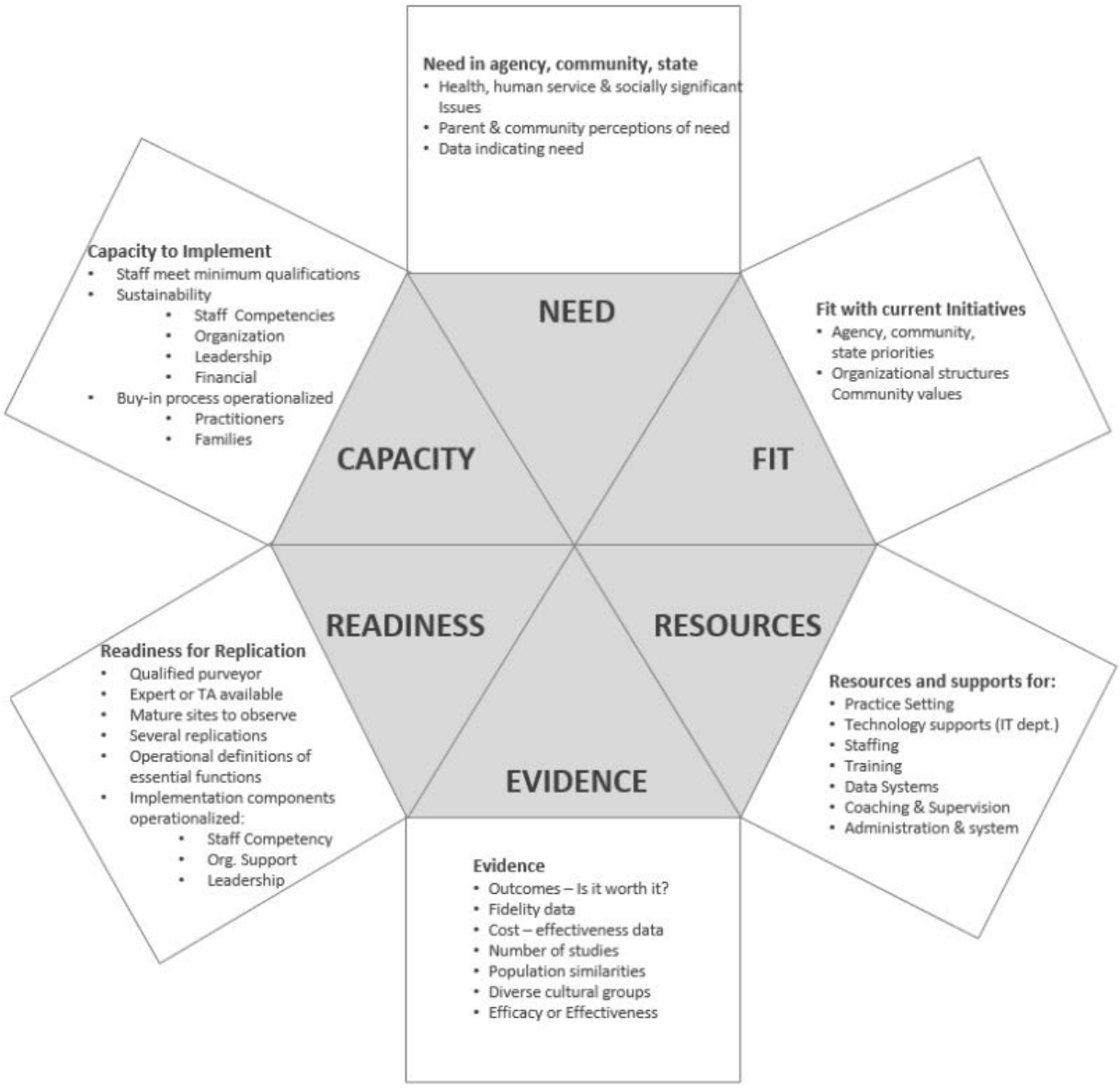
Based on the cases that are served in your jurisdiction, what do you perceive is the level of need to implement SAFERR in your LDSS?

- O High need (1)
- O Moderate need (2)
- O Low need (3)

Please describe what you might hope to achieve by implementing SAFERR in your jurisdiction? (e.g., client outcomes, workforce development, agency responsiveness to client needs, etc.)

Please review the National Implementation Research Network (NIRN) Hexagon Tool below, and rate each of the six factors as they pertain to implementing SAFERR in your jurisdiction.

	High (1)	Medium (2)	Low (3)
Need	O	O	O
Fit	O	O	O
Resource Availability	O	O	O
Evidence	O	O	O
Readiness for Replication	O	O	O
Capacity to Implement	O	O	O



After thinking through various implementation factors and completing the NIRN Hexagons, which SUD model(s) do you believe should be implemented in your jurisdiction? (please select all that apply)

- [ ] Sobriety Treatment and Recovery Teams (START) (1)
- [ ] Adult-Focused Family Behavior Therapy (AF-FBT) (2)
- [ ] Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) (3)
- [ ] Other intervention(s) (4)

Please describe other interventions or practices that you feel may be a good fit for addressing SUD in your jurisdiction.

_____

_____

Thank you!

APPENDIX C. SFY 2018 IV-E WAIVER FUNDED EBPS

SFY 2018 IV-E Waiver Funded EBPs		
County	**Program**	**Category**
Allegany	FFT	Expansion
Allegany	Incredible Years	Current-EBP funded
Allegany	IY Dina Program	Expansion
Allegany	Seeking Safety	New
Anne Arundel	FFT	Current-EBP funded
Anne Arundel	PCIT	Current-EBP funded
Baltimore City	Solution Based Casework	Current-EBP funded
Baltimore County	FFT	Expansion
Baltimore County	Partnering for Success	Current-EBP funded
Calvert	TF-CBT	New
Caroline	Families in Recovery	New
Carroll	FFT	Expansion

Cecil	TF-CBT, school-based	New
Charles	SBIRT	New
Charles	Trauma Recovery and Empowerment Model	New
Frederick	MST	New
Frederick	Safe Babies Court Team	New
Garrett	FFT	Expansion
Garrett	Incredible Years	Expansion
Harford	FFT	Expansion
Harford	Healthy Families America	New
Harford	Nurturing Parenting Program	Current-EBP funded
Howard	FFT	Expansion
Kent	Nurturing Parenting Program	Expansion
Prince George's	MST	New
Prince George's	Strengthening Families	New

Queen Anne's	Nurturing Parenting Program	Expansion
Somerset	Strengthening Families	New
St Mary's	Nurturing Heart	New
St Mary's	Strengthening Families	New
Talbot	Nurturing Parenting Program	Expansion
Washington	Bester COH (TST within it)	Current-EBP funded
Washington	MST	New
Washington	Restorative Parenting	New
Washington	STEPS	Current-EBP funded
Washington	TF-CBT	New

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