Section A: Population of Focus and Statement of Need.

A.1. Population of Focus. The Maryland Healthy Transitions (MD-HT) program will serve individuals in Anne Arundel County and the Mid-Shore Region of Maryland, including Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties (hereafter referred to as "Mid-Shore"). As a next step in Maryland's evolution of behavioral health services for transition-aged youth (TAY), the Behavioral Health Administration (BHA), in partnership with two identified local communities**,** builds upon progress made in the past several years to continue to provide evidence-based, developmentally, culturally, and linguistically competent practices to TAY. The MD-HT focus will be threefold: TAY, ages 16-25, who have a serious mental health condition (SMHC); unidentified TAY who are at risk of developing an SMHC; and the general population who could benefit from increased awareness and education. The services provided through MD-HT will help TAY improve functioning, find education and employment, and connect to a variety of needed resources as they transition into adulthood. The Behavioral Health Administration is looking to expand its target population to also include those with or at risk of a serious mental health condition who also have an intellectual or developmental disability. Some of Maryland's behavioral health community providers have stated that there has been an increase in individuals they are working with that have both a serious mental health condition and an intellectual or developmental diagnosis, indicating that there is a need for programming and supports to target this population.

County	Total Population	Racial/Ethnic Minority	Living in Poverty	Language other than English	Uninsured
Anne Arundel	573,235	31.7%	7.0%	10.7%	5.3%
Caroline	33,193	24.6%	15.3%	6.5%	8.8%
Dorchester	32,162	37.2%	17.4%	5.7%	7.8%
Kent	19,384	21.9%	14.0%	5.1%	8.2%
Queen Anne's	49,770	13.7%	7.3%	5.2%	5.6%
Talbot	37,782	22.4%	10.4%	7.2%	8.0%

A.2. Statement of Need. In Maryland in 2016, 11% of youth ages 16 to 24 were "idle", indicating they were not enrolled in school and were unemployed (The Annie E. Casey Foundation, 2018). Compared to the national data, Maryland youth have higher rates of risky behaviors, including seriously considering attempting suicide (17.3%), planning a suicide attempt (14.4%) or being offered, sold, or given an illegal drug on school property (23.5%, Centers for Disease Control & Prevention [CDC], 2018). TAY ages 16-24 are at an especially high risk for emotional and behavioral disorders, with the average age of onset for many mental health disorders falling within this age range (Arnett, 2006). National and Maryland-specific data suggest that there are service gaps related to TAY with serious mental health conditions and co-occurring disorders (CODs). One of the most striking pieces of data is that despite the prevalence of mental illness and CODs among TAY, youth with these problems access treatment at troublingly low rates. Among youth between 16 and 17, only 39.9% of those with a major depressive episode in the past year received depression treatment. Young adults between 18 and 25 were similarly unlikely to receive treatment; 66.6% with any mental illness did not receive mental health services and 47.0% with SMHCs did not receive services. For those experiencing CODs, 61.2% received no behavioral health treatment, 30.7% received mental health treatment

only, and 2.9% received only substance use treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).
In 2016, Maryland had an estimated 5.4% prevalence rate of non-institutionalized individuals between the ages of 16-20 that reported having a disability (Erickson, Lee, von Schrader, 2017). The 2017 Maryland Special Education Census Data shows that there was a total of 18,653 students, ages 16-21, with any type of disability. Specific to the communities targeted by this grant, Anne Arundel County has a total of 1,359 students with a disability between the ages of 16-21, whereas the Mid-Shore Region has a total of 368 students with a disability between the ages of 16-21 (Maryland Special Education Census Data, 2017). This data is also broken down by disability category and age:

Age	**Total** (include disabilities not listed here)	**Intellectual Disability**	**Emotional Disturbance**	**Multiple Disabilities**	**Autism**
16	7, 151	512	750	1	22
17	6,528	471	720	2	12
18	2,874	400	257	0	16
19	1,160	315	88	0	11
20	851	308	34	1	5
21	89	29	3	1	0

This data only accounts up to age 21 and those individuals in school. There is a need to look also at individuals who are not in school or working. The Governor's Office for Children has a target population that looks at "Disconnected/Opportunity Youth"—youth and young adults, age 16-24, who are not in school or working. These individuals could include youth who are homeless or transitioning from foster care or justice facilities. In Maryland, it is estimated that there are 85,000 disconnected youth, equating to about one in every ten youth that are without schooling or work. Anne Arundel County has been marked as one of the five counties in Maryland with the largest number of disconnected youth, and Dorchester and Caroline have a higher percentage of disconnected youth than the national average. Anne Arundel County has a total of 8,175 disconnected youth, whereas the Mid-Shore region has a total of 2,250. (Governor's Office for Children, 2015). This information is only representative of youth and young adults who are not in school or working but does not account for whether or not they have a serious mental health condition co-occurring with an intellectual/developmental disability.

Section B: Proposed Implementation Approach.

B.1. Describe goals and measurable objectives.

The goals & objectives of MD-HT are to:

GOAL 1. Provide coordinated, high-fidelity evidence-based services and supports that are youth-driven and culturally and linguistically competent to TAY with SMHC in the two local laboratories

OBJECTIVE 1.A: Expand access to evidence-based services and supports including Supported Employment (SE) and Assertive Community Treatment (ACT) for TAY with SMHC in Anne Arundel County and the Mid-shore region.

OBJECTIVE 1.B: Provide ongoing training, fidelity monitoring, and technical assistance for SE and ACT evidence-based practices (EBPs) to providers in each local laboratory, in partnership with the University of Maryland Evidence- Based Practice Center (EBPC).

GOAL 2. Expand and improve on local and statewide infrastructure and cross-agency collaboration to support seamless transition from child to adult systems for TAY with mental health challenges.

OBJECTIVE 2.A: Engage in a continuous feedback loop between MD-HT and the current TAY advisory infrastructure, the Governor's Interagency Transition Council for youth with disabilities (IATC).

OBJECTIVE 2.B: Partner with medicaid to explore opportunities for facilitating seamless transition between child- and adult- serving populations.

GOAL 3. Increase early identification of TAY with mental health concerns, especially those who may otherwise "fall through the cracks."

OBJECTIVE 3.A: Work with EIP to ensure that Regional Early Intervention Teams (EITs) (focused on early identification and intervention for psychosis), are trained in the Maryland Model principles in addressing the specific needs of TAY.

GOAL 4. Promote public awareness of mental health challenges faced by TAY among the general populations in the target regions, including outreach to TAY with or at-risk for developing a SMHC.

OBJECTIVE 4.A: Design and implement public awareness and outreach initiatives locally and statewide with collaboration among the MD-HT Youth/Young Adult Coordinator (YC), Outreach and Education Specialists (OES), and partner organizations including On Our Own of Maryland (OOO-MD), the Maryland Coalition of Families (MCF), MCF's Youth Council called Taking Flight, the Early Intervention Program, and others.

OBJECTIVE 4.B: Work with partner organizations to integrate MD-HT outreach and education efforts with existing efforts around the State, including the Children's Mental Health Matters! Campaign, to ensure the widest possible dissemination.

GOAL 5. Manualize the Transition-aged Youth Maryland Model (TAY MD Model) curriculum.

OBJECTIVE 5.A: Provide ongoing training and technical assistant for the Maryland Model for providers in each learning laboratory in partnership with the University of Maryland Evidence-Based Practice Center.

OBJECTIVE 5.B: Provide fidelity monitoring to each learning laboratory in partnership with the University of Maryland Evidence-Based Practice Center.

B.2. Implementation of Required Activities.

State and Local Infrastructure: We anticipate that achievement of the MD-HT goals will produce meaningful results for Maryland and the local laboratories while supporting SAMHSA's goals for the program. Namely, MD-HT will promote seamless transition to adulthood for TAY in Anne Arundel County and the Mid-Shore, and ultimately statewide, through increased early identification of TAY with or at-risk for SMHC, enhancing linkages to behavioral health services and other evidence-informed supports, and enhancing collaboration between child- and adult-serving agencies locally and at the state level.

Education and Outreach: Education and outreach efforts at the local and statewide levels will be undertaken to increase awareness of the signs of SMHC among TAY and to identify youth in need and provide linkages to appropriate, coordinated, evidence-informed services and supports, including peer and family supports. To coordinate these efforts at the local level, each local laboratory will hire one full-time Outreach and Education Specialist (OES) to spearhead local education and outreach activities in collaboration with the Youth/Young Adult Coordinator (YC). Within six months of the grant award, the MD-HT team will develop a social marketing/communication plan. The plan will build upon existing efforts, described below, and will utilize best practices in social marketing.

Evidence-Based Practices: MD-HT will also work in partnership with the University of Maryland Evidence-Based Practice Center (EBPC). The EBPC was designed to serve as Maryland's infrastructure for dissemination of evidence-based, promising and best practices. Experts in EBPs selected by BHA are hired as consultants/trainers to provide on- and off-site training and technical assistance to providers. MD-HT will utilize multiple consultant/trainers at the EBPC to provide in- kind (State-funded) training, fidelity monitoring, and technical assistance through planning and implementation of SE, ACT, Person Centered Care Planning (PCCP), and the provision of TAY services utilizing the TAY MD Model.

Statewide Expansion: As a strategic step toward statewide expansion, the MD-HT leadership team, in collaboration with stakeholders from the statewide TAY committee, will develop a finance plan to promote the provision of a seamless cross-agency service delivery system and sustainability of the project at the end of year one of the grant. In addition to addressing specific needs of the two implementation communities, and building on the lessons learned from development and implementation of the successful Healthy Transitions Initiative (HTI) and Now is The Time Healthy Transitions (HT), MD-HT will produce meaningful results to support expanded implementation of a more fully integrated continuum of behavioral health care for TAY statewide. MD-HT will provide training to providers in the target communities and across Maryland in improving early identification strategies, including identification and assessment of potential substance use disorders. MD-HT will strategically partner with efforts funded by the 10% set-aside mental health block grant funds for early identification and intervention for psychosis.

State Transition Team: The existing Maryland Transition Age Youth Steering Committee will serve as the MD-HT state transition team. The committee is comprised of key decision makers from state and local youth- and adult-serving systems, including youth, young adults and family members.

Practice Guidelines: We will follow the recommended practice guidelines stipulated by the TAY MD Model as well as the evidence-based, manualized interventions (SE and ACT). Each of the selected interventions has clear practice guidelines and fidelity scales to measure adherence to the guidelines.

Raising Awareness: In order to raise awareness among youth and families in the local laboratories and statewide, MD-HT will work with local and State partners to integrate MD-HT outreach and education messaging into existing social media efforts.

Number of Unduplicated Individuals Served: We project serving 60 youth in year one, and approximately 80 youth per year thereafter for a total unduplicated count of 380. Consistent with the county populations, we expect to serve 74.7% White, 17.5% African American, 7.9% Hispanic or Latino, Asian 4.1% and 3.1% two or more races and 0.1% native Hawaiian or other Pacific Islander TAY in Anne Arundel County. Additionally, we expect to serve 80.5% White, 15.5% African American, 5.7% Hispanic/Latino, 1.2% Asian, 2.1% two or more races, and .1% Native Hawaiian or Pacific Islander in the mid-shore region. Furthermore, we anticipate that 53% female enrollees and 47% male enrollees, with 3.7% identifying as lesbian, gay, bisexual, or transgender (The Williams Institute, 2016). Of the total 380 enrollees, we anticipate that 100% will receive the TAY MD Model intervention, 90% will utilize Supported Employment, 90% will receive clinical treatment services, and an estimated 10% youth will utilize ACT. Anticipated outcomes are positive trends in the four life domains of Education, Employment, Criminal Justice, and Housing, including an increase in paid employment, and a decrease in arrests, hospitalization, and incarceration for MD-HT-enrolled TAY.

B.3. Timeline

Activity Domain	Tasks	2018	2019				2020				2021				2022				2023			
		Pre-Award	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
	Develop a finance plan					X																
	Identify a Transition Team with key decision makers and orient members	X	X																			
	Develop a strategy to coordinate the 10% Mental Health Block Grant early intervention funds with **MD-HT** efforts	X																				
	Develop interagency mechanisms to improve outreach, engagement and service delivery activities	X	X	X	X																	
	Develop social marketing plan	X	X																			
	Biweekly meetings during initial implementation		X	X	X	X																
	Quarterly meetings, ongoing communication and sharing of fidelity monitoring and outcomes						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Write Health Disparities Impact Statement		X	X																		
TAY Maryland Model Service Provider Contracts	Train existing staff with TAY experience; hire and train OES		X	X	X	X																
	Enroll Youth/Young Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Monitor Contract – Use continuous quality improvement to assess TAY Maryland Model fidelity, TAY and family				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

	satisfaction, process and outcomes																					
Evidence-Based Practices	Ensure ongoing coordination with TAY Maryland Model staff and participant access to appropriate EBP eg. SE and ACT as required by individualized plans; Monitor EBP fidelity		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Education and Outreach	Training program staff in outreach and early identification	X	X																			
	Ongoing outreach and early intervention training and technical assistance				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Admin and Reporting	Recruit Project Director – hire pending award	X																				
	Align policy practice and financing across agencies and through local/state/federal partnerships to support and enhance improved outcomes for transitioning youth, support sustainability, and statewide replication						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Data collection, evaluation, performance measurement and quality improvement efforts		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Develop a plan for sustainability after funds expire	X	X	X	X	X																
	Complete and submit final program report																		X	X	X	X

Section C: Proposed Evidence-Based Service/Practice.

Evidence-Based and Evidence-Informed Practices: Despite the growing evidence base to support certain mental health practices, such as EBPs, the vast majority of mental health consumers with SMHC lack access to effective evidence-based rehabilitation and treatment services, such as Supported Employment (SE; Bond et al., 2001; Drake et al., 1999). Maryland is an historical leader in the national movement toward the implementation of EBPs and recovery-oriented practice. It was one of four states in 2001 to initially recognize the opportunities and promise offered by EBPs to positively impact the quality and delivery of mental health services, and to join the Dartmouth-led National Evidence-Based Practice Project (NEBPP), a research and systems change initiative. In recognition of the growing evidence base and effectiveness as a practice model, the TAY MD Model has been selected as the service delivery framework for MD-HT. The TAY MD Model is designed to guide comprehensive, community based services for youth and young adults (16-25 years old) with mental health conditions (as defined by Maryland BHA medical necessity criteria). The proposed model builds from reviews of current relevant literature, studies of best practices related to service provision of TAY, and lessons learned through practices at Maryland BHA Healthy Transitions Initiative (HTI) and Now is The Time Healthy Transitions (NITT-HT) Sites, as these sites serve as exemplar programs for the TAY MD Model. The TAY Maryland Model is specifically developed for working with youth and young adults with emotional/behavioral difficulties and SMHC to provide youth led family supported age appropriate services. Core services, provided to all youth include intensive case management to include individualized multi-systems service coordination (to assist the youth in the process of learning to understand and lead their own interdisciplinary team); guidance in the development of an individualized person centered care plan and skills development in goal setting progress measurement, and maintenance; community based services and relevant skills development delivered in environments of the youth's choosing and comfort level; assistance and guidance in understanding their mental health needs and taking charge/responsibility for treatment choices; providing access to appropriate mental health treatment and services; and guidance in the process of community resource mapping and recognition/understanding of available natural supports. Other structural components of the TAY MD Model include providing access to other available services according to individualized youth interest and need. These service options include but are not limited to high fidelity career development evidence-based or evidence-informed supported employment practices, connections to and coordination with ACT services, Family Psychoeducation, peer support and peer community building services, and or substance abuse services. Although the TAY MD Model involves multiple life domains and synthesizes many evidence-based and evidence-informed practices, certain guiding principles are evident throughout the model, regardless of the specific practice involved. These principles include but are not limited to:

1) Self-efficacy, self-determination, and empowerment, to support motivational enhancement, using evidence-based and evidence informed approaches are employed. **2)** Accessibility and appropriateness, including attention to normative development, using evidence-informed tools to guide implementation, and wherever possible locating services in the community. Services and supports are delivered in a manner that is accessible and appropriate for the population. **3)** Strengths-based, person-centered focus, well described in person-centered plans and subsequent documentation is consistently available and accessible to young adults, staff, and pervading services as verified through multi-tiered fidelity assessment.

4) Youth Voice. A dynamic relationship exists between young adults and other stakeholders in young adults' well-being, including service providers, adult allies, and even policymakers at local and state levels. The greatest threat to this relationship is the absence of genuine representation of youth voice. Effectively emerging practices provide guidance on establishing youth voice in their own services. **5)** Data-based accountability and quality improvement: Program level. TAY MD Service Delivery Model integrates collaboration with and among evidence-based and evidence-informed practices as much as possible, facilitating further opportunities to utilize measurable outcomes. Ongoing measurement of outcomes and use of these data for quality improvement is standard practice. **6)** TAY MD Model programs carefully document achievable individualized goals and steps toward goals, as well as the linkage between goals and medical necessity criteria. Goals are grounded in person-centered planning processes. Data is used to guide services and supports for TAY on an ongoing basis in order to clearly identify progress and success as well as setbacks. **7)** Focus on Education and Employment. Given well established literature on developmental needs of TAY, all services have an overarching mission to identify and assist youth in achieving independence and identity development through competitive employment, education, and other forms of active identity development such as civic or other volunteer roles. Both career and other forms of active identity development includes but is not limited to encouraging and assisting youth in providing support to peers with mental health conditions, and is grounded, as other aspects of the plan, in exploration of strengths and interests of youth.

In large part, due to the initial SAMHSA funded HTI and current MD-HT efforts, Maryland now has substantial experience providing services through utilization of the TAY MD Model and sufficient infrastructure to implement the model with fidelity. Anne Arundel County and the Mid-Shore Region will benefit from this existing infrastructure and will serve as key demonstration sites in the expansion, replication, and sustainability of TAY MD Model and TAY related EBP collaborative efforts.

Section D: Staff and organizational experience.

D.1. Organizational experience. As the State Mental Health Authority, BHA has a broad statutory requirement to oversee provision of mental health services to all citizens of Maryland. In addition to the stakeholders who will form the State Transition Team (described above), BHA has partnered with the following groups to oversee service provision, local and statewide outreach and education initiatives, and evaluation activities:

On Our Own of Maryland (OOO-MD) is Maryland's statewide mental health consumer education and advocacy organization for current or former recipients of mental health services. OOO-MD serves the TAY population through the Transitional Age Youth Outreach (TAY) Project. The mission of the TAY Project is to empower youth with mental health struggles to share their experiences and speak out about the kind of help and services they would like to see within the mental health system where they receive care.

Maryland Coalition of Families (MCF) is Maryland's statewide voice for children's behavioral health, dedicated to building a family-driven network of information and support and improving services in all systems of care for youth and their families. MCF will provide seminars designed to enhance family member knowledge of system resources in the target communities and will provide family navigation services and peer and mutual support.

Maryland Early Intervention Program (EIP) is Maryland's collaborative effort among the University of Maryland School of Medicine Maryland Psychiatric Research Center and the

Department of Psychiatry Divisions of Child and Adolescent Psychiatry, Community Psychiatry, Psychology, and Psychiatric Services Research, and the University of Maryland Baltimore County Department of Psychology. They offer specialized comprehensive programs for the early identification and treatment of adolescents and young adults at risk for or experiencing psychosis.

NAMI-MD will partner with **MD-HT** to expand the Mentor Moms program into the **MD-HT** target communities. Through Mentor Moms, parent mentors introduce new parents to the transition planning process, assist with system navigation, and provide family peer and mutual support.

D.2. Key Personnel.

Project Investigator: Natalee Solomon, MA .25 FTE In-kind**.** Ms. Solomon is Chief of TAY and Young Adult Services for MD' BHA. Ms. Solomon's TAY expertise makes her an ideal fit for the population, with 12 years working in the mental health field. As the Project Investigator, she will be responsible for overseeing all aspects of project execution and monitoring implementation of goals and objectives. She will also be responsible for all required federal reporting and coordination of State strategic planning efforts required to sustain and replicate the project statewide. Serving as State oversight of the program, Ms. Solomon will oversee program functioning and help address any emerging issues at the state level.

State Project Director: TBN, 1.0 FTE. The State Project Director will oversee all aspects of project execution, and will monitor the successful implementation of MD-HT goals and objectives. The State Project Director position will be hired through BHA as a state contractual position. The individual will have a Master's degree in a related field; 4 years of related experience in a supervisory capacity; experience working with Transition-age Youth (TAY) with mental health challenges, and experience coordinating projects across local service systems.

Youth/Young Adult Coordinator: Rowan Powell 1.0 FTE In-kind. Rowan will be responsible for initiating and coordinating the roll out of direct services to Transition-age Youth (TAY) related to the Maryland Healthy Transitions (MD-HT) project. Rowan has worked extensively within the last 5 years in the field of peer support and youth-led advocacy and systems change on county, state, and national levels, aiding organizations in incorporating the youth voice into their policy and operations, and helping young adults connect to and organize opportunities to create an equitable and reciprocal relationship with their service systems.

Evaluator: Sharon Hoover, PhD, .04 FTE. Dr. Hoover serves as the Co-Director of the National Center for School Mental Health and has a 10+ year history of program evaluation with SAMHSA. Dr. Hoover has lead the MD-HT and HTI evaluation efforts since 2009.

Section E: Data Collection and Performance Measurement.

MD-HT will be monitored by a separately-run evaluation team meeting all SAMHSA evaluation requirements. The evaluation team asserts a commitment to comply with all terms and conditions of the national evaluation of the MD-HT program. All data collected will come from TAY self-report and site administrative data. TAY self-report questionnaires will be completed with the site transition facilitators, and returned to the evaluation team through a secure electronic platform.

Collection and Reporting on Required Performance Measures. The evaluation team will collect and report on required performance measures as specified in section I-2.2 of the FOA. Specifically, SAMHSA's Performance Accountability and Reporting System (SPARS)

performance measures from the adult Government Performance and Results Act (GPRA) will be collected including data about mental illness, employment/education, crime and criminal justice, stability in housing, access to services (i.e., number of persons served by age, gender, race and ethnicity), services received, social connectedness, ability to adapt and cope with obstacles, assessment of daily functioning, substance use, and client perception of care. In addition, outcome data for TAY and their families will be collected using the protocol identified by the cross-site evaluation team. As required for the national evaluation, the GPRA and outcome data will be collected at baseline, every 6 months the TAY is enrolled in the program, and at discharge, and entered into the SPARS reporting system.

Local Evaluation Activities: In addition to analyzing data collected for GPRA and the cross-site evaluation, the local evaluation will include a longitudinal interview component across relevant domains selected by the evaluation team. These data include basic demographic information, service utilization, expenditure information, and other domains that assess TAY health and functioning. The evaluation team will examine types and patterns of service utilization and equity in services (to assess any racial, cultural, or geographic disparities). Outcomes for the broader population of TAY will allow the evaluation team to suggest avenues for future intervention, possible adjustments to services to fill any identified gaps in service delivery and assist in informing sustainment and expansion of similar TAY programs statewide. Additionally, the evaluation team will determine qualitative inquiries in collaboration with TAY and site staff.

Local Performance Assessment: As stipulated in Section I-2.3 of the FOA, a performance assessment report will be completed and submitted annually. In addition to analysis of the required performance data above, descriptive information about TAY clients and services will be collected monthly from the BHA management information system. BHA policies and procedures relevant to TAY will be collected and analyzed by the evaluation and leadership teams to identify barriers and suggest efficiencies. A primary purpose of the performance assessment is to ensure input from stakeholders to improve outcomes for TAY and their families, to ensure high fidelity of implementation, and to gain an understanding of how and why mid-course corrections are made.