Mid-Shore Behavioral Health Needs Assessment 2014

Key Findings from National, State, and Regional Demographics, Data, Surveys, & Reports

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Acknowledgements

As in all our needs assessment and planning efforts, the FY2014 Mid-Shore Community Mental Health Needs Assessment is the result of the hard work of many people, particularly the Mid-Shore Mental Health Systems (MSMHS) staff members Erica Horney, Kathy Stevens and Marshall Hallock. There was essential involvement from all groups identified in our mission: consumers, family members, providers, and community leaders. Over the past year, the participation in the process has involved garnering input from stakeholders through our Behavioral Health Services Network quarterly meetings, the monthly workgroup meetings and through electronic survey. The needs assessment information will be used to support planning efforts for the annual Community Mental Health Plan and grant application, and shared with partners to support the same activities in their domain. It is their work together that is culminated into this document. These groups include:

Consumers, Family Members and Advocacy Groups

MSMHS Board of Directors

Regional Behavioral Health Advisory Committee

Consumer Council

Defeating Stigma Coalition

Behavioral Health Services Network (BHSN) & Workgroups

Mid-Shore Roundtable on Homelessness

Provider Agencies

Local Health Systems

Local Health Departments

Local Drug and Alcohol Abuse Councils

Local Management Boards (LMB)

Local Departments of Social Services (DSS)

Eastern Shore Mobile Crisis

Other interested stakeholders and citizens of the Eastern Shore of Maryland

We at MSMHS thank all of you who contributed to the development of this plan and look forward to continued collaboration as we proceed with our goals and future endeavors. Your input and participation, through the group discussions and interactive processes, has been invaluable. We would like to also acknowledge Linda Roy Walls, who coordinator this effort, and incorporated information collected from a wide array of national, state and local information sources to provide a comprehensive perspective on the unique behavioral health needs of our mid-shore community.

Overview of Assessment Format

The purpose of this behavioral health assessment is to provide a user-friendly and straightforward extraction of key findings from national, state, and regional demographics, data, surveys, and plans specific to behavioral health or factors pertinent to effective support of optimal behavioral health for all. Commissioned by Mid-Shore Mental Health Systems, Inc., the Core Service Agency for the five mid-shore counties of Caroline, Dorchester, Kent, Queen Anne's, and Talbot, the most recent documents available during the fall of 2013 were compiled for review. Four categories of information sources emerged:

A. Environmental Scan: Using population, economic, housing, employment, and education data, an overview of key characteristics for each of the five counties of the mid-shore was generated. This assessment component also includes information about shelter housing and well-being indicators from the national Kids Count data center.

B. Quantitative Findings: For national, state, and local organizations that serve individuals with behavioral health-related conditions, a summary of data from reports issued by agencies such as the National Alliance on Mental Illness, State Health Improvement Indicators, Juvenile Services, the Eastern Shore Hospital Center, the University of Maryland School of Pharmacy, the Maryland State Police, and the Core Service Agency.

C. Qualitative Findings: Results from the Maryland Mental Health Survey and from four regional surveys developed by Mid-Shore Mental Health Systems, Inc. are included in this assessment component.

D. Meta-Analysis: This component of the assessment includes key findings from 28 sources of national to local strategic plans and status reports for agencies serving or coordinating services involving individuals with behavioral health needs.

Each summary page of this report includes the information source, authoring agency, document date, and key findings (divided according to strengths and challenges, where appropriate). Beneath the key findings on select pages are tables or graphs to further emphasize content and these are referred to as "illustrations."

A. ENVIRONMENTAL SCAN

Summary of Key Environmental Data Factors such as Population, Ethnicity, Income, Housing, and Poverty

Documents/Data Reviewed

1) Environmental Scan Summary and Data Illustrations, followed by Key Findings; Includes Data From:

- **Quick Facts from ChooseMaryland.org**
- **Free and Reduced Meal Program at Mid-Shore Public Schools**
- **American Community Survey Poverty Data from the U.S. Census Bureau**
- **American Community Survey Housing Data from the U.S. Census Bureau**
- **Industry Employment and Unemployment from the Bureau of Labor Statistics and the MD Department of Labor, Licensing and Regulation**
- **Small Area Health Insurance Estimates**
- **Educational Attainment (High School Diplomas) for People Age 25 and Up**

2) The Emergency and Transitional Shelter Population

3) Kids Count – State Trends in Child Well-Being

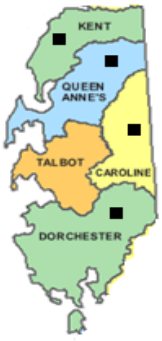
Component: ENVIRONMENTAL SCAN / 1. Summary

GEOGRAPHIC CHARACTERISTICS OF THE AREA

The five counties of the Mid-Shore region of Maryland's Eastern Shore consist of Caroline, Dorchester, Kent, Queen Anne's, and Talbot. Its residents are spread over one thousand seven hundred and seventy-seven (1,777) square miles, or roughly 18% of Maryland's land mass (Source: U.S. Census 2010, Geography QuickFacts). Dorchester is the largest land area in the Mid-Shore. All five counties are predominantly rural and agricultural in nature, but Queen Anne's County was added to the Baltimore–Columbia–Towson Metropolitan Statistical Area, also known as Central Maryland. This is due to the significant population increases, commuter rates of workers to the metro areas, and close proximity of the county to the Baltimore and Washington, D.C. city centers. The five counties all feature major waterways such as the Chesapeake Bay and tributary rivers such as the Choptank, which have helped to position the area rich in maritime and colonial history. As a result, the tourism and hospitality industries are critical to the economy of each county.

Urban Rural Distribution and Mental Health Professional Shortage Designation

The map and chart below captures the portion of the county that is designated rural and federally designated by the Health Resources and Services Administration (HRSA) as a Mental Health Professional Shortage Area (MHPSA) or Medically Underserved Area/Population (MUA/MUP).



County	Rural[1]	MHPSA[2]	MUA/MUP[2]
Caroline	76.0%	Yes	MUA
Dorchester	56.2%	Yes	MUP
Kent	72.6%	Yes	MUP
Queen Anne's	54.5%	Yes	Partial MUA
Talbot	54.7%	No	Partial MUA
State	**12.8%**	----------	----------

Sources: 1. U.S. Census Bureau, 2010 Urban and Rural Classification
2. Health Resources and Services Administration (HRSA) Database

The rural isolation of Mid-Shore counties from the state's urban centers presents challenges in workforce development, infrastructure, and transportation. These issues and their impact on mental health services will be discussed in greater detail in the needs assessment section. The mean time of workforce commute in the table below reinforces the physical distance and spatial challenges inherent to residents of Mid-Shore counties.

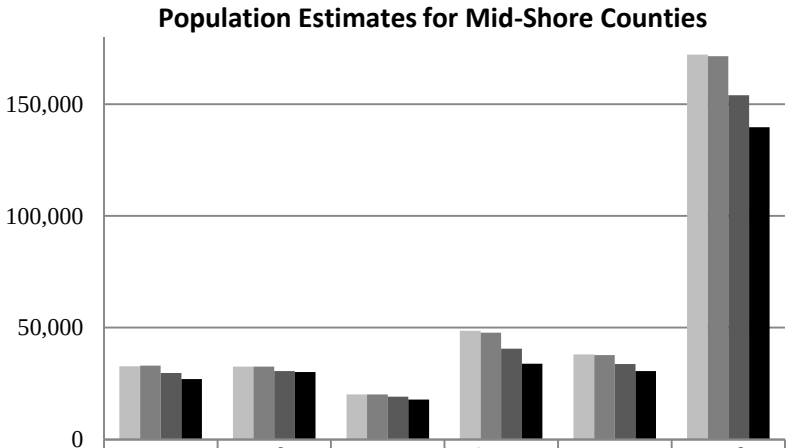
Workforce Commuting – Mean Time		
County	**2005-2009**	**2007-2011**
Caroline	30.8	33.6
Dorchester	24.1	25.3
Kent	24.5	28.1
Queen Anne's	34.2	35.2
Talbot	24.0	24.4
State	**31.1**	**31.7**

Source: U.S. Census Bureau, American Community Survey, Means of Transportation to Work by Selected Characteristics

According to the Census Bureau's 2011 American Community Survey, the State of Maryland ranks third in the U.S. in average commute time following the District of Columbia and New York. The average commute time of Maryland residents for a five-year span was 31.7 minutes for 2007-2011. Queen Anne's County has the highest commute time of all five counties, even exceeding the state average. In current times, gas prices and Bay Bridge toll charges for commuters, which jumped from $2.50 per car in October 2011 to $6.00 per car in July 2013, has propelled county residents to seek employment closer to their area of residence.

DEMOGRAPHICS

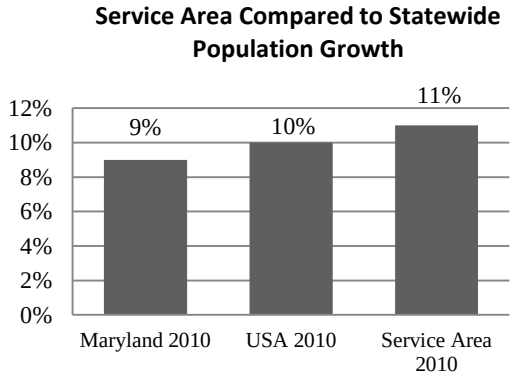
POPULATION

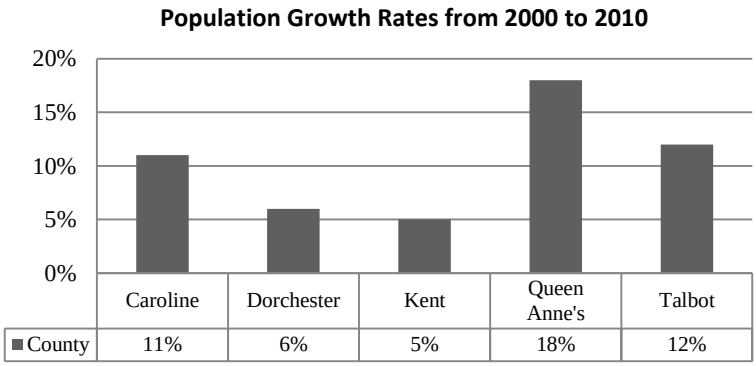


	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid-Shore
2012	32,718	32,551	20,191	48,595	38,098	172,153
2010	33,066	32,618	20,197	47,798	37,782	171,461
2000	29,772	30,674	19,197	40,563	33,812	154,018
1990	27,035	30,236	17,842	33,953	30,594	139,660

Source: U.S. Census Bureau, Population Estimates

The U.S. Census Bureau reported a total population of 171,461 for the five county region in 2010. Queen Anne's County has consistently comprised the largest number of residents for the region estimated at 47,798 (28%) in 2010, while Kent County comprised the least at 20,197 for the same census year. Growth in the number of residents between 2000 and 2010 occurred at a rate of 11% for Caroline County, 6% for Dorchester County, 5% for Kent County, 18% for Queen Anne's County, and 12% for Talbot County. Queen Anne's County has consistently shown the highest population increases between census decades since 1970. The U.S. Census Bureau estimated an additional increase of 1.7% and 0.8% for Queen Anne's and Talbot counties for 2012.



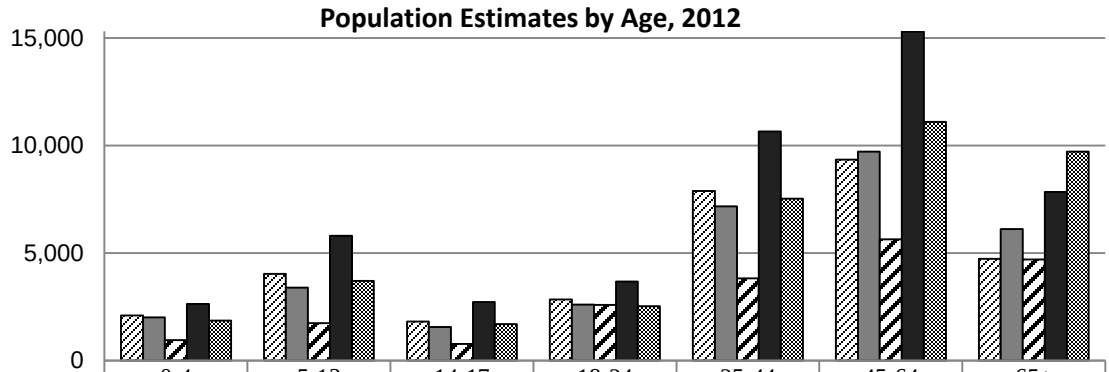


According to Maryland's Department of Labor Licensing and Regulation, the Eastern Shore region is the second fastest growing region in the state since 2000[1]. Service area population grew by 11% from 2000 to 2010, outpacing Maryland's statewide average growth of 9%. The population growth was fueled by Queen Anne's County, the largest service area county which registered an 18% increase, followed by Talbot County which grew by 12%, and Caroline County by 11% over the same period. All three of these counties exceeded the statewide growth rate over this period. Comprising 28% of the service area population and the largest percentage growth rate, Queen Anne's County accounted for about 41% of the growth of the region from 2000 to 2010, followed by Caroline County and Talbot County, 19% and 23% respectively. The U.S. Census Bureau estimates an additional 9.7% regional growth from 2012 to 2020[2].

[1] "The Job Market in Brief", Eastern Shore Region, Maryland Department of Labor Licensing and Regulation
[2] Maryland State Data Center, Population Trends in Maryland

AGE CHARACTERISTICS OF THE MID-SHORE POPULATION

The U.S. Census Bureau estimated nearly 49% of residents in the Mid-Shore region were over the age of 45 in 2012. The single largest age category for the region, approximately 30%, is the 45-64 age range, approximately 51,067 residents. Reflective of the region, the 45-64 age range carries the highest percentage for all five counties.



	0-4	5-13	14-17	18-24	25-44	45-64	65+
Caroline	2,091	4,033	1,809	2,844	7,878	9,340	4,723
Dorchester	2,008	3,380	1,560	2,605	7,172	9,712	6,114
Kent	949	1,743	765	2,581	3,825	5,631	4,697
Queen Anne	2,628	5,805	2,714	3,671	10,643	15,293	7,841
Talbot	1,849	3,707	1,689	2,529	7,525	11,091	9,708

Source: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups

Population Percentages by Age, 2012							
	0-4	5-13	14-17	18-24	25-44	45-64	65+
Caroline	6.4%	12.3%	5.5%	8.7%	24.1%	28.5%	14.4%
Dorchester	6.2%	10.4%	4.8%	8.0%	22.0%	29.8%	18.8%
Kent	4.7%	8.6%	3.8%	12.8%	18.9%	27.9%	23.3%
Queen Anne's	5.4%	11.9%	5.6%	7.6%	21.9%	31.5%	16.1%
Talbot	4.9%	9.7%	4.4%	6.6%	19.8%	29.1%	25.5%
Region	5.5%	10.8%	5.0%	8.3%	21.5%	29.7%	19.2%
State	**6.2%**	**11.4%**	**5.2%**	**9.6%**	**26.8%**	**27.7%**	**13.0%**

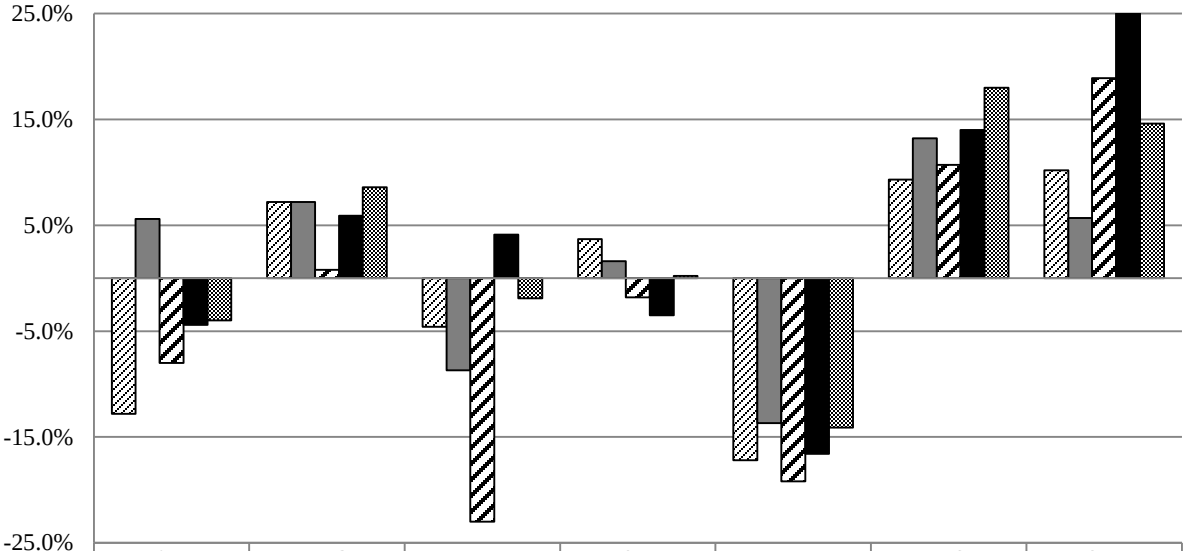
Source: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups

Proportional Population Growth

According to the 2010 Census, the most significant changes from 2009 to 2012 were estimated to occur for those over 25. The age group of 25-44 was predicted to experience an overall decrease over the Mid-Shore region and an increase for the 45-64 and 65 and older categories. Kent County shows the highest percent of change overall with a 23% decrease for those 14-17, a 19.2% decrease for those 25-44, as well as an 18.9% increase for those 45-64 and 65 and older.

Proportional Change in Growth by Age 2009-2012							
	0-4	5-13	14-17	18-24	25-44	45-64	65+
Caroline	-306	272	-87	101	-1,634	795	439
Dorchester	106	227	-149	42	-1,134	1,129	332
Kent	-83	13	-229	-46	-907	544	748
Queen Anne's	-122	324	107	-133	-2,117	1,877	1,568
Talbot	-77	295	-32	6	-1,236	1,690	1,237
Region	-482	1,131	-390	-30	-7,028	6,035	4,324

Population Change in Growth by Age/2009-2012



	0-4	5-13	14-17	18-24	25-44	45-64	65+
Caroline	-12.8%	7.2%	-4.6%	3.7%	-17.2%	9.3%	10.2%
Dorchester	5.6%	7.2%	-8.7%	1.6%	-13.7%	13.2%	5.7%
Kent	-8.0%	0.8%	-23.0%	-1.8%	-19.2%	10.7%	18.9%
Queen Anne's	-4.4%	5.9%	4.1%	-3.5%	-16.6%	14.0%	25.0%
Talbot	-4.0%	8.6%	-1.9%	0.2%	-14.1%	18.0%	14.6%

Between 2010 and 2050, the United States is projected to experience rapid growth in its older population. In 2050, the number of Americans aged 65 and older is projected to be 88.5 million, more than double its projected population of 40.2 million in 2010. The baby boomers are largely responsible for this increase in the older population, as they will begin crossing into this category in 2011. The aging of the population will have wide-ranging implications for the country. As the United States ages over the next several decades, its older population will become more racially and ethnically diverse. Projecting the size and structure, in terms of age, sex, race, and ethnicity, of the older population is important to public and private interests, both socially and economically. The projected growth of the older population in the United States will present challenges to policy makers and programs, such as Social Security and Medicare. It will also affect families, businesses, and health care providers (Source: *The Next Four Decades, The Older Population in the United States: 2010 to 2015, Population Estimates and Projections).*

GENDER CHARACTERISTICS OF THE MID-SHORE POPULATION

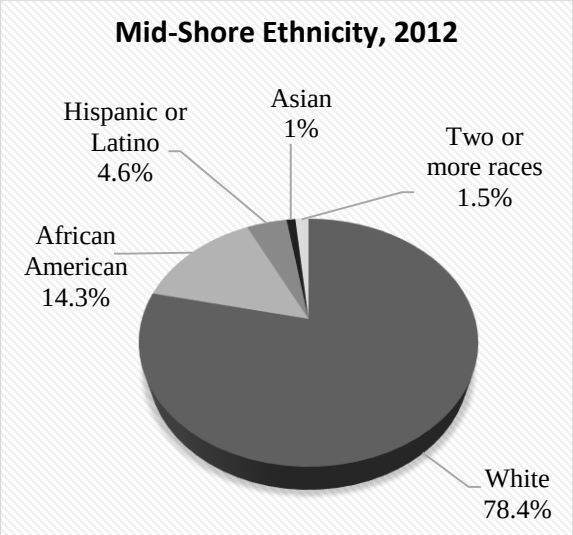
Across the state of Maryland, more females than males live in Maryland. The same is true for all counties of the Mid-Shore region. The greatest percentage difference lies in Talbot County where the U.S. Census predicted 1,828 more females than males, a 4.8% difference. This may be due to the fact that women tend to live longer than men, not necessarily that there are more females being born. If you take a look at Talbot County's 65+ population, it is larger than the other counties in the region and this age demographic may account for the higher female rate as well.

Gender Distribution by County, 2012		
	Female	Male
Caroline	51.5%	48.5%
Dorchester	52.0%	48.0%
Kent	52.2%	47.8%
Queen Anne's	50.3%	49.7%
Talbot	52.4%	47.6%
State	**51.6%**	**48.4%**

Population by Ethnicity

Across the Mid-Shore region, an estimated 78.4% of the population is Caucasian, 14.3% African American, 4.6% Hispanic, and 2.7% from other ethnic backgrounds or from a mixture of backgrounds.

Dorchester County has the highest percentage of ethnicities other than Caucasian. Queen Anne's County has the lowest percentage of total minority residents. The Mid-Shore ethnic distribution is significantly different from the average distribution across Maryland with the state having 53.9% Caucasian and 46.1% minority compared to 78.4% Caucasian and 21.6% minority for the Mid-Shore region. Minority populations have continued to increase over the years. This can be attributed to increased immigration as well as a cultural shift that has prompted acceptance of ethnic diversity.



*Less than 1% American Indian and Alaskan Native, and Pacific Islander

Population by Ethnicity, 2012						
	Caroline	Dorchester	Kent	Queen Anne's	Talbot	**State**
White	77.7%	65.6%	78.2%	87.0%	78.7%	**53.9%**
African American	13.9%	27.4%	14.8%	6.8%	12.7%	**29.1%**
Hispanic or Latino	5.7%	4.0%	4.5%	3.3%	5.7%	**8.7%**
American Indian & Alaskan Native	0.3%	0.3%	0.1%	0.3%	0.1%	**0.2%**
Asian	0.7%	1.0%	1.0%	1.0%	1.3%	**5.9%**
Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Two or more races	1.6%	1.6%	1.4%	1.6%	1.3%	**2.1%**

Source: U.S. Census Bureau, Annual Estimates of the Resident Population by Sex, Race and Hispanic Origin

According to a 2012 report, over 14 million homes in the United States speak a language other than English and 1 in 5 individuals over the age of 5 are taught to speak a language other than English. Therefore, English is only used in 82% of homes in the United States, Spanish is spoken in 10.7% of homes[1]. According to the U.S. Census Bureau, there has also been an increase in the Mid-Shore region of languages spoken in the household other than English.

Percentage Language Spoken at Home				
	English		Language other than English	
	2000	2010	2000	2010
Caroline	95.2%	93.4%	4.8%	6.6%
Dorchester	96.5%	96.0%	3.5%	4.0%
Kent	94.9%	93.4%	5.1%	6.6%
Queen Anne's	95.6%	94.2%	4.4%	5.8%
Talbot	94.3%	93.5%	5.7%	6.5%

Source: U.S. Census Bureau, Selected Social Characteristics

[1] "Increase & Downfall of Languages Spoken in the US", The Language Center, East Brunswick, NJ

INCOME AND POVERTY

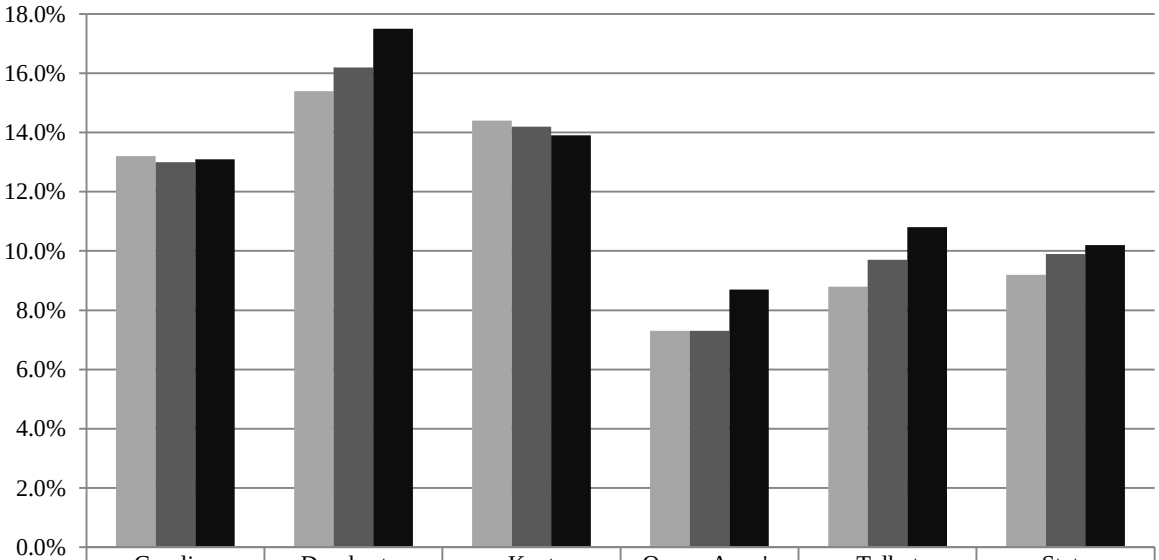
Poverty Rates for Individuals and Families 2011

	All Ages Individuals in Poverty		Ages 5-17 Families in Poverty	
	%	MD Rank	%	MD Rank
Caroline County	13.1	7	20.3	7
Dorchester County	17.5	5	28.7	3
Kent County	13.9	6	20.0	8
Queen Anne's County	8.7	15	10.3	17
Talbot County	10.8	11	15.4	11
State	**10.2**	**---**	**12.7**	**---**

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates

- Individual: Of Maryland's 24 counties, three service area counties, Caroline, Dorchester, and Kent have all consistently been within the top ten poverty rankings over the years, with poverty levels in 2011 ranging from 13.1% to 17.5% of the county population. Although Caroline, Kent, and Queen Anne's counties remained relatively consistent with their ratings, compared to the 2009 calculations, Dorchester and Talbot county percentages each rose by 2%, an increase of approximately 1,678 people within a two-year span for the two counties.
- Family: Dorchester, Caroline and Kent County rank third (28.7%), seventh (20.3%), and eighth (20.0%) highest poverty rate in Maryland.
- All counties except for Queen Anne's exceed the statewide poverty rate for families with children ages 5-17.

Estimated Poverty Rates for All Ages, 2009 - 2011



	Caroline	Dorchester	Kent	Queen Anne's	Talbot	State
2009	13.2%	15.4%	14.4%	7.3%	8.8%	9.2%
2010	13.0%	16.2%	14.2%	7.3%	9.7%	9.9%
2011	13.1%	17.5%	13.9%	8.7%	10.8%	10.2%

Income Statistics

	Median Household Income 2009 [1]		Per Capita Income 2008 [2]		Relative Gini Coefficient MD Rank 1999[3]
	$	MD Rank	$	MD Rank	
Caroline County	$49,050	16	$31,004	22	14
Dorchester County	$43,751	20	$33,654	21	5
Kent County	$50,585	15	$45,593	9	4
Queen Anne's County	$75,146	9	$47,666	6	13
Talbot County	$59,633	14	$58,172	3	1
State	**$69,193**	---	**$48,864**	---	---

	Median Household Income 2010 [1]		Per Capita Income 2010 [2]		Relative Gini Coefficient MD Rank 2006-2008[3]
	$	MD Rank	$	MD Rank	
Caroline County	$55,480	16	$31,282	23	18
Dorchester County	$39,630	21	$34,266	20	3
Kent County	$49,017	18	$44,658	10	5
Queen Anne's County	$78,503	9	$46,732	7	13
Talbot County	$56,806	14	$54,701	3	2
State	**$68,933**	---	**$49,023**	---	---

	Median Household Income 2011 [1]		Per Capita Income 2011 [2]		Relative Gini Coefficient MD Rank 2009-2011[3]
	$	MD Rank	$	MD Rank	
Caroline County	$50,809	16	$32,819	23	16
Dorchester County	$41,936	20	$34,771	21	10
Kent County	$49,795	17	$44,489	13	2
Queen Anne's County	$75,158	10	$49,605	6	18
Talbot County	$55,145	14	$55,721	4	3
State	**$70,075**	---	**$50,656**	---	---

Source: 1. U.S. Census Bureau 2. U.S. Bureau of Economic Analysis 3. American Community Survey

Median Income (all individuals): There is a glaring disparity in the median income of individuals between the counties. The U.S. Census Bureau estimated Queen Anne's County to be the tenth highest in the state for 2011 with a median household income of $75,158, exceeding the statewide average of $70,075. Dorchester County ranked among the bottom five counties, at $41,936 in 2011.

Per Capita Income: Per capita income is a measure of distributable wealth within the counties. Defined by the Census Bureau as the mean income computed for every man, woman, and child in a geographic area, per capita income is an average income figure for the population. Talbot and Queen Anne's are in the top 10 of the state, ranking fourth and sixth, respectively, whereas Dorchester and Caroline County rank within the bottom 10 of the state, ranking 21st and 23rd, respectively.

Relative Gini Coefficient: The Gini coefficient is a relative measure of inequality within an area, as determined by the dispersion of household income across that area. The Gini index measures household

income on a scale from 0-1, with 0 representing total equality and 1 representing total inequality. Kent and Talbot counties rank second and third in the state in having total inequality between 2009 and 2011.

LABOR AND EMPLOYMENT

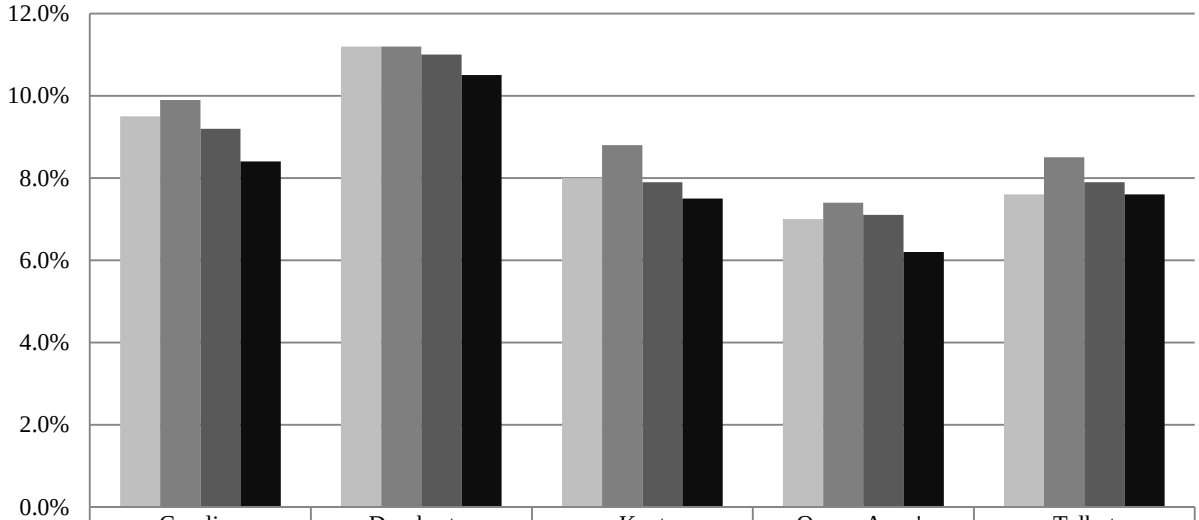
Unemployment Trend Data 2009-2012

	2009		2010		2011		2012	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Caroline	1,559	9.5%	1,678	9.9%	1,547	9.2%	1,388	8.4%
Dorchester	1,894	11.2%	1,950	11.2%	1,888	11.0%	1,779	10.5%
Kent	870	8.0%	980	8.8%	874	7.9%	812	7.5%
Queen Anne's	1,901	7.0%	1,985	7.4%	1,952	7.1%	1,723	6.2%
Talbot	1,428	7.6%	1,601	8.5%	1,496	7.9%	1,428	7.6%
Region	7,652	8.5%	8,194	9.0%	7,757	8.5%	7,130	7.8%
State	**224,002**	**7.4%**	**240,676**	**7.8%**	**224,563**	**7.3%**	**213,058**	**6.8%**

Source: Bureau of Labor Statistics, Not Seasonally Adjusted Unemployment Statistics

Unemployment rates over the region and the state peaked in 2010 and have slowly started to decline during 2011 and 2012. Dorchester County registered as the second highest unemployment rate in the state of Maryland for 2009, 2011, and 2012 with rates of 11.2%, 11.0%, and 10.5%, respectively. Dorchester retained a high unemployment rate in 2010 of 11.2%, but was bumped to the fourth highest rating as the entire state was significantly affected by the Great Recession.

Mid-Shore Unemployment Rates, 2009-2012



	Caroline	Dorchester	Kent	Queen Anne's	Talbot
2009	9.5%	11.2%	8.0%	7.0%	7.6%
2010	9.9%	11.2%	8.8%	7.4%	8.5%
2011	9.2%	11.0%	7.9%	7.1%	7.9%
2012	8.4%	10.5%	7.5%	6.2%	7.6%

Labor Force

The labor force for the state of Maryland registered an increase of 2.8% from 2009 to 2012. The Mid-Shore region registered a 0.9% increase over the same time period with increases in all counties except for Kent, which registered a decrease of 0.2%.

	2009	2010	2011	2012	% Change 2009-2012
Caroline	16,485	16,899	16,736	16,491	.04%
Dorchester	16,935	17,393	17,113	16,945	.06%
Kent	10,909	11,133	11,108	10,886	-0.2%
Queen Anne	27,086	26,969	27,441	27,728	2.4%
Talbot	18,743	18,930	18,973	18,886	0.8%
Region	90,158	91,324	91,371	90,936	0.9%
State	**3,038,182**	**3,071,745**	**3,092,754**	**3,122,629**	**2.8%**

Source: Bureau of Labor Statistics, Not Seasonally Adjusted Unemployment Statistics

COST OF LIVING/HOUSING

Cost of Living and Housing Affordability Indices

Living costs on Maryland's Eastern Shore and in Western Maryland are generally near the national average, and compare favorably with other smaller metropolitan and non-metropolitan areas in the Northeast and Midwest United States.

Cost of Living Index for Maryland Counties in 2011 (US Average 100.0) [1]				**Housing Affordability Indices First Time Home Buyers, June 2013** (Affordable ≥100.0) [2]			
Allegany	86.7	**Queen Anne's**	**106.8**	**Caroline**	**188.4**	Baltimore	110.6
St. Mary's	96.6	Carroll	107.9	St. Mary's	158.9	Anne Arundel	105.0
Dorchester	**97.2**	Harford	108.8	Allegany	138.9	**Queen Anne's**	**101.2**
Washington	98.9	Frederick	109.5	**Dorchester**	**136.7**	Baltimore City	99.3
Wicomico	98.9	Prince George's	110.0	Prince George's	135.9	Somerset	96.3
Baltimore City	99.0	Charles	110.3	Wicomico	134.5	Howard	90.6
Garrett	99.8	Baltimore	110.9	Charles	130.1	Worcester	90.1
Kent	**100.3**	**Talbot**	**111.4**	Washington	124.7	**Kent**	**85.8**
Somerset	101.9	Calvert	112.4	Harford	120.6	Montgomery	81.6
Cecil	103.0	Anne Arundel	117.7	Carroll	120.3	**Talbot**	**74.5**
Caroline	**104.2**	Howard	124.1	Cecil	119.9	Calvert	63.3
Worcester	106.1	Montgomery	127.9	Frederick	111.9	Garrett	56.9

Source: 1. Maryland Department of Business and Economic Development
2. Housing Beat, Volume 2, Issue 8 – June 2013, Maryland Department of Housing and Community Development

- **Cost of Living Index:** As the table shows, the cost of living is below the US average in only one service area county, Dorchester County, 97.2, but higher than US average for Kent, 100.3, Caroline, 104.2, Queen Anne's, 106.8, and Talbot, 111.4.

- **Housing Affordability Index First time Homebuyers:** The First Time Homebuyer Housing Affordability Index measures the percentage of households that can afford to purchase an entry-level home. According to the Maryland Department of Housing and Community Development as of June 2013, three of the five counties are below the housing affordability level: Talbot, Kent, and Queen Anne's, ranking 3rd, 5th, and 10th least affordable. Whereas Caroline County ranks 1st for the greatest affordability. Dorchester, once ranking 9th least affordable, now ranks 4th in greatest affordability, with an index of 136.7.

Properties with Foreclosure Filings in Maryland, 2011

	Housing Units [1]	# of Foreclosures [2]	% of Housing Units in Foreclosure [2]	% of Statewide Foreclosures [2]	Statewide rank [2]
Caroline	13,514	65	0.48%	0.41%	20
Dorchester	16,666	100	0.60%	0.62%	18
Kent	10,604	42	0.40%	0.26%	23
Queen Anne's	20,294	136	0.67%	0.85%	15
Talbot	19,743	80	0.41%	0.50%	19
Region	80,821	423	0.52%	2.64%	--
State	**2,387,194**	**16,048**	**0.67%**	**100%**	--

Source: [1] U.S. Census Bureau, Population Division, Annual Estimates of Housing Units for the United States, Regions, Division, States, and Counties: April 1, 2010 - July 1, 2012

[2] Maryland Department of Housing and Community Development, Property Foreclosures in Maryland, Quarterly Reports, 2011

Change in Median Housing Price from 2009-2011

	2009	2010	2011	Change 09-11
Caroline	175,000	159,950	134,500	-23.1%
Dorchester	150,000	139,950	105,900	-29.4%
Kent	210,000	193,000	207,000	-1.4%
Queen Anne's	285,000	280,000	252,500	-11.4%
Talbot	329,500	300,000	267,000	-19.0%
State	**256,217**	**245,709**	**228,629**	**-10.8%**

Source: Maryland Coastal Association of Realtors, Housing Statistics

Substandard Housing Units, 2009-2011

	Units built 1939 or earlier	Lacking Complete kitchens	Lacking complete plumbing	Overcrowded Units	Total substandard units
Caroline	2,730	41	53	347	3,171
Dorchester	3,449	162	81	249	3,941
Kent	2,133	0	3	62	2,198
Queen Anne's	1,837	17	47	209	2,110
Talbot	3,521	125	47	76	3,769
Region	13,670	345	231	943	15,189
State	**289,120**	**15,434**	**10,068**	**48,689**	**363,311**

Source: U.S. Census Bureau, American Community Survey, Selected Housing Characteristics, 2009-2011, 3 Year Estimates

Renter Occupied Units by County from 2009-2011 and Projected Shortage of Workforce Affordable and Available Rental Housing in Maryland

	Percent Renter occupied 09-11[1]	Shortage of affordable and available rental housing units 2015[2]			
		Families	Seniors	Disabled	Total
Caroline	28.4%	73	126	112	311
Dorchester	31.1%	0	76	112	188
Kent	27.2%	81	137	100	318
Queen Anne's	14.6%	430	26	144	600
Talbot	25.5%	421	171	201	793
Region	24.5%	1,005	536	669	2,210
State	**32.3%**	**80,349**	**20,973**	**28,993**	**130,315**

1. U.S. Census Bureau, American Community Survey, Selected Housing Characteristics, 2009-2011, 3 Year Estimates
2. Maryland Department of Housing and Economic Development, Housing Analysis Report 2005-2009

HEALTH CARE

2009-2011 Health Insurance Estimates

Queen Anne's County has the lowest percentage of uninsured, 6.6%, with Caroline and Talbot counties at the highest for the region at 12.6% and 12.5%, respectively. Kent and Talbot counties have the highest rate of uninsured children under 18 in the region at 6.8% and 5.8%, both exceed the statewide rate.

	All Ages					Children (Under 18)			
	Insured		Uninsured			Insured		Uninsured	
Caroline	28,402	87.4%	4,106	12.6%		7,950	96.3%	304	3.7%
Dorchester	28,495	88.8%	3,590	11.2%		6,782	97.6%	167	2.4%
Kent	17,412	88.0%	2,379	12.0%		3,272	93.2%	237	6.8%
Queen Anne's	44,25	93.4%	3,133	6.6%		11,110	97.7%	263	2.3%
Talbot	32,669	87.5%	4,678	12.5%		6,896	94.2%	427	5.8%
State	**5,060,187**	**89.0%**	**622,676**	**11.0%**		**1,285,312**	**95.3%**	**63,065**	**4.7%**

Source: U.S. Census Bureau, American Community Survey, Selected Economic Characteristics, 2009-2011, 3 year estimates

For those insured through the federal Medicaid system or on means-tested public insurance with eligibility based on income, Caroline and Dorchester counties hold the highest percentages for the region based on three year estimates from 2009-2011. Dorchester County has a significantly higher percentage of children under 18 with Medicaid at 62.2%. Queen Anne's County has the lowest percentage for the region for those insured through Medicaid across all ages, in congruence with its low poverty rating.

	Medicaid/Means-Tested Public Insurance Estimates, 2009-2011	
	All Ages	Children under 18
Caroline	20.3%	42.9%
Dorchester	27.5%	62.2%
Kent	17.5%	41.7%
Queen Anne's	10.5%	19.7%
Talbot	10.9%	30.2%
State	**13.7%**	**28.8%**

Source: U.S. Census Bureau, American Community Survey, Medicaid/Means-Tested Public Coverage, 2009-2011, 3 year estimates

EDUCATION

Drop-Out Rates Grades 9-12

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	**State**
2011-2012	3.07%	3.83%	3.12%	1.37%	1.58%	**3.45%**
2010-2011	3.21%	2.92%	1.67%	1.84%	2.64%	**3.18%**
2009-2010	3.51%	2.10%	1.52%	1.69%	2.17%	**2.54%**
2008-2009	3.90%	3.52%	2.99%	2.07%	2.56%	**2.80%**
2007-2008	4.28%	4.62%	4.98%	2.34%	4.07%	**3.40%**

Source: Maryland State Department of Education, Summary of Attendance, Maryland Public Schools 2010-2011

There was a decline in drop-out rates for all counties through the 2009-2010 school year. Dorchester and Kent counties rates rose over the next two years, with Kent County almost doubling its drop-out rate, while Caroline, Queen Anne's, and Talbot counties' rates were lower in the 2011-2012 school year, compared to 2009-2010. All counties except Dorchester were below the state average in 2012.

Educational Attainment Population 25 years or older

As shown in the chart below, based on three year estimates between 2009 and 2011, the percentage of the population 25 years and over with at least a high school diploma is higher in each of the five counties of the mid-shore region than the statewide percentage, specifically in Caroline and Dorchester counties. However, if you take a look at the percentage of the population with a Bachelor's Degree or higher for both of those same counties, they are significantly lower when compared to the state, with rates of 14.1% and 17.8%, compared to 36.2% statewide. Additionally, Queen Anne's County carries the largest percentage of those in the mid-shore region with the highest levels of education.

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	**State**
Less than 9th grade	5.9%	4.6%	4.5%	1.5%	3.7%	**4.5%**
9th to 12th grade, no diploma	12.8%	12.7%	8.7%	6.3%	6.6%	**7.1%**
High School graduate	39.4%	38.4%	31.2%	31.6%	29.9%	**26.1%**
Some college, no degree	21.2%	21.3%	17.8%	20.3%	19.7%	**19.7%**
Associate's Degree	6.5%	5.3%	6.7%	7.3%	7.3%	**6.3%**
Bachelor's Degree	9.3%	10.2%	18.3%	20.1%	14.9%	**19.9%**
Graduate or professional degree	4.8%	7.6%	12.7%	13.0%	17.9%	**16.3%**

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	**State**
High School Diploma or higher	81.3%	82.8%	86.7%	92.2%	89.7%	**88.3%**
Bachelor's Degree or higher	14.1%	17.8%	31.0%	33.1%	32.7%	**36.2%**

Source: U.S. Census Bureau, Selected Social Characteristics, 2009-2011, 3 year estimates

VETERANS

Based on three year estimates between 2009 and 2011 by the U.S. Census Bureau of the civilian population 18 years and older, there are an estimated 16,845 veterans in the Mid-Shore region, approximately 12.6% of the region's civilian population. Of the five counties of the mid-shore, Caroline, Dorchester, and Kent all exceed the statewide rate for those veterans that are unemployed and below the federal poverty level, whereas Queen Anne's has the lowest percentage for the region, but has the highest number of veterans. According to the U.S. Census Bureau and the National Center for Veterans Analysis and Statistics, the veteran population is projected to decrease nationwide by 8.2 million from 2011 to 2040.

Veteran Status, 2009-2011			
	Civilian Population 18 and over	% Unemployed	% below poverty (12 mo. span)
Caroline	3,075	6.4%	7.7%
Dorchester	3,403	10.2%	7.4%
Kent	1,814	10.1%	6.2%
Queen Anne's	4,344	1.8%	1.9%
Talbot	4,209	5.2%	2.9%
State	**434,199**	**6.0%**	**4.3%**

Source: U.S. Census Bureau, American Community Survey, Veteran Status, 2009-2011, 3 Year Estimates

The chart below indicates the age and gender breakdown for the veteran population across the mid-shore. Caroline County has the highest percentage of female veterans at 9.3% and also the youngest, with the highest percentages for the region in both the 18-34 and 35-54 age groups at 12.6% and 26.4%, respectively. Kent County is estimated to have the highest percentage of veterans in the 75 years and older category at 40.6%.

Veteran Status, Age and Gender, 2009-2011								
	18-34	35-54	55-64	65-74	75+		Female	Male
Caroline	12.6%	26.4%	25.3%	16.7%	19.0%		9.3%	90.7%
Dorchester	4.2%	22.8%	33.2%	21.4%	18.5%		5.1%	94.9%
Kent	0.3%	12.0%	22.4%	24.7%	40.6%		7.9%	92.1%
Queen Anne's	6.3%	22.7%	24.9%	22.9%	23.1%		4.0%	96.0%
Talbot	3.2%	14.8%	21.6%	28.2%	32.2%		6.9%	93.1%
State	**9.3%**	**30.1%**	**23.7%**	**17.5%**	**19.5%**		**10.3%**	**89.7%**

Source: U.S. Census Bureau, American Community Survey, Veteran Status, 2009-2011, 3 Year Estimates

Regarding education, much like the overall region's statistics, Caroline and Dorchester counties hold the lowest percentages for those veterans with a Bachelor's Degree or higher than the other counties, compared to statewide where 34.1% of the veteran population listed Bachelor's Degree or higher as their highest level of education.

Veteran Status, Educational Attainment, 2009-2011				
	Less than high school	High School graduate	Some college or Associates Degree	Bachelor's Degree or higher
Caroline	14.3%	40.2%	33.7%	11.8%
Dorchester	13.7%	38.2%	36.9%	11.2%
Kent	14.8%	30.6%	18.1%	36.5%
Queen Anne's	6.7%	31.0%	28.1%	34.1%
Talbot	6.2%	30.6%	27.1%	36.1%
State	**7.1%**	**26.2%**	**32.6%**	**34.1%**

Source: U.S. Census Bureau, American Community Survey, Veteran Status, 2009-2011, 3 Year Estimates

Component: ENVIRONMENTAL SCAN/ 1. Summary Continued

Report	Source	Date
Environmental Scan Summary	Mid Shore Mental Health Systems	2009-2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Challenges

- Dorchester County has the highest unemployment on the mid-shore and has more than 25% of households with income under $25,000.
- With the exception of Queen Anne's County, all other mid-shore counties have median household incomes lower than the state average of $70,017.
- All counties except for Queen Anne's County exceed the statewide poverty rate for families with children ages 5-17.
- Dorchester, Caroline, and Kent County rank third (28.7%), seventh (20.3%), and eighth (20.0%) highest poverty rate in Maryland.
- According to 2009-2011 Health Insurance Estimates, Caroline and Talbot counties have the highest rates of uninsured residents at 12.6% and 12.5% respectively.
- Among the estimated 16,845 veterans living in the Mid-Shore region, poverty levels and unemployment rates are above the statewide average in Caroline, Dorchester, and Kent Counties.
- Three mid-shore counties far exceed the state average for the percentage of students receiving Free and Reduced Meals.
- The percentage of children living below 200% of poverty increased between 2005-2007 in Dorchester County and Queen Anne's County.
- In Talbot County, the percentage of children living in poverty has fluctuated between 23% (2008-2010) and 32% (2009-2011), but recently seems to be on the rise.
- According to the 2009-2011 American Community Survey on Housing Characteristics, Dorchester County has an estimated 10.1% of residents with no available vehicle.
- Also noted in the survey results, Dorchester County had an estimated 0.6% (81) of residents lacking complete plumbing facilities in their housing unit.
- Kent County has the highest percentage of uninsured children.
- All five mid-shore counties have a higher percentage of uninsured children and youth when compared to the state average.
- For Maryland, the percentage of residents ages 25 and above with a high school diploma is 87.8. Three of the five mid-shore counties fall below the state average.

Illustration

Free and Reduced Meal (FARM) Program Recipients in Public Schools/2012-2013

Category	CAR	DOR	Kent	QA	TAL	MD
Percentage of FARM Students	57.9	62.3	51.8	25.7	38.9	42.9
Number of Farm Students	3,324	2,958	1,104	1,995	1,790	376,303

Source: MarylandHungerSolutions.org

Housing Characteristics and Income for Mid-Shore Residents

Characteristic	Maryland	Caroline	Dorchester	Kent	Queen Anne's	Talbot
NO VEHICLE AVAILABLE	9.60%	3.70%	10.10%	7.60%	2.60%	5.40%
LACKING COMPLETE PLUMBING FACILITIES	0.50%	0.30%	0.60%	0.00%	0.30%	0.30%
OWNER-OCCUPIED HOUSING UNITS WITH A VALUE LESS THAN $50,000	1.60%	3.30%	8.20%	2.70%	0.30%	1.40%
TOTAL MOBILE HOME UNITS	1.80%	8.30%	8.70%	4.50%	2.80%	3.50%
HOUSEHOLD INCOME-LESS THAN $10,000	1.50%	1.30%	1.80%	0.90%	1.20%	2.10%
HOUSEHOLD INCOME-$10,000-$24,999	4%	8.30%	7.20%	10.30%	3.90%	6.80%

Source: American Community Survey, U.S. Census Bureau/ 2010

Component: ENVIRONMENTAL SCAN/ 1. Summary Continued

Report	Source	Date
Environmental Scan 2009-2013	Mid Shore Mental Health Systems	2009-2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Strengths

- Of the mid-shore region, Queen Anne's County is the most populous, has the lowest unemployment rate and the lowest percentage of households with incomes under $25,000.
- Talbot County's median house selling price of $329,500 is the highest on the mid-shore.
- Unemployment rates over the region and the state slowly started to decline in 2011 and 2012.
- The labor force for the State of Maryland registered an increase of 2.8% from 2009 to 2012.
- According to the Maryland State Department of Education, there was a decline in drop-out rates for all counties through the 2009-2010 school year.
- All counties except for Dorchester were below the state average in 2012 for drop-out rates.
- The percentage of children living below 200% of poverty has decreased slightly in Caroline County when comparing 2005-2007 to 2009-2011.
- According to the 2009-2011 American Community Survey on Housing Characteristics in Maryland, Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties had a higher rate of owner-occupied housing units compared to Maryland's rate of 67.7%.
- Also noted in the survey results, Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties had lower rates of housing units with a mortgage compared to Maryland's rate of 76.6%.
- According to the Bureau of Labor Statistics for years 2010-2013, Kent, Queen Anne's and Talbot Counties have experienced significant reductions in rates of unemployment.
- In 2011, Maryland's Industry Employment Fact Sheet showed high numbers of employment in the following areas: Government (9,234); Trade, Transportation and Utilities (11,827); Education and Health Services (9,591); and Leisure and Hospitality (7,831).
- Queen Anne's County has the lowest percentage of uninsured residents under the age of 65.
- Four of the five mid-shore counties have uninsured percentages that are lower than the Maryland average for people under the age of 65.
- The highest percentage of mid-shore residents with a high school diploma (89.7%) reside in Queen Anne's County.
- Two mid-shore counties, Queen Anne's and Talbot, exceed the Maryland average for educational attainment among those age 25 and above.

Component: ENVIRONMENTAL SCAN/
2. Emergency & Transitional Shelter Population

Report	Source	Date
The Emergency and Transitional Shelter Population: 2010	U.S. Census Special Reports	2010

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓	✓	

KEY FINDINGS

- 209,000 people were counted in March of 2010 in emergency and transitional shelters in the United States.
- 62% of those sheltered were males and 38% were females.
- The group quarters population totaled 8 million people with a similar gender distribution to the emergency and transitional shelter population (a share of the group quarters population).
- People aged 18 to 64 made up the largest segment of the emergency and transitional shelter population (77%) and the group quarters population (79%).
- For the emergency and transitional shelter population, the second largest age group was the one for people under 18 years of age, 42,000 people or 20%. Females comprised the majority gender in this age group.
- For the group quarters population, the second largest segment was people 65 years and over, accounting for 1.5 million people or 18%. Males comprised the majority in this age group.
- In terms of racial composition, Black or African Americans accounted for nearly 23% of the group quarters (congregate living arrangements) and nearly 41% of the shelter population, while people of Hispanic or Latino origin accounted for 11.2% and 17.9% respectively.
- The Maryland count for sheltered individuals was 4, 227. Of that number, nearly 60% were males and just over 40% were females, and 22.9% of those sheltered were under the age of 18.

Component: ENVIRONMENTAL SCAN/
3. MD Kids Count Ratings

Report	Source	Date
Kids Count – 2013 Data Book	Annie E. Casey Foundation	June 2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓	✓	

KEY FINDINGS

Challenges

- Maryland ranks at #20 of 50 states for "Family and Community" which includes cultural and social institutions, role models, safety resources, good schools, and quality support services.
- In 2011, 27% of children lived in a household where parents did not have secure employment.
- In 2011, 41% of Maryland children lived in a household with a high housing cost burden.
- In Maryland, the rate of teen deaths per 100,000 youth was 24 in 2010 (342 deaths).
- 37% of Maryland youth live in single parent families (2011).

Strengths

- Maryland ranks at "10" among the 50 states for "Overall Child Well-Being" (#1 is highest, # 50 is lowest).
- For "Economic Well-Being" (employment, household income), Maryland ranks at #14.
- For "Education" (entering school, academic achievement, attendance, graduation), Maryland ranks at #5 of 50 states.

- For "Health," (nutrition, preventative health care, substance abuse, maternal depression, family violence) Maryland children rank at #8.
- Six percent (6%) of Maryland youth were reported to abuse alcohol or drugs during 2010-11.

B. QUANTITATIVE

Summary of Key Data Sets Pertaining To
Health and Behavioral Health Conditions

Documents/Data Reviewed

1) National Alliance on Mental Illness (NAMI) Behavioral Health Data
2) State Health Improvement Program Indicators
3) Maryland Youth Risk Behavior Survey Data
4) MD Department of Juvenile Services Intakes, Releases, and Rearrests
5) Eastern Shore Hospital Center Admissions
6) Public Mental Health Services Utilization
7) Core Service Agency Program Data
8) Uniform Crime Report Data for the Mid-Shore
9) Uniform Crime Report Data Corresponding to Substance Use
10) Epidemiological Data
11) Point in Time Summary for Shelters
12) Number of Veterans Residing on the Mid-Shore

Component: QUANTITATIVE / 1.National Behavioral Health Data

Report	Source	Date
Mental Illness Facts and Numbers	National Alliance on Mental Illness	March 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
						✓	

KEY FINDINGS

- One in four adults−approximately 61.5 million Americans−experience mental illness in a given year. One in 17−about 13.6 million−live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.
- Approximately 20% of youth ages 13 to 18 experience severe mental disorders in a given year. For ages 8 to 15, the estimate is 13%.
- Approximately 1.1% of American adults—about 2.6 million people—live with schizophrenia, 2.6% of American adults−6.1 million people−live with bipolar disorder, and 6.7% of American adults−about 14.8 million people−live with major depression.
- Approximately 18.1% of American adults−about 42 million people−live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.
- About 9.2 million adults have co-occurring mental health and addiction disorders.
- Approximately 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or substance use disorders.
- Approximately 20% of state prisoners and 21% of local jail prisoners have "a recent history" of a mental health condition.
- Approximately seventy percent (70%) of youth in juvenile justice systems have at least one mental health condition and at least 20% live with a severe mental illness.
- Approximately 60% of adults, and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year.
- African Americans and Hispanic Americans used mental health services at about one-half the rate of Caucasian, non-hispanic in the past year and Asian Americans at about one-third the rate.
- Although military members comprise less than 1% of the U.S. population, veterans represent 20% of suicides nationally. Each day, about 22 veterans die from suicide.

Component: QUANTITATIVE / 2. SHIP Indicators

Report	Source	Date
MD State Health Improvement Program Indicators	Maryland Department of Health and Mental Hygiene	2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Challenges

- For Dorchester County, 13 of 15 indicators show worse percentages than the MD average.
- Domestic violence and cancer death rates are worse in all mid-shore counties than MD.
- Behavioral health emergency department visits are at a higher percentage than MD in 4 of 5 mid-shore counties.

Strengths

- For Queen Anne's County, 12 of 15 indicators show better percentages than the MD average.
- The percentage of adolescent wellness checks are above the MD average in 4 of 5 counties.
- The percentage of child/teen dental care is above the MD average in 4 of 5 counties.

Illustration

Differences than MD for SHIP Indicators/ Mid-Shore Counties

County ➔ Indicator ⬇	Car	Dor	Kent	QA	Talbot
Life Expectancy	-3.8%	-2.65%	-1.13%	+0.5%	+0.50%
Teen Birth Rate	+88.34%	+145.97%	-13.89%	-13.89%	-24.01%
Child Maltreatment	-40.08%	+77.44%	+6.45%	-49.90%	+99.22%
Ready to Learn	+16.87%	-4.82%	+1.20%	+9.64%	-1.20%
High School Graduation	-3.57%	-5.18%	-0.20%	+8.33%	+5.76%
Domestic Violence	+57.36%	+229.4%	+294.55%	+45.68%	+4.82%
Asthma Related ER Visits	-5.67%	+65.87%	-56.46%	-45.42%	-13.68%
Reduce deaths from Heart Disease	+26.37%	+9.07%	+4.62%	-13.63%	-6.15%
Cancer Death Rate	+14.51%	+7.31%	+21.42%	+4.10%	+3.39%
Diabetes Related ER Visits	+25.30%	+93.83%	-11.88%	-0.72%	+32.93%
Hypertension Related ER Visits	-1.76%	+99.94%	-42.08%	-30.19%	+4.16%
Child/ Adolescent Obesity	+19.02%	+56.13%	+51.97%	-14.80%	-2.21%
Behavioral Health ER Visits	+35.01%	+97.14%	+0.48%	-13.93%	+24.83%
Adolescent Annual Wellness Check	+9.76%	+4.71%	+7.64%	-6.68%	+19.89%
Child/Adolescent Dental Care	+12.06	+0.03%	-5.73%	+6.55%	+3.76%

Red = Worse/ Green = Better Than MD;
Source: The MD Department of Health and Mental Hygiene

Component: QUANTITATIVE /
3. Maryland Youth Risk Behavior Survey Data

Report	Source	Date
MD Youth Risk Behavior Survey – **High School**	Department of Health and Mental Hygiene	2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Challenges	Strengths
➢ All of the mid-shore counties had higher percentages than the MD average for the following questions concerning Substances: 11) Among students who drove a car or other vehicle during the past 30 days, the percentage who drove when they had been drinking alcohol one ore more times during the past 30 days; 43) Percentage of students who had at least one drink of alcohol on one or more of the past 30 days; 50) Percentage of students who used any form of cocaine, including powder, crack, or freebase one or more times during their life; 52) Percentage of students who used heroin one or more times during their life; 33) Percentage of students who smoked cigarettes on one or more of the past 30 days; QNANYTOB) Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days. ➢ All of the mid-shore counties had higher percentages than the MD average for the following questions concerning Threats and Safety: 13) Percentage of students who carried a weapon such as a gun, knife, or club on one or more of the past 30 days; 16) Percentage of students who did not go to school on one or more of the past 30 days because they felt they would be unsafe at school or on their way to or from school.	➢ All of the mid-shore counties had high percentages for the following questions concerning Parental Disapproval: 110) Percentage of students who responded that their parents would feel it would be wrong or very wrong for them to drink beer, wine, or hard liquor (such as vodka, whisky, or gin) at least once or twice a month; 112) Percentage of students who think people are at moderate or great risk of harming themselves (physically or in other ways) if they have five or more drinks of alcohol (beer, wine, or liquor) once or twice a week. ➢ Both Queen Anne's County and Talbot County had a lower percentage than the MD average for question 60 – the percentage of students who had sexual intercourse for the first time before age 13 years. ➢ Kent County and Queen Anne's County had a lower percentage than the MD average for question 27 – percentage of students who seriously considered attempting suicide during the past 12 months. ➢ For question 113 – percentage of students who have an adult outside of school they can talk to about things that are important to them, both Caroline and Dorchester Counties had higher percentages than the MD average.

Illustration

Note: Survey respondents range from 300 to 1300 depending on the county and the question.

SUBSTANCES:

Survey Question ↓ Jurisdiction →	MD	CAR	DOR	KENT	QA	TAL
QN10: Percentage of students who rode one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol	**20.7**	24.9	23.5	27.1	24.4	22.3
QN11: Among students who drove a car or other vehicle during the past 30 days, the percentage who drove when they had been drinking alcohol one or more times during the past 30 days	**8.8**	17.8	17.6	20.6	10.9	10.9
QN43: Percentage of students who had at least one drink of alcohol on one or more of the past 30 days	**19.3**	36.9	35.9	38.5	39.7	30.7
QN44: Percentage of students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days	**17**	24.5	21.9	27.7	23.9	19
QN99: Among students who drank alcohol during the past 30 days and who have a usual type of alcohol that they drink, the percentage who reported liquor, such as vodka, run, scotch, bourbon, or whisky, as their type of alcohol they usually drank during the past 30 days	--	43.7	49	56.1	48.2	51.3
QN110: Percentage of students who responded that their parents would feel it would be wrong or very wrong for them to drink beer, wine, or hard liquor (such as vodka, whisky, or gin) at least once or twice a month	--	67.1	69.8	64.2	67.2	73.3
QN111: Percentage of students who think people are at moderate or great risk of harming themselves (physically and in other ways) if they have five or more drinks of alcohol (beer, wine, or liquor) once or twice a week	--	59.6	52	54.2	57.1	57.1
QN112: Percentage of students who think people are at moderate or great risk of harming themselves (physically and in other ways) if they have five or more drinks of alcohol (beer, wine, or liquor) once or twice a week	--	71	65.1	65.7	68.6	67.9
QN49: Percentage of students who used marijuana one or more times during the past 30 days	**19.8**	21.2	22	19.3	22.2	17.9
QN50: Percentage of students who used any form of cocaine, including powder, crack, or freebase one or more times during their life	**6.5**	10.7	9.8	10	9.1	9.3
QN51: Percentage of students who sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life	**10.4**	12.7	12.1	10.4	11.3	11.4
QN52: Percentage of students who used heroin one or more times during their life	**4.9**	8.1	8.2	5.4	7.5	8
QN53: Percentage of students who used methamphetamines one or more times during their life	**5**	7.8	6.7	8.2	6.4	6.8
QN54: Percentage of students who used ecstasy one or more times during their life	**8.3**	11.8	11.4	9.8	11.8	10.1
QN55: Percentage of students who took steroid pills or shots without a doctor's prescription one or more times during their life	**5.1**	10.1	6.6	9.5	5.9	6.9

Illustrations continued on next page

Survey Question ⬇ Jurisdiction ➔	MD	CAR	DOR	KENT	QA	TAL
QN56: Percentage of students who have taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription one or more times during their life	**15.2**	17.9	18.3	20.6	17.4	16.5
QN100: Percentage of students who took a prescription drug without a doctor's prescription one or more times during the past 30 days	--	13	14.6	12	11.7	12.8
QN57: Percentage of students who used a needle to inject any illegal drug into their body one or more times during their life	**3.9**	5.9	5.8	5.6	5.2	5.7
QN33: Percentage of students who smoked cigarettes on one or more of the past 30 days	**11.9**	22.2	17.7	22.2	17.6	16
QNFRCIG: Percentage of students who smoked cigarettes on 20 or more of the past 30 days	--	10.9	6.9	11.5	7	5.9
QNANYTOB: Percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days	**16.9**	25.4	24.4	25.7	22.5	20.2

THREATS AND SAFETY:

Survey Question ⬇ Jurisdiction ➔	MD	CAR	DOR	KENT	QA	TAL
QN13: Percentage of students who carried a weapon such as a gun, knife, or club on one or more of the past 30 days	**4.8**	23.1	20.3	24.7	20.6	19.2
QN16: Percentage of students who did not go to school on one or more of the past 30 days because they felt they would be unsafe at school or on their way to or from school	**8.8**	11.5	9.1	11	9.7	7.9
QN17: Percentage of students who had been threatened or injured with a weapon such as a gun, knife, or club on school property one or more times during the past 12 months	--	10.8	10.7	10	10.9	8.6
QN20: Percentage of students who were in a physical fight on school property one or more times during the past 12 months	**14.3**	15.4	16.6	14.2	12.4	14.3
QN21: Percentage of students who had ever been physically forced to have sexual intercourse when they did not want to	**9**	12.1	12.3	14.1	11.2	13.1
QN22: Among students who dated or went out with someone during the past 12 months, the percentage who had been physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months	**11.1**	12.5	14.3	10.7	12.5	11.5
QN23: Among students who dated or went out with someone during the past 12 months, the percentage who had been forced by someone they were dating or going out with to do sexual things that they did not want to one or more times during the past 12 months	**10.2**	12.9	12.4	14.2	14	11.4
QN24: Percentage of students who had ever been bullied on school property during the past 12 months	**19.6**	24	23.8	24	25	21.2
QN25: Percentage of students who had ever been electronically bullied during the past 12 months	**14**	16.9	13.3	14.4	18	16.4
QN60: Percentage of students who had sexual intercourse for the first time before age 13 years	**6.6**	8.2	9.6	10.4	4.5	5.8
QN58: Percentage of students who were offered, sold, or given an illegal drug by someone on school property during the past 12 months	--	26	29.6	28.9	26.4	24.3

SADNESS AND SUICIDAL FEELINGS:

Survey Question ↓ Jurisdiction →	MD	CAR	DOR	KENT	QA	TAL
QN26: Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	--	27.6	25	22.9	24.7	25
QN27: Percentage of students who seriously considered attempting suicide during the past 12 months	**16**	16.7	16.5	15.2	15.9	17.1
QN28: Percentage of students who made a plan about how they would attempt suicide during the past 12 months	**12.5**	13.1	12.8	14.1	12.7	10.3

SENSE OF SUPPORT:

Survey Question ↓ Jurisdiction →	MD	CAR	DOR	KENT	QA	TAL
QN113: Percentage of students who have an adult outside of school they can talk to about things that are important to them	**84**	83.1	83	86.7	85.7	86.4
QN114: Percentage of students who would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life	**77.3**	79.5	77.5	81.5	78.5	78.3
QN115: Percentage of students who talked to a teacher or other adult in their school about a personal problem they had during the past 12 months	--	35	37.4	37.1	35.4	40.4

Source: 2013 Maryland Youth Risk Behavior Survey, Department of Health & Mental Hygiene

Component: QUANTITATIVE / 4. Juvenile Services Data

Report	Source	Date
Data Resource Guide	MD Department of Juvenile Services	FY 2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- Juvenile intakes in Queen Anne's County increased in 2011 to 320, and then dropped to 257 in 2012.
- For juveniles released in Kent and Queen Anne's Counties, rearrests occurred more often in 2011 and 2010, respectively.

Strengths

- The number of Juvenile Services intakes has decreased in all mid-shore counties since 2010.
- Total juvenile intakes have dropped by 24% between 2010 and 2012 across the mid-shore.
- The percentage of rearrests decreased in Caroline, Dorchester, and Talbot Counties between 2009 and 2011.

Illustrations

Number of Juvenile Services Intakes for the Mid-Shore/2010-2012

County↓ Year→	2010	2011	2012
Caroline	362	283	256
Dorchester	449	439	387
Kent	232	214	139
Queen Anne's	285	320	257
Talbot	355	272	234
TOTALS	**1683**	**1528**	**1273**

County↓ Year→	2009 Releases	2009 Rearrest	2010 Releases	2010 Rearrest	2011 Releases	2011 Rearrest
Caroline	14	50.0%	15	46.7%	13	46.2%
Dorchester	15	60.0%	12	50.0%	9	33.3%
Kent	16	25.0%	7	57.1%	7	42.9%
Queen Anne's	14	50.0%	18	44.4%	7	57.1%
Talbot	18	66.7%	12	41.7%	9	44.4%

Source: Maryland Department of Juvenile Services

Component: QUANTITATIVE / 5. Eastern Shore Hospital Admissions

Report	Source	Date
Eastern Shore Hospital Center Admissions	Maryland Department of Health and Mental Hygiene	2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Challenges

- Mid-shore resident admissions to the Eastern Shore Hospital Center (an in-patient state psychiatric facility) between FY 09 and FY 13 were highest among Dorchester County residents at 84 total admissions.
- For all jurisdictions in Maryland, admissions were highest (120) among Wicomico County residents between FY 09 and FY 13.
- Hospital admissions among residents of Kent and Queen Anne's counties have increased in recent years.
- For admissions across Maryland, the legal class referencing "Incompetent to Stand Trial" has shown a dramatic increase (from 3 to 23) since FY 09.

Strengths

- The total admissions to the Eastern Shore Hospital Center from all Maryland jurisdictions were 121 in FY 09 and the total has declined to 66 in FY 13.
- Eastern Shore Hospital Center admissions of residents from Dorchester County have decreased from 21 to 18 between FY 11 and FY 13.
- For admissions across Maryland, the legal class referencing "Involuntary Admission, From Local Jail" has shown a dramatic decline (from 29 to 1) since FY 09.

Illustration

Eastern Shore Hospital Center Admissions/ Mid-Shore Counties

County	FY 09	FY 10	FY 11	FY 12	FY 13	Totals
Caroline	6	6	8	4	3	**27**
Dorchester	23	9	21	13	18	**84**
Kent	4	5	7	3	6	**25**
Queen Anne's	5	2	2	5	7	**21**
Talbot	20	8	5	2	3	**38**
TOTALS	**58**	**30**	**43**	**27**	**37**	**195**

Component: QUANTITATIVE /6. Public Mental Health Services

Report	Source	Date
Mid-Shore Core Service Agency Reporting Data	Mental Hygiene Administration	2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- The number of dually diagnosed individuals has increased from FY 2011 to FY 2013 in Dorchester and Queen Anne's County.
- The number of children served by mental health facilities has increased in every mid-shore county, except Caroline since FY 2011.
- The number of adults served in programs funded by public mental health dollars has increased in all mid-shore counties since FY 2011.
- Utilization of public mental health funding for adolescents and children dropped significantly between FY 2012 and 2013 in Caroline, Kent and Queen Anne's counties.

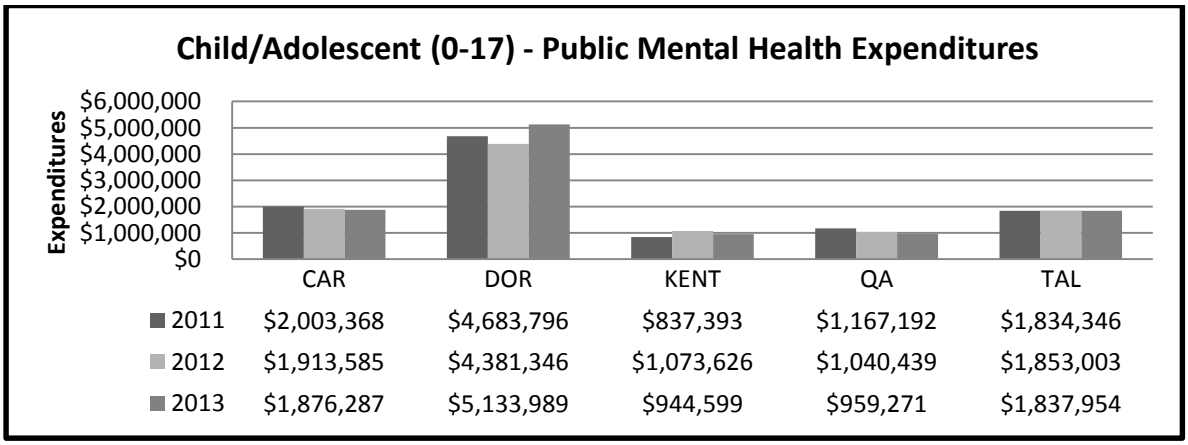
Strengths

- Programs funded with public mental health dollars have increased capacity to serve a rising number of consumers since FY 2011.

Illustrations

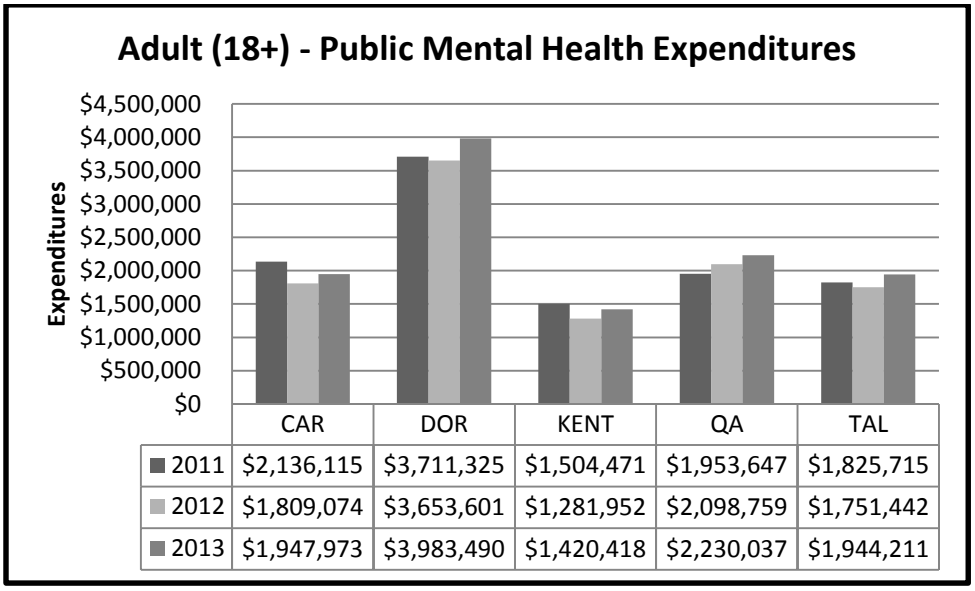
CSA REPORTING DATA/ FY 2011- FY 2013

Category →	Dually Diagnosed			Child/Adolescent (0-17)			Adults (18+)		
Year →	FY 2011	FY 2012	FY 2013	FY 2011	FY 2012	FY 2013	FY 2011	FY 2012	FY 2013
Caroline	193	158	160	826	796	822	944	964	983
Dorchester	291	277	296	952	1,049	1,181	1,260	1,356	1,448
Kent	78	62	71	357	345	370	452	463	505
Queen Anne's	121	126	143	483	458	487	671	762	852
Talbot	126	125	102	646	688	692	662	716	777



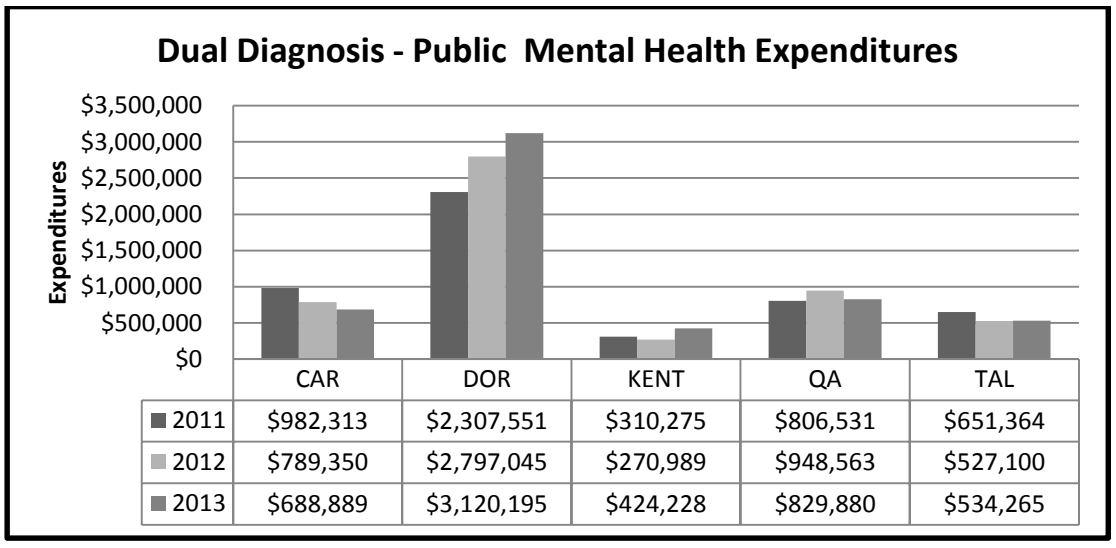
Source: MHA and Crystal Reports MARF004 based on claims paid through September 30, 2013; report run date 10/15/13

Illustrations Continued--



	CAR	DOR	KENT	QA	TAL
2011	$2,136,115	$3,711,325	$1,504,471	$1,953,647	$1,825,715
2012	$1,809,074	$3,653,601	$1,281,952	$2,098,759	$1,751,442
2013	$1,947,973	$3,983,490	$1,420,418	$2,230,037	$1,944,211

Source: MHA and Crystal Reports MARF004 based on claims paid through September 30, 2013; report run date 10/15/13



	CAR	DOR	KENT	QA	TAL
2011	$982,313	$2,307,551	$310,275	$806,531	$651,364
2012	$789,350	$2,797,045	$270,989	$948,563	$527,100
2013	$688,889	$3,120,195	$424,228	$829,880	$534,265

Source: MHA and Crystal Reports MARF5120 based on claims paid through September 30, 2013; report run date 10/15/13

Component: QUANTITATIVE / 7. Core Service Agency Community Alternative Framework (CAF) Report

Report	Source	Date
CAF Report	Mid-Shore Mental Health Systems	2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

- Dispatch numbers for the Mobile Crisis Teams have increased significantly from 139 to 877 since the first year of operations.
- The Eastern Shore Operations Center experienced peak service numbers in FY 10 and FY 13.
- Urgent Care doubled the number of individuals served between FY 10 and FY 11.
- During the last quarter of FY 13, Dorchester County residents were the most frequent callers to the Eastern Shore Operations Center.
- The types of calls received at the Center were either urgent or information and referral.
- Operations Center callers were most commonly in the age range of either 50-59 or 20-29. For the Urgent Care Clinic, consumers were more commonly in the age range of 20-29.

Illustrations

CAF Annual Program Service Summary for FY 10 to FY 13

Program	FY 10	FY 11	FY 12	FY 13
Eastern Shore Operations Center	1355	769	1209	1305
Mobile Crisis Teams	139	292	734	877
Urgent Care	490	1098	861	999

CAF Quarterly Service Summary for FY 13

Program	QU 1	QU 2	QU 3	QU 4
Eastern Shore Operations Center	338	303	298	366
Mobile Crisis Teams	259	154	167	297
Urgent Care	241	253	250	255

Source: Mid-Shore Mental Health Systems, Inc.

Component: QUANTITATIVE / 8. Crime

Report	Source	Date
Uniform Crime Report	Maryland State Police	2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- Caroline County experienced three homicides in 2012, compared to two in 2011 and one in 2010. Dorchester County had 1 homicide per year during the same time period.
- Reported rapes occurring from 2010 to 2012 increased significantly in Caroline (2 to 11), Dorchester (9 to 15), Kent (3 to 7), and Talbot (7 to 13) Counties.
- Robberies in Dorchester (21 to 35) and Kent (9 o 21) Counties increased from 2011 to 2012.
- Aggravated assaults increased in Dorchester, Kent and Talbot Counties between 2011 and 2012.
- Of the five mid-shore counties, both Talbot and Dorchester saw increases in robberies between 2011 and 2012.
- Arson arrests increased from 1 arrest in 2011 to 11 arrests in 2012 in Dorchester County.

Strengths

- Kent and Talbot counties did not experience any homicides in 2011 and 2012.
- The number of robberies dropped in Caroline, Queen Anne's, and Talbot counties between 2011 and 2012.
- Aggravated assaults declined in Caroline and Queen Anne's counties.
- The number of robberies dropped in Caroline, Kent and Queen Anne's counties between 2011 and 2012.
- Larceny-thefts decreased in four of the five mid-shore counties between 2011 and 2012.
- Domestic violence arrests rose in Kent County, but decreased in the other four mid-shore counties between 2011 and 2012.

Component: QUANTITATIVE / 9. Substance Use Related Crime

Report	Source	Date
Uniform Crime Report	Maryland State Police	2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- Arrests for narcotic have increased recently in Kent, Queen Anne's and Talbot Counties.
- Disorderly conduct arrests have increased slightly in Dorchester County between 2010 and 2012.
- Talbot County has the greatest number of DUI arrests at 367 and Narcotics arrests at 368 in 2012.

Strengths

- Arrests for Driving under the Influence have decreased in recent years in all mid-shore counties compared to 2009. Additional funding for law enforcement strategies has been allocated by the State Highway Administration and the Alcohol and Drug Abuse Administration since 2010.
- The number of arrests/citations for liquor law violations (such as open containers or public drunkenness) have declined when comparing 2011 to 2012.

Illustration

MARYLAND UNIFORM CRIME REPORT
2009-2012

CHARGE →	NARCOTICS				DWI/DUI				LIQUOR LAWS				DISORDERLY CONDUCT			
YEAR →	09	10	11	12	09	10	11	12	09	10	11	12	09	10	11	12
CAROLINE	265	212	191	184	324	212	179	137	37	23	22	6	50	61	82	53
DORCHESTER	225	217	310	276	213	202	154	142	106	152	236	127	43	67	68	70
KENT	197	171	181	199	103	85	85	67	14	5	21	3	43	53	57	18
QUEEN ANNE'S	286	324	286	346	392	309	335	297	5	5	85	54	29	36	31	20
TALBOT	327	258	250	368	443	412	383	367	76	116	28	14	35	36	25	20

Source: Crime in Maryland, Uniform Crime Report, Maryland State Police, 2010 & 2012.

Component: QUANTITATIVE / 10. Epidemiological Profile for Substances

Report	Source	Date
MD Jurisdiction Epidemiological Profiles Chartbook	University of Maryland Baltimore School of Pharmacy	February 13, 2014

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓	✓		

KEY FINDINGS

Challenges

- Of the 5 mid-shore counties in 2012, Kent had the highest alcohol-related inpatient hospitalizations at 55.9 per 1,000 events (above the MD average).
- Four of the 5 mid-shore counties had alcohol-related Emergency Department visit rates in 2012 above the MD average of 24.8 per 1,000 events. Kent had 54.8.
- Treatment admission rates for alcohol, marijuana and opioids were above MD averages (per 1,000 population) for all 5 mid-shore counties in 2012.
- Dorchester and Kent Counties had the highest percent (66.5 and 55.2, respectively) of co-occurring mental illness among cases of patients treated in each jurisdiction in FY 2012.

Strengths

- All 5 mid-shore counties had 2012 rates of opioid-related hospitalizations that were below the MD average of 35.6 per 1,000 events.
- The 5 mid-shore counties had among the lowest number of fatal crashes involving alcohol-impaired drivers from 2008-2011 in Maryland.

Illustrations

Rate of Alcohol-Related Inpatient Hospitalizations and Emergency Department Visits per 100 Events

Location →	CAR			DOR			Kent			QA			TAL			MD		
Year →	10	11	12	10	11	12	10	11	12	10	11	12	10	11	12	10	11	12
Inpatient	4.5	4.2	4.2	5.1	5.0	5.3	4.2	4.4	**5.6**	3.9	4.1	4.7	4.6	4.7	4.7	5.3	5.4	5.5
ED	0.7	1.0	2.2	**1.3**	1.1	**2.5**	0.7	0.9	**5.5**	1.1	0.7	**4.9**	1.1	1.0	**3.5**	1.2	1.3	2.5

***ED: Emergency Department**

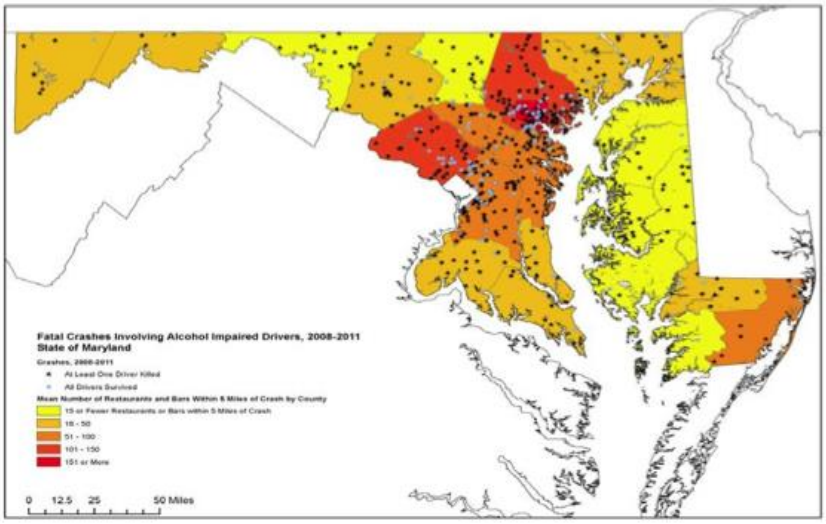
Rate of Opioid-Related Inpatient Hospitalizations and Emergency Department Visits per 100 Events

Location →	CAR			DOR			Kent			QA			TAL			MD		
Year →	10	11	12	10	11	12	10	11	12	10	11	12	10	11	12	10	11	12
Inpatient	1.9	1.8	2.3	1.9	1.5	2.1	NA	NA	NA	1.9	2.0	2.4	1.0	1.4	2.0	3.4	3.4	3.6
ED	0.2	**1.4**	**1.9**	0.3	**0.9**	**0.8**	NA	NA	NA	**1.0**	**1.1**	0.3	0.1	**1.1**	0.7	0.5	0.6	0.7

***Inpatient and Emergency Department rates are not listed for Kent County.**

***ED: Emergency Department**

Fatal Crashes Involving Alcohol-Impaired Drivers, 2008-2011



Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, The Maryland Statewide Epidemiological Outcomes Workgroup, Department of Pharmaceutical Health Services Research, University of Maryland Baltimore School of Pharmacy, February 13, 2014.

MARYLAND JURISDICTION EPIDEMIOLOGICAL PROFILES

Jurisdiction Rankings for 2012

Findings Category	CAR	DOR	Kent	QA	TAL	MD
1. Rate of alcohol-related inpatient hospitalizations in 2012 per 1000 events	42.4	52.7	55.9	46.7	46.6	54.8
2. Rate of alcohol-related Emergency Department visits in 2012 per 1000 events	22.2	25.4	54.8	48.8	34.7	24.8
3. Rate of opioid-related hospitalizations in 2012 per 1000 events	23.4	21.1	22.4	24.0	19.6	35.6
4. Rate of opioid-related Emergency Department visits in 2012 per 1000 events	**19.0**	8.5	0.0	3.5	6.9	6.6
5. Rate of alcohol (primary substance) treatment admissions in FY 2012 per 1000 population	5.23	**7.11**	5.59	5.92	4.47	2.22
6. Rate of marijuana (primary substance) treatment admissions in FY 2012 per 1000 population	2.99	**6.10**	3.71	2.49	2.67	1.66
7. Rate of opioids (primary substance) treatment admissions in FY 2012 per 1000 population	2.72	2.05	2.62	2.53	0.95	0.85
8. Rate of benzodiazepines (primary substance) treatment admissions in FY 2012 per 1000 population	0.06	0.25	0.00	0.19	0.13	0.08
9. Rate of heroin (primary substance) treatment admissions in FY 2012 per 1000 population	2.15	2.21	0.79	2.55	1.61	1.80
10. Rate of crack/cocaine (primary substance) treatment admissions in FY 2012 per 1000 population	0.57	**3.04**	2.08	1.11	1.03	0.72
11. Percent of co-occurring mental illness among cases of patients residing in each jurisdiction FY 2012	38.4	42.6	39.5	47.6	42.8	44.3
12. Percent of co-occurring mental illness among cases of patients treated in each jurisdiction FY 2012	26.9	**66.5**	**55.2**	44.8	36.9	44.2
13. Alcohol or alcohol and drug impaired crashes as a percentage of all motor vehicle crashes – all ages	**9.39**	**8.20**	**9.73**	**7.55**	5.09	4.58
14. Alcohol or alcohol and drug impaired crashes as a percentage of total crashes among 16 – 25 year olds	**10.53**	**8.45**	**15.00**	**9.24**	5.71	5.75

Source: Health Services Cost Review Commission (HSCRC), 2012, http://www.hscrc.state.md.us/

Component: QUANTITATIVE / 11. Point in Time Shelter Data

Report	Source	Date
Point in Time Summary for the Mid-Shore	Core Service Agency	1/30/2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

- At the time of the count, there were 50 people in emergency shelters, 17 in transitional and 20 unsheltered.
- Of the 87 total persons needing shelter, there were 11 children.
- The total number of households involved in being sheltered was 7 and the total number unsheltered was 2. The average sized household was 2.3.
- There were eight (8) children sheltered and three (3) children unsheltered.
- Twelve (12) persons utilized emergency shelter and 27 people utilized transitional shelter.
- 14 persons were chronically homeless.

Component: QUANTITATIVE / 12. Military and Veteran Status

Report	Source	Date
3 Year Estimates of Veterans Status	U.S. Census Bureau	2009-2011

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

- A total of 16,845 veterans is estimated to reside on the mid-shore.
- Of that number, a range of 90% to 96% are males.
- Unemployment rates for veterans varied from 1.8 in Queen Anne's County to 10.2 in Dorchester County.
- The percentage of veterans believed to be living below the poverty level is 1.9% for Queen Anne's County and up to 7.7% in Caroline County.
- The percentage of veterans with a disability is estimated between 23.9% in Dorchester County and 30.3% in Kent County.

Illustration

Number and Status of Veterans Residing on the Mid-Shore

Veterans Estimate	CAR	DOR	Kent	QA	TAL	Total
Number	3,075	3,403	1,814	4,344	4,209	16,845
Unemployment rate in last 12 months	6.4	10.2	10.1	1.8	5.2	NA
Living below poverty in last 12 months	7.7	7.4	6.2	1.9	2.9	NA
With any disability	24%	23.9%	30.3%	22.2%	25.9%	NA

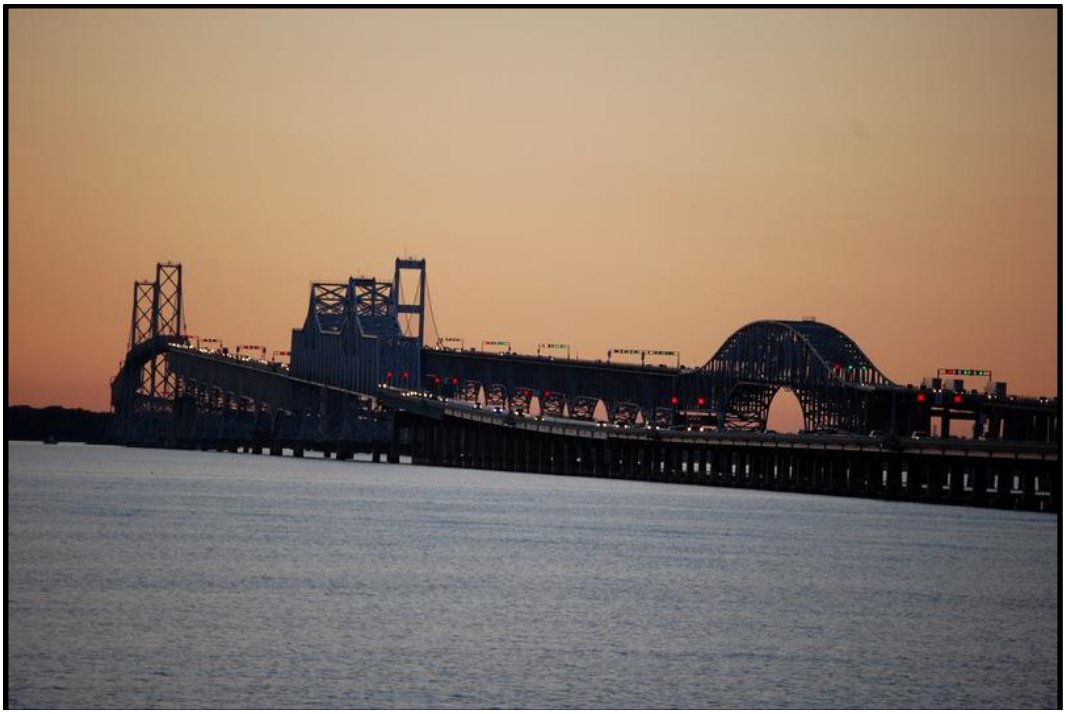
Source: American Community Survey, U.S. Census Bureau, 2009-2011

C. QUALITATIVE

Summary of Surveys Pertaining To
Behavioral Health Conditions and Services

Documents/Data Reviewed

1. Maryland Public Mental Health Survey
2. Core Service Agency 3 and 3 Survey
3. Mental Health Consumer Education and Training Needs
4. Perception of the Core Service Agency
5. Workforce Development Survey



Component: QUALITATIVE / 1. MD Public Mental Health Survey

Report	Source	Date
Maryland's Public Mental Health System Consumer Perception of Care Survey	Maryland Department of Health and Mental Hygiene	2012

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

Of the 611 adults who completed a statewide telephone survey and 848 child/caregiver consumers who also completed the survey, the following summary responses were noted:

- Nearly 80% of adults and 82% of caregivers were satisfied with mental health services they or their children received.
- Regarding satisfaction with specific aspects of outpatient mental health treatment services, over 76% of adults responded positively for 21 of the 23 survey items.
- Regarding satisfaction with specific aspects of psychiatric rehabilitation services, over 77% of the survey takers responded positively to 19 of the 21 items.
- Regarding satisfaction with specific aspects of outpatient mental health services for children, over 80% of the caretakers responded positively to 15 of the 16 items.
- Regarding satisfaction with specific aspects of family support services for children, over 80% of the caregivers responded positively to 15 of the 16 items.
- According to the Consumer Perception of Care Survey administered in 2012, of the 99 individuals who were referred for substance abuse services, 94.9% were able to receive substance abuse services.
- Of the participants who received substance abuse services, 91.5% were satisfied with the substance abuse services received.

Component: QUALITATIVE / 2. 3 and 3 Survey

Survey	Source	Date
3 and 3 Survey	Mid-Shore Mental Health Systems	2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Of the 121 adults who completed the CSA survey, the following gaps or "What's not working well in the public mental health system" were noted (from most to least mentioned):

- There is a need for more psychiatrists and therapists specifically (support for therapists, more school therapists, more juvenile sex offender therapists)
- There is a need for more providers in general, quality providers (trauma trained, more pediatric)
- There should be shorter wait times for accessing services (the time it takes to get appointments)
- There should be greater access, more affordability and flexibility of transportation
- There is a need for more education, training, and public awareness (a mention of a lack of Mental Health understanding in nursing homes)
- There is lack of affordable housing, housing for the mentally ill, and homeless services
- There is a need for access to and availability of services and treatment
- Suggestions for expanded services included: emergency response and crisis beds, addictions, dual services, RRP services, respite, veteran/military, transitional, post jail, community support, specialized services for psych patients
- There is a need for collaboration/communication between providers and providers and hospitals
- There is a lack of sufficient resources
- There should be behavioral health integration detailing communication/ complications
- There is a need for more funding
- There is a need for beds (detox, co-occurring, RRP, Inpatient rehab)
- There is a need for medication management and accessibility (and prescription assistance)
- There should be better discharge planning
- There are problems with insurance, inadequate insurance
- There is a need for improved electronic health records
- There is a lack of support groups, peer groups
- There needs to be quality and coordinated care
- Other suggestions included the topics of confusing phone systems, family involvement, more long term care, wellness and recovery, high risk facilities locations, treatment for elders, improved PRP and case management for children, too much emphasis on crisis, allow for local decisions, reimbursement, more juvenile groups sessions, assurance of safety net services for substance abuse patients, minority disparities, group home care for transitional age youth (TAY), cheaper and more affordable counseling, therapist willing to

testify in court for child welfare, more community support on dealing with stress, jobs for the mentally ill, MSMHS develop healthy working relationships with providers.

For the question of "What is working well in the public mental health system?" the following responses were noted (from most frequently mentioned to least mentioned):

- Collaboration and communication from and between partner agencies and providers
- Diversity, availability, and improvement of services provided
- Providers/professionals – provider care and quality
- Mobile Crisis- including ESOC and emergency response
- Outpatient/ Intensive outpatient
- The Core Service Agency (MSMHS)
- Appointments –same day and ease of scheduling
- Anti-stigma efforts and community involvement
- Access to and availability of training resources
- Mobile Treatment
- Peer support
- Active committees and workgroups
- Urgent care
- Homeless services and housing availability
- Inpatient care
- Medication management
- Effective integration efforts
- Access to providers
- Treatment
- School-based services
- Referrals
- Support groups/ improved community support
- Transportation
- Access to grant funding
- Insurance coverage/ Access to services
- More program awareness, Co-occurring treatment/ same office, ASO/Value options, relationships with ehap specialists, Strategic planning, Mental health assessments, Forensic Mental Health, Specialized providers, Self-services, Employment assistance, Local Management Board, Willingness to serve, Drop in clinics, Short term acute hospital services, Varied age of providers, Networking, Rural mental health clinics, Addictions services, Day program management, Measurement of services, Attention to problems, Local health departments

Component: QUALITATIVE / 3. Education and Training Needs

Survey	Source	Date
Mental Health Consumer Education and Training Needs	Mid-Shore Mental Health Systems	2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Of the 120 adults who completed the CSA survey, the following findings were noted:

- The majority of respondents were providers, followed by community members, a family member, or a mental health service recipient.

- Respondents rated all choices as very important for those with mental health conditions and including:
  Knowledge in how to take personal responsibility in maintaining wellness
  Support from others and how to access and maintain it
  Self-advocacy skills
  Education about mental health and substance abuse related issues
  Hope, the importance of it and how to gain a sense of hope

- Nearly all respondents (97.5%) answered “true” to the statement of “Recovery from a mental health or substance-related condition is possible.”

Component: QUALITATIVE / 4. Perception of the CSA

Survey	Source	Date
Perception of the CSA	Mid-Shore Mental Health Systems	2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Of the 78 adults who completed the CSA perception survey, the following comments were noted (from most to least mentioned):

- Nearly 76% said they knew what a Core Service Agency is.
- In response to the question of "How is a CSA funded?" 77% chose state grants, 59% chose federal grants, 24% chose foundation grants, 24% chose private/foundation grants, and 21% chose "I don't know."
- When asked, "What is the role and the function of the CSA?" responses were: 81%= community resource developer; 79% = local planning and management; 76% = program oversight; 67% =funding agent; 64% = program development; 55% = advocacy group; 44% = homeless service coordinator; 14% = treatment provider; and 5% = long term care.
- When asked, "Who does the CSA serve?" responses were: 88% = consumers of behavioral health services; 78% = family members of behavioral health services; 78% = Medicaid recipients; 74% = community members; 70% = uninsured; 68% = providers of mental health services; Choices for age groups were evenly selected in a range of 64% (under age 5) to 74% (18-24 year olds).
- Staff credentials cited as most popular among the respondents were: professional and work experience with behavioral health @ 83%; training and higher education in behavioral health @ 72%; and licensure in behavioral health at 47%.
- In response to the question of "If you had interaction with the CSA staff, did staff demonstrate expertise with the issue at hand?" Responses were 76% = yes; 12% = NA; 10% = Somewhat; and 3% = No.
- Nearly 81% said the quality of response received from the CSA staff was "satisfactory."
- In answer to the question, "In what ways have you heard about MSMHS," responses were: word of mouth = 62%; Other agencies = 62%; Email = 58%; website = 36%; social media = 29%, newspapers = 24%.

Component: QUALITATIVE / 5. Workforce Development Survey

Survey	Source	Date
Workforce Development	Mid-Shore Mental Health Systems	2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Twenty-Six (26) agencies providing behavioral health services completed the "Workforce Development Survey" administered by Mid-Shore Mental Health Systems, Inc. From the results, are the following key findings:

- **Employment**: Of the 639 employees represented among the 26 agencies who completed the survey, 71% are full-time employees, 17% are part-time employees, and 12% are contractual.
- **Professional Status**: 57% are direct service, 15% are categorized as administrative support, 12% are support service (bus drivers, food prep, attendant care), 10% are supervision staff (other than clinical), and 6% are clinical supervision staff.
- **Gender**: 80% of employees are female and 20% are male.
- **Age Distribution**: 39% are ages 50-64, 36% are ages 35-49, 15% are ages 25-34, 6% are ages 65 and over, 3% are ages 21-24, 1% are ages 18-20.
- **Ethnicity**: 68% are Caucasian, 30% are African American/Black, and 2% are Asian.
- **Highest Level of Education Completed**: 23% have a high school diploma, 15% have some college, 6% have an Associate's degree, 29% have a Bachelor's Degree, 24% have a Master's Degree, 1% have a Doctoral Degree, and 2% have a Medical Doctor Degree.
- **Residence**: 40% of employees do not live in the county where they work.
- **Length of Stay**: The average length of stay is nine (9) years.
- **Current Vacancies**: 11 Direct Support Staff, 5 Support Staff, 1 Supervision Staff
- **Licensure and Certification**: 33% = Licensed Certified Social Worker-Clinical, 10% = Licensed Graduate Social Worker, 9% = Certified Nursing Assistant, 7% = Doctor of Medicine, 7% = Board Certified Practitioner, 5% = Certified Addictions Counselor, 5% = Certified Supervised Counselor, 4% = Licensed Social Worker Associate, 4% = Licensed Clinical Professional Counselor, 4% = Certified Registered Nurse Practitioner, 3% = Licensed Practical Nurse, 3% = Licensed Clinical Alcohol and Drug Counselor, 1% or less (each) = Licensed Certified Social Worker, Licensed Graduate Professional Counselor, Doctor of Psychology, Doctor of Philosophy, Certified Chemical Dependency Counselor, Certified Co-Occurring Disorders Professional, Certified Criminal Justice Professional, International Certified Criminal Justice Professional, Certified Alcohol and Drug Counselor, International Certified Alcohol and Drug Counselor, Certified Supervised Counselor Alcohol and Drug.
- **Certifications**: 10 = Trauma Certification, 3 = Peer Support Certification, 3 = MD w/ C&A Certification, 2 = Admitting, Discharge, Transfer Certification, 1 = Death, Dying, Bereavement Certification.

D.META ANALYSIS

Summary of National, State, Mid-Shore and County Planning Documents and Needs Assessments Corresponding to Behavioral Health

Documents Reviewed

1. United States Department of Agriculture Strategic Plan
2. United States Department of Health and Human Services Strategic Plan
3. Shore Health Needs Assessment
4. Physician Resources – National Report
5. Physician Resources – Maryland Report
6. National Alliance on Mental Illness Plan
7. Maryland Strategic Plan of the Division of Early Childhood Development
8. Maryland Disabilities Plan
9. Maryland Mental Health Plan
10. Maryland Mental Health Plan Implementation
11. Maryland Association of Core Service Agencies White Paper
12. Maryland Governor's Office for Crime Control and Prevention
13. Department of Juvenile Services Strategic Plan
14. Mid-Shore Transitional Aged Youth Needs Assessment
15. Maryland Drug and Alcohol Council Plan
16. Maryland Opiate Prevention Plan
17. Mid-Shore Opiate Prevention Plan
18. Caroline County Drug Abuse Advisory Council Plan
19. Dorchester County Drug Abuse Advisory Council Plan
20. Kent County Drug Abuse Advisory Council Plan
21. Queen Anne's County Drug Abuse Advisory Council Plan
22. Talbot County Drug Abuse Advisory Council Plan
23. Mid-Shore Department of Social Services Annual Reports
24. Caroline County Local Management Board Needs Assessment
25. Dorchester County Local Management Board Needs Assessment
26. Kent County Local Management Board Needs Assessment
27. Queen Anne's County Local Management Board Needs Assessment
28. Talbot County Local Management Board Needs Assessment

Component: META ANALYSIS / 1. US Dept. of AG Plan

Report	Source	Date
Strategic Plan FY 2010-2015	United States Department of Agriculture	Plan for FY 2010-2015

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
						✓	

KEY FINDINGS

The United States Department of Agriculture's strategic goals are:

Goal 1: Assist Rural Communities to Create Prosperity so They Are Self-Sustaining, Repopulating, and Economically Thriving.
Objectives include: Enhancing rural prosperity; Creating thriving communities; Supporting a sustainable and competitive agricultural system.

Goal 2: Ensure our National Forests and Private Working Lands Are Conserved, Restored, and Made Resilient to Climate Change, While Enhancing Our Water Resources.
Objectives include: Restoring forests, farms, ranches, and grasslands; Leading efforts to mitigate and adapt to climate change; Protecting and enhancing water resources; Reducing risk from catastrophic wildfire and restore fire to appropriate landscape places.

Goal 3: Help America Promote Agricultural Production and Biotechnology Exports as America Works to Increase Food Security
Objectives include: Ensuring agricultural resources contribute to enhanced global food security; Enhancing ability to develop and trade agricultural products derived from new technologies; Supporting sustainable agricultural production in food-secure nations.

Goal 4: Ensure That All of America's Children Have Access to Safe, Nutritious, and Balanced Meals.
Objectives include: Increasing access to nutritious food; Promoting healthy diet and physical activity behaviors; Protecting public health by ensuring food is safe; Protecting agricultural health by minimizing major diseases and pests to ensure access to safe, plentiful and nutritious food.

Component: META ANALYSIS / 2. US DHHS Plan

Report	Source	Date
U.S. Department of Health and Human Services Strategic Plan	U.S. Department of Health and Human Services	Plan for 2010-2015

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
						✓	

KEY FINDINGS

The US Department of Health and Human Services' strategic goals are:

Goal 1: Transform Health Care.

Objectives include: Securing health insurance and extending affordable care to those without insurance; Improving health care quality and safety; Emphasizing primary and preventative care; Reducing health care costs; Ensuring access to quality, culturally competent care for vulnerable populations; Promoting meaningful use health information technology.

Goal 2: Advance Scientific Knowledge and Innovation

Objectives include: Accelerating scientific discovery to improve patient care; Fostering innovation toward shared solutions; Investing in regulatory sciences to improve food and medical product safety; Increasing understanding of what works.

Goal 3: Advance the Health, Safety, and Well-Being of the American People.

Objectives include: Promoting the healthy development of children/youth; Promoting economic and social well-being for individuals, families and communities; Improving accessibility and service quality for people with disabilities and older adults; Promoting prevention and wellness; Reducing infectious disease occurrence; Protecting Americans' health and safety during emergencies and fostering resilience.

Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs.

Objectives include: Ensuring program integrity and responsible resource stewardship; Fighting fraud and eliminating improper payments; Using HHS data to improve health and well-being; Improving HHS environmental, energy, and economic performance to promote sustainability.

Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

Objectives Include: Investing the HHS workforce to meet needs today and tomorrow; Ensuring that the nation's health care workforce can meet increased demands; Enhancing the public health workforce to improve public health at home and abroad; Strengthening the nation's human service workforce; Improving surveillance and epidemiology capacity.

Component: META ANALYSIS / 3. Shore Health Assessment

Report	Source	Date
Community Health Needs Assessment and Action Plan	Shore Health and Chester River Health University of MD Medical System	May 22, 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- Among 323 consumers surveyed by phone, the top health concerns were cancer, obesity, affordable health care, substance abuse, and diabetes.
- A range of 17% (QA) to 39% (Dor) of consumers listed mental illness as a top concern.
- Among 479 online survey respondents, top concerns were obesity, substance abuse, diabetes, mental illness, and cancer.
- Among online survey respondents, the top three specific populations perceived as not being adequately served by the healthcare system are mental health/psychiatric, under insured, and substance abuse.
- Behavioral health was listed as one of the top six areas of health care needs for the mid shore, after review of all survey and public hearing responses. Another top need noted was access to care/ Prevention.

Strengths

- All five counties have a Substance Abuse Prevention Coordinator and a Local Management Board to respond to community or family based substance abuse and/or behavioral health needs.
- Key state health priorities include Violence Prevention (aligned with healthy social environments) and Behavioral Health (aligned with chronic conditions).
- Significant funding was received in 2013 through the Health Enterprise Zone to support four years of behavioral and somatic health interventions in Dorchester and Caroline Counties including a dedicated Mobile Crisis Team, a new Federalsburg Mental Health Clinic, a middle/high school based social worker in Federalsburg, a middle school-based Nurse Practitioner with a Primary Mental Health Certification, two Peer Recovery Support Specialists, and 4 part-time Community Health Outreach Workers to guide citizens toward primary and behavioral health resources.

Component: META ANALYSIS / 4. Physician Resources

Report	Source	Date
Recent Studies and Reports no Physician Shortages in the US	Center for Workforce Studies Association of American Medical Colleges	October 2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
						✓	

KEY FINDINGS

Challenges

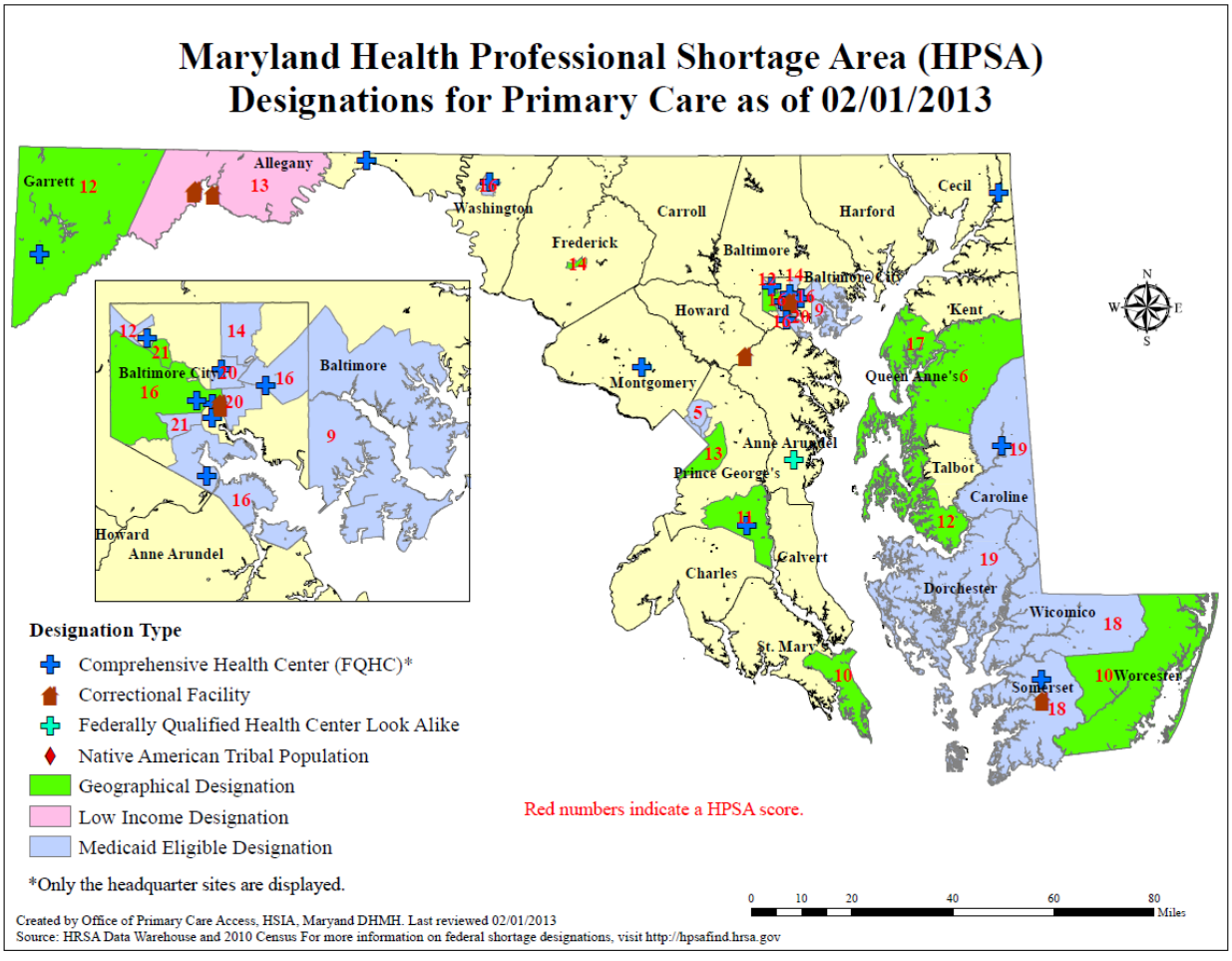
The report cites conclusions by state based on local studies regarding physician resources.

- For Maryland –According to a Maryland Hospital Association/ MedChi study, Maryland is 116% below the national average for the number of physicians available for clinical practice.
- The shortage of physicians has most affected rural areas including the Eastern Shore.
- One reason for shortages is an aging workforce with 33.4% of physicians over age 55.

Strengths

- Strategies suggested for curtailing physician shortages in Maryland include: initiating a state loan forgiveness program, increase the number of residency slots, and offer incentives to encourage physicians to practice in the state's rural areas.

Illustration



Component: META ANALYSIS / 5. MD Physician Resources

Report	Source	Date
Maryland Physician Workforce Study/ Applying the Health Resources and Services Administration (HRSA) Method to Maryland Data	Maryland Health Care Commission	May 19, 2011

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

Challenges

- The supply of physicians on the Eastern Shore (9 counties) was at the HRSA benchmark for some types of physicians (primary care and surgeons).
- The Eastern Shore has the second lowest physician to population rate in MD, with 1.86 physicians to 1,000 people, compared to the state at 2.44. The rates per 1,000 people for specific types of physicians are .62 for primary care, .27 for medical specialties, .39 for surgical specialties, and .57 for all others.
- This study (of adjusted measures) puts the Eastern Shore at -4% below HRSA baseline for physician supply, -10% for primary care, and -11% for surgical specialties.
- The average patient-care hours per physician per week on the Eastern Shore at 45.14 is higher than any other Maryland region.
- The percent of practices accepting Medicaid on the Eastern Shore is 89% (18% above the state average) and 91% for Medicare (8% above the state average).
- Physicians who are 60 years and older account for about 27% of active Maryland physicians, compared to roughly 25% nationwide.

Strengths

- For the entire state, physician population ratios exceeded the US average for broad categories of physicians.
- Data suggest that there are pockets of physician shortages, rather than wide spread shortages, which allows for a concentrated effort to remediate.
- The percent of practices accepting Medicaid on the Eastern Shore is 89% (18% above the state average) and 91% for Medicare (8% above the state average).

Component: META ANALYSIS / 6. NAMI Plan

Report	Source	Date
Strategic Plan	National Alliance on Mental Illness (NAMI)	2011-2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
						✓	

KEY FINDINGS

The National Alliance on Mental Illness declared the following goals in association with their 2011-2013 strategic plan:

Goal 1: NAMI is a dynamic and well-run organization.

Strategies include: Implementing standards of excellence; Developing and maintaining effective information technology; Defining and clarifying membership goals and supporting systems; Developing a marketing communications plan; Increasing diversity and cultural competence in outreach, planning and training; Cultivate strategic partnerships; Clearly articulating outcomes.

Goal 2: NAMI is financially secure and independent.

Strategies include: Securing funding; Ensuring dedicated resources; Develop successful collaborative fund raising with affiliates; Diversifying funding sources.

Goal 3: NAMI is the leading voice in mental illness advocacy nationally and at the state and local levels.

Strategies include: Growing membership; Engaging affected constituents in timely advocacy and policy development; Training members for self-advocacy; Increasing focus on disparities in mental health in diverse communities; Continuing as a major national presence; Developing capacity; Being proactive in promoting legislation; Focusing on key populations to include underserved, aging, transitional aged youth, veterans and active military, people who are homeless and have a mental illness, and those residing in institutional settings; Ensure integration of mental health and physical health for people living with mental illness across the lifespan.

Goal 4: NAMI offers state-of-the art education and information.

Strategies include: Engaging target audiences in program planning, development and evaluation; Model best and emerging practices; Help people to develop skills for self-advocacy and empowerment; Ensure effective communications for target audiences; Expand social media outreach.

Goal 5: NAMI seeks out, listens to and engages people of diverse perspectives and experiences in ways that are inclusive, respectful, relevant and responsive.

Strategies include: Engaging the National Consumer Council; Promoting and demanding full consumer integration; Promoting and demanding cultural competence; Acknowledging and addressing internal stigma.

Component: META ANALYSIS / 7. MD Early Childhood Plan

Report	Source	Date
Strategic Plan of the Division of Early Childhood Development	MD State Department of Education	Plan for FY 2010-2012

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

Strategic goals for Maryland's Early Childhood Development are:

Goal 1: All children, birth through age five, will have access to adequate and equitably funded quality early care and education that meet the diverse needs of families.

Objectives include: The Early Childhood Advisory Council will carry out a coordination and information sharing role with local early care and education service providers and community partners; Maintain viability of high-quality early care and education provided by non-public programs; Explore options to expand state and federal funding by establishing public-private partnerships; Develop a state-wide strategy that involves families, schools, and early care and education programs to ensure a successful transition; Build family, community and societal demand for high-quality early care and education services and expand the existing infrastructure; Make quality early care and education services affordable; Advance credentials through improved training and increased compensation for early care and education staff; Develop strategies for longitudinal data analysis.

Goal 2: Families of all young children will have access to the resources needed to be their child's first teacher.

Objectives include: Create and expand community based partnerships; Encourage each jurisdiction to develop a coordinated network to provide "just in time" culturally and linguistically sensitive information and resources to families; Sponsor community listening forums for families, caregivers, and community members; Develop and implement a communications strategic plan.

Goal 3: Children, birth through age five, will have access to adequate and equitable resources that will enable them to arrive at school with healthy minds and bodies.

Objectives include: Include children in strategies and actions, with focus on populations to include minorities, patterns of gender, ELL, low-income and children who use special education services; Support the use of the Maryland Center for Social and Emotional Foundations of Early Learning (SEFEL); Increase the number of eligible children participating in Medical Assistance or Medicaid; Provide information to families about the benefits of "medical homes"; Extend the Child Care and Adult Care Food Program to informal child care providers; Promote awareness of available health resources.

Component: META ANALYSIS / 8. MD Disabilities Plan

Report	Source	Date
MD State Disabilities Plan 2012-2015	Maryland Department of Disabilities	2012-2015

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Maryland State Disabilities Plan encompasses the following goals:

Employment and Training:

1. Ensure implementation/achievement of disability related items within Maryland's Skills to Compete Action Plan.
2. Increase access to and availability of quality work incentives, higher education and other resources to support individuals with disabilities in achieving their employment goals.
3. Create and replicate best practices that increase integrated, individualized employment outcomes for Marylanders with disabilities.
4. Promote awareness of the skills and abilities of job seekers with disabilities to large and small employers.

Community Living

1. Receive supports and services in the most integrated community setting based on the needs and preferences of the individual with an emphasis on rebalancing resource utilization and delivery of services in the community as opposed to institutional settings.
2. Benefit from Maryland policy initiatives that reflect the state's commitment to provide quality and more person-directed supports and services in community-based settings thereby offering individuals the opportunity to exercise greater control and choice.
3. Increase access to accurate information that promotes increased awareness of available public and private resource options.
4. Increase access to resources and information that supports community living and addresses functional needs in response to emergency situations.
5. Increase access to information and resources concerning the Americans with Disabilities Act (ADA).

Housing

1. Create strategies to increase affordable, accessible, integrated housing for individuals with disabilities.
2. Develop and implement access to housing in the communities where people with disabilities choose to live by increasing the availability of visitability and other accessibility features in newly constructed or renovated housing in Maryland.
3. Incorporate the needs of people with disabilities into transit oriented development (TOD) and the creation of livable communities.

Education

1. Educate students with disabilities in the least restrictive environment with their nondisabled peers at a greater percentage.

2. Provide preschool services to children with disabilities in settings with their nondisabled peers to facilitate entry into kindergarten ready to learn.
3. Increase the number of students with disabilities scoring proficient or advanced on the MSAs and increase the number of students with disabilities scoring proficient or advanced on the HSAs and receive a high school diploma.
4. Support effective transition planning so students with disabilities will exit high school better prepared for employment and/or post-secondary education.

Children, Youth and Families

1. Improve capacity that fosters individualized community-based services for children and youth with disabilities to remain in their communities and decrease reliance on out-of-state options.
2. Increase access to out-of-school time programs for children and youth with disabilities in settings with nondisabled peers.
3. Increase access to transition planning information, supports and services for youth, young adults, and their families.

Technology

1. Provide Marylanders with disabilities the information and training needed to make informed choices about selection, funding, acquisition, and operation of assistive technology.
2. Reduce financial barriers to acquiring assistive technology for eligible Marylanders with disabilities who are seeking independent living and employment opportunities.
3. Provide technical assistance and information to improve the accessibility of State agency websites and other information technology-based services.
4. Collaborate with responsible state and local agencies to help ensure uninterrupted access to assistive technology devices and services for eligible students including those who are transitioning from high school to work or higher education and individuals who receive services through DDA.
5. Develop a plan with key agencies and stakeholders to create environmentally responsible, medically safe and fiscally sound durable medical equipment and assistive technology reuse programs.

Health and Behavioral Health

1. Ensure access to high quality, consumer- centered behavioral health services
2. Improve access to behavioral health services for people with a wide range of non-psychiatric disabilities and co-occurring psychiatric disabilities.
3. Rebalance the State's behavioral health service delivery to ensure that people with disabilities have access to these services in the most integrated setting based on their needs and community living preferences.
4. Improve access for children and adolescents with metal health disabilities to supports and services within their communities.
5. Improve access to care for people with disabilities and ensure Healthcare Reform efforts incorporate the needs of people with disabilities.

Transportation

1. Improve access to public and personal transportation for people with disabilities.
2. Increase use fixed route transportation by people with disabilities.
3. Examine cross-regional transportation capacity in both the fixed route and paratransit systems to enable people with disabilities to travel across regions using multiple systems.
4. People with disabilities will have improved access to specialized health related transportation options with flexibility and efficiency of scheduling.

Component: META ANALYSIS / 9. MD Mental Health Plan

Report	Source	Date
FY 2013 Annual State Mental Health Plan	MD DHMH Mental Hygiene Administration	July 2012

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Maryland State Mental Health Plan includes these goals:

Goal I: Increase public awareness and support for improved health and wellness.

Objectives include: Working with CSA and behavioral health community to educate and disseminate current information re: disorders, prevention, treatment and supports; Continuing efforts to facilitate recovery, build resiliency, and promote health and wellness across the lifespan; Increasing opportunities for community engagement.

Goal II: Promote a system of integrated care where prevention of substance abuse and mental illness is common practice across the life span.

Objectives include: Promoting integrated health care in collaboration with CSA's, administrative service organizations, managed care organizations, and the behavioral health community; For individuals with or at risk for psychiatric disorders, developing, screening, and implementing prevention/early intervention services across the lifespan; Addressing the needs of children, teens, transitional aged youth – and their families.

Goal III: Work collaboratively to reduce the impact of violence and trauma for individuals with serious mental illness and other special needs.

Objectives include: Protecting rights of those receiving services; Improving access to those receiving services for psychiatric disorders and co-existing conditions; Addressing issues concerning improvement in community service integration.

Goal IV: Provide a coordinated approach to increase employment and promote integration of services and training to develop and sustain an effective behavioral health workforce.

Objectives include: Developing employment options and supports; Developing and implementing collaborative training initiatives for those agencies serving the public; Promoting culturally competent and linguistically appropriate services.

Goal V: Build partnerships to increase the provision of affordable housing and reduce barriers to access in order to prevent homelessness for individuals with mental illness.

Objectives include: Maximizing current resources to promote affordable safe housing; Improving access to mental health services for those who are homeless.

Goal VI: Utilize data and health information technology to evaluate, monitor, and improve quality of behavioral health system of care services and outcomes.

Objectives include: Identifying and promoting evidence-based, effective, promising, and best practices for mental health services and facilities; Monitoring and evaluating performance of key contractors; Utilizing data and health information technology to evaluate and improve outcomes; Promoting the use of technology for information sharing, training, data collection, and evaluating performance and outcomes.

Component: META ANALYSIS / 10. MD Mental Health Plan Implementation

Report	Source	Date
Implementation Report of the FY 2013 State Mental Health Plan	MD DHMH Mental Hygiene Administration	November 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Maryland State Mental Health Plan includes these goals:

Goal I: Increase public awareness and support for improved health and wellness.

Achievements Include: 1,300 Marylanders were trained in Mental Health First Aid; A Youth Mental Health First Aid training program was launched; The Mental Health Administration (MHA) in collaboration with the Core Service Agencies (CSA) continue to provide mental health public education and training opportunities; A Children's Mental Health Awareness Campaign resulted in over 1.1 million media impressions; Other awareness campaigns included the Anti-Stigma project, May Mental Health Month, Network of Care access, Campaign for Older Adults, and increased awareness of Core Service Agencies and Wellness and Recovery Centers; Social media utilization has been increased; CSAs have established All Hazards Plans for behavioral health response during disasters or community emergencies; Wellness Recovery Action Plan trainings are ongoing; Smoking cessation efforts continue for mental health constituents; Self-directed care and Peer Advocacy strategies remain central to recovery plans; The core concepts of resilience are being emphasized in child and adolescent mental health services, and expanded to include adults and the elderly; The Consumer Quality Team is actively engaged in feedback sessions with mental health consumers; The Maryland Coalition of Families for Children's Mental Health is supported through state funding to provide advocacy training and youth leadership development; The Leadership Empowerment Advocacy Project (LEAP) provides skill building for consumers to become leaders, advocates, and policy changers.

Goal II: Promote a system of integrated care where prevention of substance abuse and mental illness is common practice across the life span.

Achievements include: MHA is monitoring data, developing wellness activities, and facilitating coordination of care; Monitoring systems to include Pharma Connect, Medicaid Pharmacy for Peer Review, Coordination of Care Committee, and the Quality Incentive Program (for outpatient mental health centers) are ongoing; Behavioral health financing and systems integration is promoted through workgroups, the Behavioral Health Integration website, stakeholders meetings, and development of a new organizational model for the new behavioral health administration; A peer review authorization process is now in place to ensure optimal treatment for children and youth using non-pharmacological measures when possible; Collaborations with key agencies have been heightened to include the Developmental Disabilities Administration, the Department of Aging, Public Safety and Corrections, Juvenile Services, the Judiciary, the Office of Health Care Quality, Office of the Deaf and Hard of Hearing, Department of Veterans Affairs, Department of Human Resources, Housing and Community Development, Division of Rehabilitative Services, Governor's Office for Children, Maryland State Department of Education, Family Health Administration DHMH Prevention and Health Promotion, Maryland Emergency Management Agency, DHMH Office of Capital Planning, Budgeting, and Engineering, Maryland Health Care Commission, Health Services Cost Review Commission, Alcohol and Drug Abuse Administration, and Medical Care Programs; Screening,

prevention, and early intervention initiatives include the Early Childhood Mental Health Certificate Course program, Social and Emotional Foundations of Early Learning framework, Project Launch, and suicide prevention activities; Plans are being implemented and developed to address the needs of children, adolescents, and transition-age youth with psychiatric disorders (and their families) such as the Healthy Transitions Initiative and refinement of the Care Management Entity approaches; Collaborative efforts to improve Dual Diagnosis Capability and response is occurring across agencies and especially with the Alcohol and Drug Abuse Administration; The activities of national and state health care reform are being monitored for optimal utilization of mental health care

Goal III: Work collaboratively to reduce the impact of violence and trauma for individuals with serious mental illness and other special needs.

Achievements include: The Office of Forensic Services, the Mental Health and Criminal Justice Partnership, and the Interagency Forensic Services Committee are continuing to promote the development of community reentry services such as diversion, housing, and case management for individuals with mental illness who encounter the criminal justice system; The DataLink system has proved successful for sharing mental health information with the criminal justice system; Best practices are being shared for pre-trial coordination, detention center care, and discharge from corrections programs; Increased strategies are underway to improve access to mental health services for co-existing conditions to include court and criminal justice involvement, deaf and hard of hearing, traumatic brain injury (TBI), homelessness, substance abuse, developmental disabilities, and victims of trauma; Improvement in integration of community services is being addressed through stakeholder workgroups, diversion activities and initiatives, Psychiatric Residential Treatment Facility demonstration waiver, review of mental health services within the State's Medicaid Plan, building upon strengths in the existing system, improve the monitoring and use of screening tools, and revise financing mechanisms to improve the delivery of integrated behavioral health care.

Goal IV: Provide a coordinated approach to increase employment and promote integration of services and training to develop and sustain an effective behavioral health workforce.

Achievements include: MHA and CSAs are working together to develop employment options and supports to increase the number of gainfully employed consumers – using strategies such as Ticket to Work, intensive benefits counseling, the Johnson & Johnson Dartmouth Community Mental Health Program Family Advocacy Project, "Employment and Families" workshops, peer employment training, motivational interviewing, and person centered care planning; Core competencies training for children's mental health has been developed and will be implemented through the University of Maryland School of Social Work; Cross educational events and initiatives to improve best practices concerning mental health and substance abuse have been launched across the state; Strategies to improve cultural/ linguistic competencies are ongoing.

Goal V: Build partnerships to increase the provision of affordable housing and reduce barriers to access in order to prevent homelessness for individuals with mental illness.

Achievements include: Affordable and safe housing is being promoted for individuals with ; serious mental illness via the development of 550 new housing units from Community Bond funding, improved transition between mental health facilities and community living, improved rental assistance programs, and housing vouchers.

Goal VI: Utilize data and health information technology to evaluate, monitor, and improve quality of behavioral health system of care services and outcomes.

Achievements include: Evidence-based practices implemented for this goal are Way Station, Inc., Tool for Measurement of Assertive Community Treatment, Integrated Illness Management and Recovery, diversion program as part of re-entry services for inmates, and enhanced monitoring of contract requirement for the administrative services organization and CSAs.

Component: META ANALYSIS/ 11. MD MACSA Plan

Report	Source	Date
Integrated Care for Individuals with Behavioral Health Disorders	Maryland Association of Core Service Agencies	August 30, 2011

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

- Behavioral health issues related to the well-being of the Maryland citizens include: (1) Criminal and Juvenile Justice; (2) Prevention, Early Intervention and Treatment; (3) Crisis Support; (4) Community Based Care; (5) Vulnerable Populations; (6) Homeless Services; (7) Evidence Based and Promising Practices; (8) Integrated Care; (9) Peer Support; (10) Non-DHMH Funding; (11) Public Health Agenda; (12) Substance Use/Addictions Collaboration; (13) Somatic Care Collaboration; and (14) Other Unique CSA Initiatives.

- Core Service Agencies are the local mental health authorities responsible for planning, managing and monitoring the Maryland Public Mental Health System (PMHS) at the local level, as mandated in 1991, by Health General, Title 10, Subtitle 12. There are 19 distinct local CSA's in Maryland's 24 jurisdictions. Responsibilities include service authorization, care coordination, quality assurance, residential program inspections, audit for regulatory compliance, needs assessments and strategic planning, development of annual budgets, local vendor contract execution, contract monitoring, and CSA network development (plus other duties).

- CSA programs in Maryland have been very creative in increasing mental health resources and leveraging funding. They have proven to be value-added services in their communities.

- Each CSA, while having the same legal mandate, operates in a manner unique to the jurisdiction it serves, based on local needs, innovation and availability of human and fiscal resources and some have recently become integrated with County substance abuse/addictions programs to form behavioral health entities.

- The goals of the CSAs are to focus on the improvement of behavioral health services, expand access to care, identify gaps in services and create initiatives to fill them, provide leadership and maximize resources through partnerships with other local, regional and State agencies. In FY 2011, the mid-shore CSA received $2,402,041 in funding and awarded 31 CSA contracts. In FY 2010, the total costs of the CSAs represented less than 2% of the total PMHS costs.

- Exemplary and unique programs developed by the MSMHS included the five-county Forensic, Mental Health Program; use of reinvestment dollars to establish the Eastern Shore Operations Center, Mobile Crisis Teams, and the Urgent Care Clinic; Administration of the Homeless Management Information System and Continuum of Care; support of WRAP Certification classes; development of a mechanism for psychiatric consultation to primary care and pediatricians; Defeating Stigma Workgroup; Deaf and hard of hearing support, and the Latino population therapist.

Component: META ANALYSIS / 12. GOCCP Plan

Report	Source	Date
Maryland's Comprehensive State Crime Control and Prevention Plan	Maryland –Governor's Office for Crime Control and Prevention	2012-2014

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Governor's Office of Crime Control and Prevention have identified the following priority strategies:

Corrections/Offender Supervision – Following consistent evidence-based strategies in offender supervision via the Division of Parole and Probation; Improving safety and security of Maryland's prisons and better prepare inmates for returning to society; Managing sex offenders using the Collaborative Offender Management& Enforced Treatment program; Establishing a closer relationship with federal probation; Identifying core group of violent offenders and effectively maintaining a containment model.

Crime Analysis - Ensuring MD law enforcement agencies have resources to develop CompStat programs to improve data-driven policing; Giving law enforcement tools to evaluate crime characteristics and factors; Mapping crime to monitor patterns, trends and concentration areas; Using best and promising public safety strategies; Focusing on traditional criminal activity as well as terrorism and homeland security; Providing comprehensive, accurate, and timely intelligence.

Crime Control Programs and Services – Providing user-friendly web-based resources to connect ex-offenders with critical resources; Identifying drug court opportunities for non-violent substance abusing offenders; Expanding drug treatment options across continuum of care; Streamlining grant funding; Through Operation Safe Kids, enhancing an effective community-based supervision model for at-risk juveniles; Expanding Safe Streets Model.

Legislation – Creating and passing public safety legislation.

Public Safety Collaboration – Implementing cross-border collaboration, effectively managing dangerous offenders; Curbing the growth of criminal street gangs and effectively dismantling existing gangs; Targeting known gun traffickers; Prioritizing warrants for most dangerous offenders; Creating strong collaboration between police and Parole & Probation.

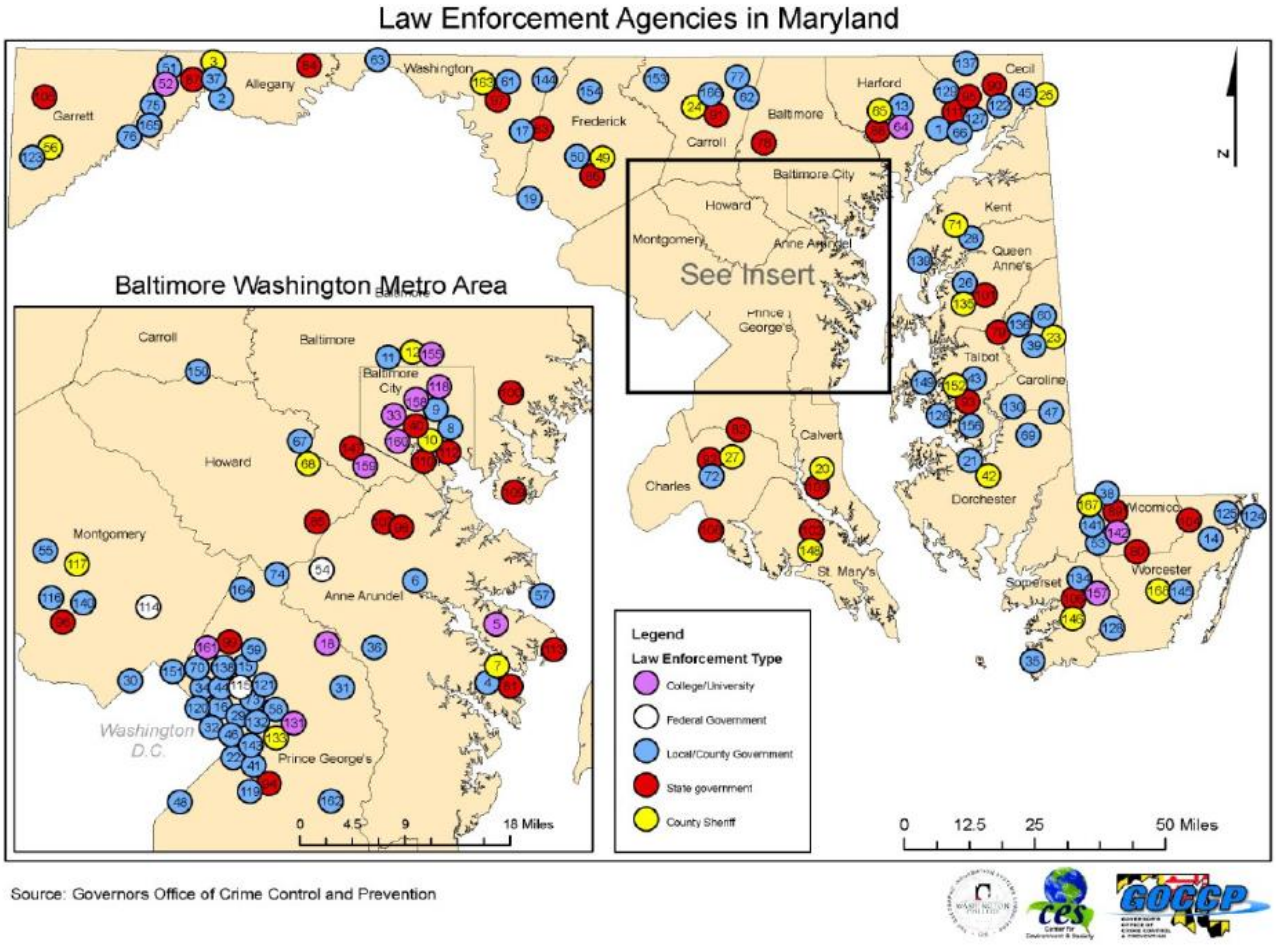
Technology – Expanding and improving web-based user-friendly information consolidation for law enforcement access; Enhancing ability and resources to combat Cybercrime; More effectively utilizing state's forensic DNA resources; Expanding inventory of License Plate

Recognition systems; Developing an improved Offender Case Management System from arrest to release; Providing a central repository of transaction pawn data.

Training – Educating, connecting and empowering criminal justice personnel with training.

Victim-Related – Developing risk assessment process to identify families most likely to abuse children; Filling gaps in criminal justice system where greater assistance is needed; Reducing domestic violence crimes; Creating Family Violence Councils; Coordinating a human sex trafficking summit; Ensuring that all crime victims in Maryland are treated with dignity and respect, their rights are upheld, and funding for assistance and support is available.

Illustration



Source: Governors Office of Crime Control and Prevention

Component: META ANALYSIS / 13. MD DJS Strategic Plan

Report	Source	Date
DJS Comprehensive Strategic Plan Update	MD Department of Juvenile Services	July 9,2010

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Maryland Department of Juvenile Services has identified the following goals and strategies:

Treating Maryland's Youth in Maryland – Building in-state capacity to treat Level V youth; Diverting youth to wraparound and evidence-based programs; Improving case management processing; Improving capital.

Improving Conditions of Confinement at All DJS Facilities – Eliminating the inappropriate use of secure detention; Replacing outdated facilities with new construction.

Achieving Better Outcomes for Youth and Families and Becoming a More Data Driven and Results Driven Agency - Expanding community-based services, treatment, and placements; Enhancing core programming at DJS treatment facilities; Implementing the truancy initiative.

Reducing the Number of Homicides and Non-Fatal Shootings of Youth Under DJS Supervision – Implementing the Violence Prevention Initiative; Implementing Community Detection and Electronic Monitoring.

Aligning Organizational Development with the Strategic Planning Goals - Integrating services to youth; Professional development; Leadership development.

Component: META ANALYSIS / 14. Mid-Shore TAY Assessment

Report	Source	Date
Mid-Shore Transitional Age Youth Needs Assessment	Mid-Shore Mental Health Systems, Inc.	January 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- Depending on the county, 12% (Queen Anne's) to 28% (Kent) of high school students are missing 20 or more days per school year.
- In 2011, there were a total of 859 high school students with diagnosed disabilities at the nine mid-shore high schools. Special education enrollment ranged from 8.2% in Talbot County to 17.1% in Kent County during 2011-2012.
- In 2007, Kent County had the highest student smoking rate (37.7%) and the highest Grade 10 alcohol use rate (42.4%) and Talbot had the highest Grade 12 alcohol use rate at 59.5%.
- Four of the five mid-shore counties have high school asthma rates at levels greater than the Maryland average. Kent is the exception.
- Adolescent obesity rates are highest among African Americans on the mid-shore and overall obesity rates are above the state average in three of the five mid-shore counties.
- The mid-shore exceeded Maryland averages for alcohol crashes for all ages, DUI arrest rates, and liquor violation arrest rates for people under age 21 (in 2008).
- Every mid-shore county also has higher rates than the Maryland average of reported bullying on school grounds.
- The 2010 correctional facilities Census showed 300 young people ages 10-24 as detained or incarcerated.
- From 2003 to 2011, 25 mid-shore youth between the ages of 10 and 24 committed suicide. All were male and 23 of the 25 were White.
- In Maryland, the rate for births to unmarried women in 2010 was 41.7%, while it was 48% across the mid-shore.

Strengths

- Approximately 26,180 mid-shore residents are between the ages of 14-26.
- Nearly 100% of mid-Shore high school students are successfully passing their high school assessment tests prior to graduation.
- Drop-out rates are below the state's satisfactory standard of 3% at six of the nine mid-shore high schools.
- A range of 30.7% (Caroline) to 47.2% (Talbot) of high school seniors plan to attend a 4-year college after graduation, with a range of 27.3% (Kent) to 38.3% planning to attend a 2-year college.
- The majority of high school grads hope to attend college (60%-84%), secure a job (10%-12%), or enter the military (<5% to 7%).
- Of the 69 transitional aged youth who completed surveys in 2012, the average of time spent "enjoying life" was 76%.

Component: META ANALYSIS/ 15. MD DAAC Plan

Report	Source	Date
Strategic Plan for the Organization and Delivery of Substance Abuse Services	Maryland State Drug and Alcohol Abuse Council (SDAAC)	Plan for 2012-2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

The Maryland State Drug and Alcohol Abuse Plan encompasses the following goals:

Goal I: Establish and maintain a statewide structure that shares resources and accountability in the coordination of, and access to, prevention prepared communities and comprehensive recovery-oriented services.

Objectives include: Involving relevant agencies in Recovery Oriented System of Care (ROSC); Improving coordination and collaboration; Reducing gap between need and availability of services; Promoting/expanding evidence-based prevention strategies through Maryland Strategic Prevention Framework (MSPF) and SAMHSA; Developing survey and trend data to assist in planning and evaluating; Exploring ways to transition from grant funding to fee for service; Improving data gathering and sharing; and Improving workforce and cultural competency.

Goal II: Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance abuse conditions.

Objectives include: Improving screening, assessment, evaluation, placement, and aftercare for all individuals in treatment, criminal justice, and juvenile justice.

Goal III: To improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.

Objectives include: Engaging stakeholders in coordinated and integrated system of care for individuals with co-occurring problems – and expand service provision; Recruiting, training, and providing adequate resources to co-occurring workforce.

Goal IV: Codify the State Alcohol and Drug Abuse Council to assure a sustained focus on the impact of substance abuse.

Objectives include: Sustaining mission and work of SDAAC by codifying; Improving understanding of policy makers, leaders, and public of relationship between public safety, health, mental health, and substance abuse treatment and recovery; Publicizing ROSC progress.

Component: META ANALYSIS / 16. MD Opiate Plan

Report	Source	Date
Maryland Opiate Overdose Prevention Plan	MD Department of Health and Mental Hygiene	January 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
					✓		

KEY FINDINGS

Challenges

- The number of heroin-related deaths occurring in Maryland increased to 372 in 2012, up from a low of 238 in 2010. (Note: The total had reached 382 in 2007.)
- The age group with the greatest number of deaths is 45-54, followed by 35-44 year olds.
- Deaths among whites are nearly double deaths among blacks.
- Deaths among males are more than three times higher than deaths among females.

Strengths

- Epidemiology has been enhanced in Maryland to assist overdose prevention planning activities. All data is available online at the DHMH website. Unintentional drug intoxication deaths will be monitored and reported.
- One of the key state strategies is an Overdose Fatality Review process, along with a CDS Emergency Preparedness Plan.
- Another key strategy is implementation of the Prescription Drug Monitoring Program – launch expected by October – to reduce potential for overprescribing/negative cross drug effects and incidents of doctor shopping.
- Two other strategies are a Controlled Dangerous Substance Integration Unit (information, investigation, medical review) and a Medicaid "Lock-In" Corrective Managed Care Program (MA pharmacy benefit misuse prevention, etc.)
- Local jurisdictions are required to submit local opiate prevention plans. (Mid-shore's was submitted in June of 2013.)

Component: META ANALYSIS / 17. Mid-Shore Opiate Plan

Report	Source	Date
Local Opiate Overdose Prevention Plan	Mid-Shore Local Health Department Improvement Coalition (LHIC)	June 28, 2013

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

Challenges

- The number of Mid-shore arrests for possession, sale, and manufacturing of drugs total 1501 in 2008 and dropped to 1220 in 2011.
- Treatment admissions have steadily declined from 2798 in FY 2010 to 2549 in FY 2012, while opioid use outpatient treatment numbers climbed from 274 to 361 during the same time period.
- The percentage of admissions where opioids are assessed as a problem for the individual being admitted has increased from 3.5% in FY 2008 to 6.4% in FY 2012.
- The total inpatient admissions at the AF Whitsitt Center (where opiates were assessed as the drug of choice) was 103 or 46% of the total 222 admissions in FY 2012.
- Narcan administrations by EMS personnel are increasing steadily, with at least 199 administrations noted over a 12-month period on the mid-shore (only 5 months of data was available for Dorchester County).
- From 2007 to 2011, there were 91 intoxication deaths on the mid-shore; 66 were opioid-related deaths, 23 were heroin-related.

Strengths

- At least 65 community stakeholders collaborated to create the Opiate Overdose Prevention Plan.
- The plan goal is to reduce unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit opioid drugs (i.e. heroin) and pharmaceutical opioid analgesics. The plan encompasses efforts to reduce poisonings related to the ingestion of opioids alone or in combination with other substances, as well as both fatal and non-fatal poisonings.
- The mid-shore LHIC developed a comprehensive list of strategies ranging from no/low cost (awareness-oriented) to high cost (professional marketing, increase in Peer Recovery programs, increase in-patient beds, more school-based counselors and drug courts) strategies.

Component: META ANALYSIS / 18. CAR DAAC Plan

Report	Source	Date
Strategic Plan Progress Report	Caroline County Drug and Alcohol Abuse Council	July 15, 2011

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓							

KEY FINDINGS

Challenges	Strengths
➢ Numbers for Juvenile Drug Court have decreased in recent years due to the voluntary nature and juveniles opting out of participation. ➢ The Drug Free Communities grant was not refunded beyond FY 12. ➢ The County's TIPS line has seen limited calls, but efforts are underway to more widely publicize the resource. ➢ Rising prescription drug use is a critical concern among Council members.	➢ Goals include: expanding Juvenile Drug Court and creation of an Adult Drug Court; Increasing prevention efforts to educate youth and families to live healthy, free of drug and alcohol abuse and addiction; Continuing to forge partnerships among courts, public agencies, and community-based organizations to impact effects of substance abuse. ➢ Funding was awarded at $355,000 in 2011 for Adult Drug Court – to serve 10 individuals in the first year. ➢ The county was awarded a Drug Free Communities Support Grant for five years, effective through FY 12. ➢ Nearly 300 alcohol servers/sellers were trained in responsible beverage service. ➢ Compliance checks (to deter underage service to minors) were funded beginning in 2011. ➢ An environmental strategies campaign to reduce underage drinking and alcohol crashes was funded and launched in 2011. ➢ The Council has worked to change laws in support of banning synthetic drugs. ➢ The Caroline Counseling Center will develop and implement a full continuum of ASAM Level I Treatment for the incarcerated population of Caroline County – beginning with female inmates.

Component: META ANALYSIS / 19. DOR DAAC Plan

Report	Source	Date
Strategic Two-Year Plan	Dorchester County Drug and Alcohol Abuse Council	July-December 2012

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
	✓						

KEY FINDINGS

Challenges

- According to the MD budget figures for Dorchester County, Treatment efforts receive 96% of funding from the Maryland Alcohol and Drug Abuse Administration, while Prevention receives 4% of the funds.
- According to the Communities That Care survey results released in July 2013, 3.9% of sixth graders, 14.2% of eighth graders, 29.2% of tenth graders and 32% of twelfth graders used alcohol in the 30 days prior to the survey.
- Also taken from the Communities That Care survey, 1.2% of sixth graders, 4.3% of eighth graders, 11.9% of tenth graders and 17.2% of twelfth graders have used marijuana within the past thirty days.

Strengths

- A number of Dorchester County agencies, including the Dorchester County Health Department and the Dorchester County Addictions Program, have participated in the application for a Health Enterprise Zone (HEZ) grant that would build significant bridges between somatic and behavioral health.
- Dorchester County is a model, nationally, in implementing a Recovery Oriented System of Care (ROSC) through the DRI-DOCK Recovery and Wellness Center.
- Generally, alcohol, tobacco, and marijuana use among high school students is steadily declining, but prescription drug use is on the rise, according to the Communities That Care surveys administered in 2005, 2011, and 2013.
- The Partnership for Drug Free Dorchester (PDFD) is holding monthly coalition meetings to continue planning and implementing evidence-based environmental strategies.
- The Partnership for Drug Free Dorchester conducted a Prescription Take Back Day on September 29, 2012, with 150 pounds of medications collected at four sites, up from 15 pounds collected in 2011.

Component: META ANALYSIS / 20. Kent DAAC Plan

Report	Source	Date
Strategic Plan for Alcohol and Drug Abuse/ For FY 12-14	Kent County Drug and Alcohol Abuse Council	January 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
		✓					

KEY FINDINGS

Challenges	Strengths
➢ It was an involved and time consuming process to achieve approval for the environmental strategies plan funded through the Maryland Strategic Prevention Framework (Note: approval was received in April of 2013). ➢ Kent County has the fourth highest rate of intoxication deaths in Maryland. ➢ AF Whitsitt Center was forced to reduce the number of beds from 40 to 26 in FY 12 due to budget cuts.	➢ Goals include: Developing linkages between treatment providers and other community agencies to improve access to resources for those in recovery; Developing and maintaining an accessible community system of intervention and treatment; Educating and assisting the citizens of Kent County to live healthy and drug free lives ➢ An abundance of collaborating agencies provide supports to individuals in recovery. These include 12-Step groups, churches, public agencies, and medical professionals. ➢ Access to treatment is facilitated through working relationships with local hospitals on the Eastern Shore, with Health Departments, and with Mental Health Care providers. ➢ Several partners have been identified to provide resources for those in recovery such as housing, transportation, and job readiness. These include Harvest House (in Cecil County), Samaritan House (Anne Arundel), Stepping Stones Recovery Houses, Dollar Bus, and the Kent County Rotating Shelter. ➢ Kent County Behavioral Health conducts intervention and evaluation for treatment with referrals from agencies in both public and private sectors. ➢ Kent County Behavioral Health has increased availability to care with walk-in appointments, thus eliminating service waits.

Component: META ANALYSIS / 21. QAC DAAC Plan

Report	Source	Date
Queen Anne's County Strategic Plan	Queen Anne's County Drug and Alcohol Abuse Council/ Alcohol and Drug Abuse Services	2012-2014

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
			✓				

KEY FINDINGS

Challenges

- There has been funding loss for inpatient detoxification and residential treatment; the target is to provide approximately 265 intermediate care facility bed days.
- There is a need for the development of sober housing programs in and around the jurisdiction.
- Current measures/ results for alcohol and drug use among youth are outdated (from 2007); A new measure is planned for 2013 (Note: This measure was administered in the schools in 2013; results are pending.)
- Binge drinking rates in Queen Anne's County are believed to be high (measure pending in 2013).

Strengths

- Goals include: Ensuring the availability of the appropriate level of care for all citizens of Queen Anne's County in need of substance abuse treatment; Reduce the incidence and prevalence of alcohol and drug abuse and its consequences to affected individuals, their families, and all residents; Partner with appropriate community entities to reinforce the "No use is the norm" message for underage alcohol use.
- Queen Anne's County will have available for citizens the current level of treatment including assessment, Level I and Level II treatment, services for those with co-occurring disorders, and referrals as needed to higher levels of care.

Component: META ANALYSIS / 22. Talbot DAAC Plan

Report	Source	Date
Drug and Alcohol Prevention, Intervention, and Treatment 2012-2014 Plan	Talbot County Drug and Alcohol Abuse Council	January 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
				✓			

KEY FINDINGS

Challenges	Strengths
➢ According to a Maryland Adolescent Survey conducted in 2007 by the Maryland State Department of Education, the rates of substance abuse among youth in Talbot County are among the highest in the state. ➢ The results from the Maryland Adolescent Survey also showed that 33.5% of Grade 10 students and 53.3% of Grade 12 students reported consuming beer or wine coolers in the 30 days prior to the survey. ➢ According to the Maryland Alcohol and Addictions Program: Outlook and Outcomes, the rate of adolescent admissions to Maryland alcohol and addictions treatment programs for Talbot County youth is the second highest in the state (this can be a strength as well).	➢ Goals include: Reducing the incidence and prevalence of alcohol and other drug abuse and its consequences to individuals, families and the community; Enhancing the Talbot Circuit Court Problem Solving Court; Expanding the outpatient program to engage and retain patients in treatment and recovery by identifying and enhancing services and supports that make it more likely that they will achieve and sustain their recovery. ➢ The Talbot County Youth Coalition continues to sponsor youth events and programs and saw an increased level of participation at the end of 2011. ➢ In June 2010, the Circuit Court's proposal to implement its Problem-Solving Court program (the "Program") was approved. ➢ A pilot re-entry program is currently underway and expected to begin accepting participants during the 2013 calendar year. ➢ A Truancy Reduction Court Program has been approved by the General Assembly, signed by the Governor and accepted its initial group of students in early 2012.

Component: META ANALYSIS / 23. DSS Annual Reports

Report	Source	Date
Annual Reports	Caroline, Dorchester, Kent, Queen Anne's, and Talbot County Department of Social Services	2011 (Queen Anne's only) 2012 (Other Counties)

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓	✓	✓	✓	✓			

KEY FINDINGS

- The Departments of Social Services across the Mid-Shore are providing emergency assistance, energy assistance, temporary cash assistance, employment support, and help with Medical Assistance applications collectively to thousands of customers annually. In addition, Social Services provides child welfare and adult services, family investment programs, in-home services, and out-of-home services as needed.

- Each county Social Services office offers specialized programs to benefit children and families including the Children's Advocacy Center in Talbot County and the Parents as Partners program in Caroline County.

- The number of child maltreatment investigations ranged from 103 in Kent County to 374 in Dorchester County.

- Child support payments collected for the year ranged from $1.1 million in Caroline County to nearly $4 million in Queen Anne's County.

Illustration

Key Social Services Data for 2011-2012

	CAR	DOR	Kent	QA*	TALBOT
Number of child maltreatment investigations	214	374	103	171	179
Amount collected for child support payments	$1,110,529	$3,110,775	$1,800,000	$3,855,255	$2,325,950
Average number of children in foster care monthly/annually	39 (7-1-11)	7	6	20	27
Number of children adopted	4	1	1	2	Unknown
Number of adult protective services investigations	114	Unknown	29	28	125

Source: Annual Reports – County Department of Social Services/ * 2011 data

Component: META ANALYSIS / 24. LMB Assessment - Caroline County

Report	Source	Date
Caroline County's Results for Child Well-Being/ Caroline County Community Needs Assessment	The Human Services Council for Caroline County Children, Youth, and Families	June 2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
✓							

KEY FINDINGS

Challenges

- In 2009, Caroline County had the third highest percentage (at 7.4) of uninsured people under age of 19.
- According to the Four Core Measures Survey administered to Caroline County public school students in 2011, youth perception of low or no risk and harm when using substances ranged from 33% to 47% among Grade 10 and Grade 12 for alcohol and marijuana.
- Also indicated in survey results for Grades 10 and 12, 24% to 29% of youth did not believe their parents would disapprove of their alcohol use.

Strengths

- Rates of substance abuse among middle and high school students for alcohol, cigarettes, and marijuana are on a downward trend over the past 10 years.
- Among adults, the number of domestic violence incidents in Caroline County decreased by 33% between 2007 (at 215) and 2010 (at 143).
- Juvenile intake cases were much lower in 2010 (361) and represented approximately two thirds of the number of cases (509) recorded in 2006.
- According to the 2011 State of Maryland Out-Of-Home Placement and Family Preservation Resource Plan, the rate of new admissions in out-of-home care in Caroline County has declined from 9.9 to 7.8 (per 1,000) and is far less than Maryland's rate for 2011 at 10.8.

Illustration

Four Core Measures Survey – Caroline County Public School Students – 2011

Indicator n = 967	% 6th n=241	% 8th n=313	% 10th n=218	% 12th n=195
Last 30 days use – any amount of **ALCOHOL**	4.56	18.53	46.79	44.10
Age first used alcohol – age 11 or less	13.69	19.81	15.4	18.46
Perception of risk and harm – no or slight risk	21.57	35.78	32.57	41.03
Parent disapproval – not wrong or a little wrong	4.14	11.5	24.31	29.23
Last 30 days use – any amount of **TOBACCO**	0.41	6.71	13.30	23.59
Age first used tobacco – age 11 or less	6.22	10.86	6.88	12.82
Perception of risk and harm – no or slight risk	7.46	8.95	8.72	13.85
Parent disapproval – not wrong or a little wrong	2.07	5.43	9.63	18.97
Last 30 days use – any amount of **MARIJUANA**	1.24	7.67	17.89	19.49
Age first used marijuana – age 11 or less	1.65	2.88	2.75	6.15
Perception of risk and harm – no or slight risk	5.39	16.92	27.98	47.18
Parent disapproval – not wrong or a little wrong	1.24	6.07	9.63	16.92

Source: Caroline County Prevention Office, January 2012

Component: META ANALYSIS / 25. LMB Assessment – Dorchester County

Report	Source	Date
Dorchester County Results for Children and Families	Dorchester County Local Management Board	June 2011

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
	✓						

KEY FINDINGS

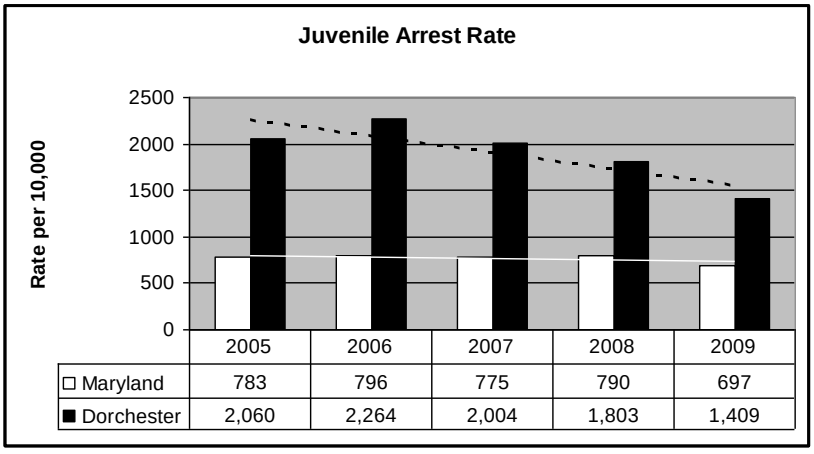
Challenges

- The percentage of all county people who live in poverty is 15.4 (MD =9.2%).
- County children under age 18 who live below the Federal Poverty Line (FPL) currently total 25.2%, the second highest rate in Maryland (MD=11.8%).
- Although trending downward, Dorchester's rates of child maltreatment, child injury, and juvenile arrests are higher than Maryland rates.
- Among 240 middle school students who completed the "Ten Minute Survey," students most frequently listed safety, specifically crime and bullying, as a community problem.
- Among 1197 students who completed a "Communities That Care" survey in 2011, the percentage of students reporting prevalence of risk factors was highest for low neighborhood attachment (59%), community disorganization (58%), poor family supervision (55%), community transitions and mobility (54%) and friends' delinquent behavior (53%),.

Strengths

- In recent years, significant improvements in school attendance have been noted.
- There have been steady improvements in assessment scores related to Pre-K children entering school ready to learn.
- Among 1197 students who completed a "Communities That Care" survey, the percentage of students reporting prevalence of protective factors was highest for belief in moral order (55%), social skills (48%), and family opportunities for prosocial involvement (47%).

Illustration



	2005	2006	2007	2008	2009
□ Maryland	783	796	775	790	697
■ Dorchester	2,060	2,264	2,004	1,803	1,409

Source: MD Department of Juvenile Services, Statistical Reports

Component: META ANALYSIS / 26. LMB Assessment – Kent County

Report	Source	Date
Kent Counts on Community: Kent County Community Needs Assessment	The Local Management Board for Children's and Family Services of Kent County	May 2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
		✓					

KEY FINDINGS

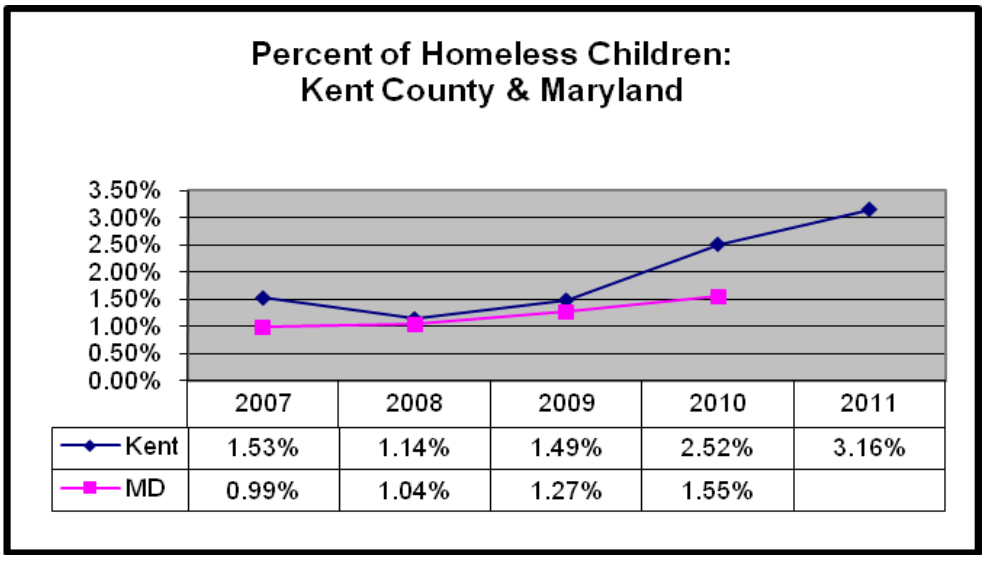
Challenges

- According to data taken from the U.S. Census Bureau and Centers for Disease Control and Prevention in 2009, at 8%, Kent County had the highest percentage of individuals under age 19 who are uninsured, when compared to all of Maryland's 24 jurisdictions and the state average.
- In the past five administrations of the Maryland Adolescent Survey (1998, 2001, 2002, 2004, and 2007), Kent County students in Grades 8, 10 and 12 generally reported higher use of alcohol in the 30 days prior to the survey than their Maryland counterparts. Binge drinking for Grades 8 and 10 were at least twice the percentage reported by Maryland teens in 2007.
- In 2010, the Maryland Youth Tobacco Survey revealed that 37.7% of Kent County students used tobacco, compared to 24.8% of the Maryland average.
- The percent of homeless Kent County children was higher from 2007-2011 than the Maryland average.
- In 2010, Kent County had the third highest bullying rate in Maryland (incidents per 1,000 students) at 21.1 %.

Strengths

- According to Kent County Department of Social Services, the number of children in foster care has been steadily declining between the years of 2006-2012.
- Second Step and Positive Behavior Interventions and Supports are two Evidence Based programs in the Kent County Public School system designed to address bullying and violent behaviors.

Illustration



Component: META ANALYSIS / 27. LMB Assessment – Queen Anne's

Report	Source	Date
Building on Success 2012 Needs Assessment	Queen Anne's County Local Management Board	2012

Geographic Focus

CAR	DOR	Kent	QA's	Talbot	MD	National	Other
			✓				

KEY FINDINGS

Challenges

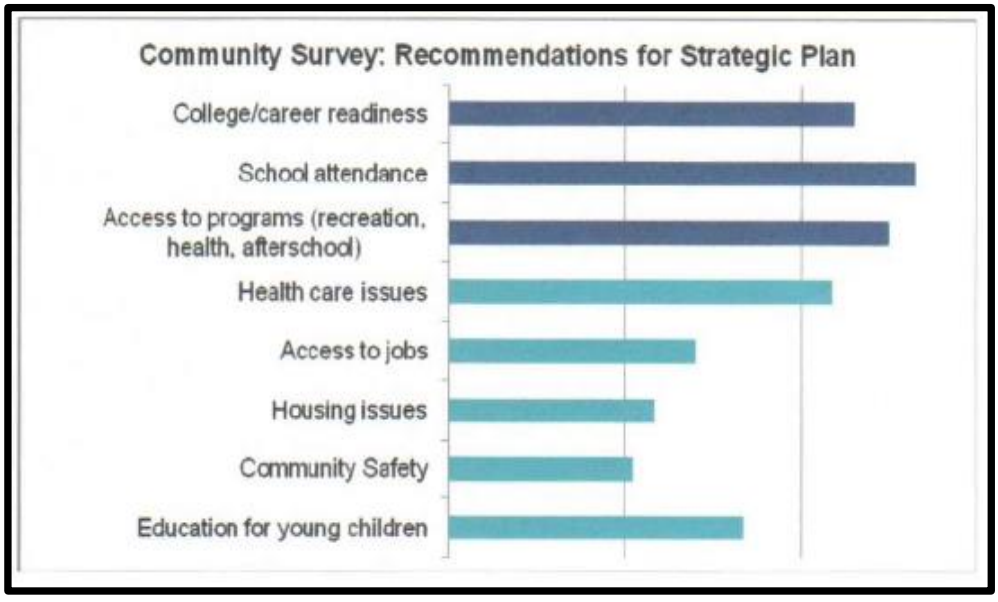
- The number of grandparents living with their own grandchildren under 18 years of age is 735 in Queen Anne's County.
- Queen Anne's County has been experiencing a decline in the minority population as more affluent white families move into the county.
- Nearly 42% of families with a female head of household and children under age 5 are living in poverty. Nearly 21% of families with a female head of household and children under age 18 are living in poverty.
- In 2010, at least 20% of Queen Anne's County residents commuted 60 or more minutes to work.
- Food stamp utilization has increased by 221% between 2007 and 2012.
- Queen Anne's County had the third highest rate (23.5%) in Maryland of children bullied on school property in 2009.
- The percentage of Grade 10 students using alcohol in 2007 was 39% and was 17% for marijuana.
- The DUI Arrest rate for QAC was 2.82 (per 1,000) in 2011, compared to 127.6 for Maryland.

Strengths

- 91% of Queen Anne's County residents ages 25 and older have a high school diploma, compared to 88.1% of Marylanders.
- The percentage of children entering school ready to learn has steadily increased and is now at 91%.
- Academic performance on Maryland School Assessments in Math and Reading is steadily climbing among county students.

Illustration

QA Needs Assessment Survey Results – Strategy Recommendations



Component: META ANALYSIS / 28. LMB Assessment – Talbot County

Report	Source	Date
Charting Trends, Affecting Change Talbot Family Network Needs Assessment for Children, Youth and Families	Talbot Family Network	June 2013

Geographic Focus							
CAR	DOR	Kent	QA's	Talbot	MD	National	Other
				✓			

KEY FINDINGS

Challenges	Strengths
➢ From American Community Survey data, the percentage of families living in poverty with a female head of the household, no husband present and related children under the age of five was 73.4% compared to 28.3% for Maryland -the second highest in Maryland (2007-2011). ➢ Of the 388 individuals responding to 2013 Talbot needs assessment survey, 30.67% indicated that the lack of health insurance was a concern in Talbot County (with greater levels of concern among Hispanics and African Americans). ➢ Of the 381 adults responding to the 2013 Needs Assessment, 40.68% listed obesity as the greatest concern in the Health related section of the survey. ➢ For the Talbot County Addictions Program, there has been a 264% increase, from 2010 to 2012, in the clients reporting Heroin as their primary drug, a 92% increase in Prescription Opiates, 200% increase in Benzodiazepines and a 53% increase in Cocaine/Crack. ➢ In 2012, 492 children and 591 adults with Medical Assistance received mental health treatment in Talbot County, an increase of 86 individuals over the prior year. ➢ Bullying was rated at high concern for adults and youth completing the Needs Assessment Survey in 2013.	➢ Talbot County has generally shown a decline in births to adolescent mothers for the last 10 years. ➢ The percentage of students missing 20 or more days of school in 2010-11 was 7.3%, compared to 11.3% for Maryland. ➢ The high school dropout rate has been on a steady decline in Talbot County. ➢ A significant portion (57.7%) of high school students with disabilities are fulfilling the Career and Technology Education program requirements at graduation, compared to the MD average of 25%. ➢ Juvenile Services referral rate is on a slight downward trend. Talbot County led the state with 0 recidivists (reconvictions) in 2010. ➢ While Child Protective Services (CPS) investigations have increased, the percentage found "indicated" remains steady at 24%. ➢ Crime indicators have generally shown a decline in Talbot County since 2008.

Mid-Shore Behavioral Health Needs Assessment 2014

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