WHITE PAPER

THE INTEGRATION OF BEHAVIORAL HEALTH AND SOMATIC CARE IN MARYLAND:

A CONSUMER PERSPECTIVE

A Report from the Office of Consumer Affairs Integrated Care Advisory Council

May 4, 2012
Introduction

This is a report of the Maryland Mental Hygiene Administration’s Office of Consumer Affairs (OCA) Integrated Care Advisory Council (ICAC) giving its observations, findings and recommendations on the integration of behavioral health (mental health and substance use) and somatic care in the state of Maryland. It outlines a clearly defined vision, what is currently working well, barriers and challenges throughout the System of Care in Maryland and other areas and offers suggestions on how to make the system resilient and recovery based.

Under the leadership of Susan Kadis, Coordinator of Special Programs of the Mental Hygiene Administration’s Office of Consumer Affairs, the Council serves an important role as an advisory arm to the Director of the Office of Consumer Affairs. The Council draws its agendas from the members as they relate to any concerns, problems or solutions in any jurisdiction of Maryland.

As Maryland moves towards a consumer driven integrated system of care, the Council outlines a system that:

- Is Person-Centered
- Addresses Personal Support Systems
- Is Recovery/Resiliency/Wellness Based
- Embraces Peer Support
- Addresses Cultural Diversity/Disparity
- Is Trauma Informed

Our Mission: The Integrated Care Advisory Council is comprised of consumers of behavioral health services representing all jurisdictions in Maryland who use their lived experiences to provide feedback to the Mental Hygiene Administration through the Office of Consumer Affairs. The Council advises and consults to the Office of Consumer Affairs regarding policies and procedures that educate, empower and advocate for consumers. These include quality improvement initiatives that focus on consumer rights, community building and the promotion of integrated care.

Our Vision: An integrated health system that is culturally competent and trauma informed while embracing recovery and resiliency.

For each topic, we will address the following:

- Our vision of an ideal consumer-driven, integrated system of care.
- Programs/Services/Models that are currently working.
- Barriers and challenges.
- Making our vision a reality.
Education and Training

Our Vision of an Ideal Consumer-Driven, Integrated System of Care

Basic and ongoing training and technical support on the integration of mental health, substance use and somatic care will be provided to all consumers, providers and stakeholders.

Programs/Services/Models that are Currently Working

There are programs currently working in Maryland that provide training for behavioral health consumers and professionals. Recovery based, peer facilitated trainings include the Wellness Recovery Action Plan (WRAP), Leadership Empowerment Advocacy Project (LEAP), Peer Employment Resource Specialist (PERS) training and Person Centered Planning.

On Our Own of Maryland and MHA’s Office of Consumer Affairs offer ongoing technical support and educational workshops to the Wellness and Recovery Centers. The Mental Hygiene Administration in collaboration with the University of Maryland Mental Health Services Training Center offer training opportunities to the mental health workforce as well as the consumers they serve.

In 2009, the Director of the Alcohol and Drug Abuse Administration with a workgroup comprised of county coordinators, addiction treatment providers, members of the recovery community, a recovery advocacy organization, and ADAA staff implemented a plan to develop a Recovery Oriented System of Care (ROSC). Currently there are ROSC trainings around the state, which are now including mental health practitioners in order to move towards integrated care.

Barriers and Challenges

A major barrier to education and training is resources and budget cuts at a time when it is imperative that those serving behavioral health consumers receive timely, intensive training. Another concern is resistance by mental health, substance use and somatic care health care professionals to the concept of patient centered decision making in an integrated care system.

Making our Vision a Reality

The use of ongoing advisory and focus groups that will assess the process of how integrated care is affecting those receiving services is an important tool that should continue throughout the integration process.

The use of self-management tools such as Whole Health, Recovery Dialogues and Wellness Recovery Action Plan (WRAP) to improve mental and physical health.

Person centered integrated healthcare needs to be woven into curricula in colleges and other forms of training.
Create workforce orientation, training, support, competencies, and job standards related to trauma informed care. Educating and training all staff that comes into contact with consumers, from the receptionist to maintenance staff, not only clinical staff.

**Peer Support**

**Our Vision of an Ideal Consumer-Driven, Integrated System of Care**

Peer-operated services for those with behavioral health needs are one piece of an integrated system that adds great value and success to service delivery. As consumers serving on this council, we agree it is vital that peer-operated services play a significant role in Maryland’s integrated system of care. Peer operated services practice a whole-health approach by recognizing each person’s overall wellness and incorporating a variety of programs and services, including referrals to somatic healthcare. Peer operated services are evidence based and/or best practices.

**Programs/Services/Models that are currently working**

Peer-support services are strong, valuable resources in Maryland that complement an integrated health care system. Peer Support Specialists (PSS) are consumers who have lived experience with behavioral health needs who are in recovery. PSS offer support and tools for people in their communities that are interested in exploring and/or working on their recovery. Peer-operated programs practice a “no wrong door” approach for any consumer who is in need of support, education and resources. Peers within the Statewide Consumer Network of Peer-operated Wellness and Recovery Centers are skilled at empowering peers and connecting them in the community to services they desire.

Maryland’s Consumer Network of 26 Wellness and Recovery Centers, 23 of which are completely consumer-operated, independent, 501c 3 organizations, touch approximately 5,000 consumers of behavioral health services per year at a cost of approximately $2,574,491/year. (MHA, Office of Finance). Peer-support programs provide a variety of life experiences and recovery tools to assist someone with both behavioral health and somatic healthcare concerns.

The emphasis on self-care resonates with the behavioral health system’s movement towards a Resilience and Recovery Orientated model, utilizing approaches such as Mary Ellen Copeland’s Wellness Recovery Action Plan (WRAP). As an Evidence Based Practice (EBP), WRAP can be used as a tool for individual and integrated whole health care. Individuals can share WRAP plans with doctors and create a clear plan that define roles and responsibilities for themselves and others (supporters) during crisis and post crisis. Often those supporters are peers and are chosen for having gone through crises themselves.
Integrated care is currently taking place in Assertive Community Treatment (ACT) through their utilization of peer support specialists. ACT provides services to consumers in the community who might not otherwise receive services within the public mental health system. The services offered to consumers are based on person-centered care. ACT is comprised of an inter-disciplinary team that includes a psychiatrist, nurse, social worker, substance use disorder specialist, vocational rehabilitation specialist and peer support specialist. This model offers consumers a level of care and understanding that other services are unable to.

On Our Own of Maryland, Inc. as a result of the Olmsted Act, hired Peer Support Specialists to assist patients leaving from state psychiatric facilities to transition into the community. The PSS work closely with the staff in hospitals and social work departments to obtain community resources and information to pass on to the consumers leaving the facilities. The PSS provide their personal knowledge and experience to consumers, both in group facilitation and in one-on-one interaction. By providing a listening ear, sharing their mutual experiences, and finding a connection PSS can help to support consumers during the difficult period of beginning anew in the community.

**Barriers and Challenges**

Although Peer Support has proven to bring great value and success to the behavioral health community, there continues to be significant challenges. There is a great deal of stigma attached to peers being able to assist other peers with services that have historically been provided by case managers and therapist. Peer Support services are not intended to take over the role of traditional mental health services; rather they are complement to one’s recovery process. It is important to weave PSS into the cultures of the provider agencies and to educate the system on the value of peers. Peer Support are often volunteers and if paid, often underpaid.

Training needs to be offered to peers who work as Peer Support Specialists (PSS). A pilot project on Maryland’s Eastern Shore offered Peer Support Specialist Training through MAPSS (Maryland Association of Peer Support Specialists) for eighteen (18) peers in August and September of 2010. A workgroup is currently meeting at MHA to address Peer Support Specialist training and certification.

**Making Our Vision a Reality**

Funding is essential, especially for new programs and those that have shown success. The Mental Hygiene Administration and the Center for Medicaid and Medicare Services can work in tandem to create a state plan that will reimburse federal dollars for peer support services within the public mental health system. However, Medicaid reimbursable Peer Support Services, if required in Wellness & Recovery Centers would hinder the mission and core values of the organizations. This needs to be taken into consideration as plans are developed in this area.

Peer Run Crisis Respite (PRCR) would bring a well needed crisis alternative to consumers. Hospital emergency rooms, acute psychiatric units, detoxification beds and
crisis beds continue to be overused in crisis situations. Peer Run Crisis Respite offers a less traumatic, more supportive and less expensive alternative with better outcomes for recovery. Chronic Health Homes is another approach at bringing peer support specialists into the Healthcare Reform Exchange.

**Substance Use Disorders**

**Our Vision of an Ideal Consumer-Driven, Integrated System of Care**

A system where individuals can receive tailored, effective services regardless of readiness to change, from acute care (detoxification) to long term recovery supports, that do not require immediate prior use of substances in order to receive referral and treatment, and where triage for behavioral health services includes assessment for somatic care. The use of an individualized approach, (person-centered planning) employs evidence based, scientifically validated treatment methodologies.

The system would embrace and recommend not only twelve-step programs, faith and non-faith based, but also secular, cognitive-behavioral and strengths based self-help groups. A system where Peer Recovery Coaches are trained not only in the substance use realm but also mental health, trauma informed care and somatic health issues that particularly plague individuals with behavioral health needs, including smoking, obesity, sedentary lifestyles and lack of nutritious eating habits.

**Programs/Services/Models that are Currently Working**

The Co-Occurring Disorders (COD) Supervisors’ Academy provides in-depth training for clinicians from the DHMH public mental health, substance use disorders, traumatic brain injury and developmental disabilities fields in the screening, assessment, treatment and support of adults with co-occurring mental health needs, substance use disorders, traumatic brain injury and/or cognitive disability. The goal of the Academy is to promote co-occurring disorders competency throughout the State of Maryland through professional development of clinical trainers and supervisors. In the future, additional COD Academies will be held.

Recovery Oriented Systems of Care (ROSC) training, a best practice model has been provided for both traditional providers and peer providers as a framework for service delivery, moving from an acute care model to a realization that substance use requires a chronic care approach. An important component of Maryland’s ROSC is RecoveryNet, a four-year Access to Recovery (ATR) grant awarded to ADAA in 2010 by SAMHSA. ATR is an initiative that provides Medicaid reimbursable vouchers to individuals for clinical and recovery support services while linking individuals to resources. ATR emphasizes choice and increases the array of available community and faith-based services, supports and providers. All services are designed to assist individuals in remaining engaged in their recovery while promoting independence, employment, housing, stability and self-sufficiency. Services by RecoveryNet are managed through an electronic Voucher Management System (VMS). ValueOptions, under contract with
the Maryland Alcohol and Drug Abuse Administration, pays RecoveryNet providers by matching claims to authorization.

Baltimore Recovery Corps (BRC) is providing training to 100 Peer Recovery Support Coaches/Peer Recovery Advocates in partnership with Baltimore Substance Abuse Systems (BSAS). Once fully trained, BRC graduates will be assigned to serve as peer-recovery support advocates/coaches in a number of treatment, recovery and community-based settings. As newly trained peer advocates, BRC graduates will provide assistance and support to individuals seeking to access treatment, as well as offering support and assistance to individuals preparing to complete treatment and transition back into the community.

**Barriers and Challenges**

The integration of the MHA and ADAA will present many challenges including administrative, oversight, certification and funding.

**Making Our Vision a Reality**

Strong partnerships are forged that allow for a grassroots, consumer driven, EBP based system while maintaining a “no wrong door” approach. MHA and ADAA will have a shared vision of integrated care.

**Somatic Health Care**

**Our Vision of an Ideal Consumer-Driven, Integrated System of Care**

Health care professionals will become more involved in consumers’ wellness and recovery plans. The primary care doctor’s role needs to be expanded to include diagnosis and treatment of behavioral health issues as well as somatic care. He/she must be willing to communicate with behavioral health providers and accept the consumer as the primary decision maker. It may be useful to think of the consumer as the spoke of the wheel, and everyone else, doctors, family, friends and colleagues would be connected on the periphery but also through the delivery of services.

**Programs/Services/Models that are currently working**

In 2009, Maryland’s Federally Qualified Health Centers (FQHCs) provided health services to over a quarter million of its citizens whose income hovers around the Federal Poverty Level (FPL). FQHCs are required to serve all the health needs of their clients. Services can be co-located within a healthcare facility which gives patients easier access to complementary disciplines.

FQHCs must provide primary care services and preventative health services for all age groups. Services are provided on site or by arrangement with another provider.
Services must include dental care, mental health, substance use, specialty care and transportation services necessary for adequate patient care.

Further advantages of this are better access to care, more time given to each individual, a strong working relationship between providers, ease of sharing e-records and obtaining consent, expanded knowledge among providers of services.

Healthcare for the Homeless is an example of co-location. In Baltimore, Healthcare for the Homeless delivers pediatric, adult and geriatric medical care, mental health services, case management, addiction treatment, dental care, HIV services, prison re-entry services, supportive housing and access to education and employment for thousands of Baltimore City residents.

**Barriers and Challenges**

This collaborative model establishes relationships with outside providers. The challenge is maintaining a strong collaboration so that referrals are followed through and appropriate care is given.

Research conducted by the National Association of State Mental Health Programs Directors and others shows that people with untreated behavioral health needs may die 25 years earlier than the general population.

SAMSHA has stated that higher risk factors are due to high rates of smoking, substance use, obesity, and “unsafe” sexual practice; poverty, social isolation, trauma, and incarceration; A lack of coordination between behavioral and primary health care providers; discrimination; side effects from psychotropic medications; and an overall lack of access to quality, culturally appropriate health care services.

Trauma informed care in a Somatic care setting is lacking or non-existent, depending on the care provider. While many ER and Urgent Care visits are due to traumatic incidences, there is very little training available for the staff working in these settings.

For people with past trauma seeking help with an unrelated health issue, past events seem to have little to no influence on current health treatment. If a person prefers a Doctor who is a particular gender, they may have to choose to be seen by a Doctor they are not comfortable with. Some Doctors try to be sensitive to past trauma, but seem uncertain about what to do to help their patients.

**Making Our Vision a Reality**

Required training in medical school, and other healthcare fields, continuing education (CME) regarding the integration of behavioral health and somatic care that is trauma informed.
Partnerships

Our Vision of an Ideal Consumer-Driven, Integrated System of Care

Strong partnerships between all consumer operated organizations and providers to offer support, education, resources and treatments that address the individual needs of consumers.

Programs/Services/Models that are Currently Working

The following Wellness and Recovery Centers currently are or working on integration programs with the Alcohol and Drug Abuse Administration to serve both mental health and substance use disorder peers. On the Lower Eastern Shore, in Wicomico County, Lower Shore Friends is expanding their location to include more programming for behavioral health and somatic care including smoking cessation.

Chesapeake Voyagers, Inc. (CVI) located in the mid-shore is partnering with the Dorchester Recovery Initiative (DRI- Dock).

Silver Spring Wellness & Recovery Center at Affiliated Santé Group has been holding free auricular acupuncture for several years, using the NADA (National Acupuncturists Detoxification Association) protocol, assisting with tobacco and other substance use detoxification, which has drawn several people from Avery Road Combined Care and others who might not otherwise frequent a mental health wellness and recovery center.

Since, February of 2012, the Dundalk center of On Our Own, Inc. has been implementing integrated services. These services include a peer support specialist trained in behavioral health. A qualified health care specialist is on site to address acute somatic needs.

The Office of Consumer Advocacy in Hagerstown is receiving a grant from ADAA, through the Washington County health department, to expand their Self Directed Care Program and serve people with substance use disorders as well as mental health issues. This grant is expected to begin 7/1/12.

Other Wellness and Recovery Centers planning to implement Substance Use Disorder programs as partners with ADAA include On Our Own of Anne Arundel County, and SPIN in Harford County.

Barriers and Challenges

Perceptions and language vary in the mental health and substance use communities can lead to challenges in partnerships. “We have to develop a workforce that is bilingual” says Matthew T. Clune, Regional Services Manager, Alcohol and Drug Abuse Administration. The Substance Use Disorders Peer Support Specialists (SUD) need to be conversant and trained the in the principles of mental health recovery, as well as the
Mental Health Peer Support Specialists need to be trained in SUD recovery and peer support.

**Making Our Vision a Reality**

Wellness and Recovery Centers and Substance Use Disorder programs can collaborate and have dialogue about what is working well in both systems. Participate in joint programming and activities. This level of collaboration does not have to wait for funding. It simply requires a willingness to take personal responsibility for what we have control over and being open-minded.

**Cultural Competency/Health Disparities**

**Our Vision of an Ideal Consumer-Driven, Integrated System of Care**

Diversify the healthcare workforce to better reflect the population served in a culturally competent manner.

Educating consumers on other cultures and lifestyles would be mandated to minimize problems in utilizing integrated services with consumers of substance use or homeless services. To uniformly coexist would eliminate a major barrier from a consumer perspective.

Behavioral health professionals must be sensitive and/or trained about the added stigma and problems faced by the GLBTQ population. They face higher rates of suicide, substance use, and cancer relative to heterosexuals. GLBTQ people experience rejection, prejudice, and discrimination.

**Programs/Services/Models that are Currently Working**

The *Maryland Plan to Eliminate Minority Health Disparities, Plan of Action for 2010 - 2014*, includes data on health disparities by racial group and provides specific action steps to address disparities.

There is a Wellness & Recovery Center in Baltimore for Lesbian, Gay, Bisexual, Transgendered and Questioning individuals with behavioral health needs.

**Barriers and Challenges**

Growing diversity challenges the healthcare system to adapt to meet a broad spectrum of new, often unrecognized or unknown needs.

Transportation for many minorities, especially new refugee and immigrant arrivals and deaf or blind individuals is yet another barrier to care. Availability of public transit is often limited, especially in rural parts of the state, and poses a particular burden on low-income individuals.
Cultural stigma regarding behavioral health needs also creates a significant barrier to care for many minority persons in need of assistance. While many people face economic and geographic barriers to accessing health care and health, minorities face additional social and cultural barriers. Cultural norms and low health literacy are common impediments to minorities’ access to all types of healthcare. The Institute of Medicine reports that nearly half the population in the United States has difficulty understanding and using health information.

Making Our Vision a Reality

Interpreters, when assessed and trained, can help in bridging this critical communication gap between provider and patient.

“Every Marylander, of every race, ethnicity, and nationality, in every part of our state, should have the chance to live a healthy, productive life,” said Lt. Gov. Anthony Brown, who pushed for the administration bill. “With our Health Enterprise Zone program, we will be able to saturate underserved communities with primary care and other health services to help reduce rates of chronic and often preventable illnesses, such as hypertension, asthma, diabetes and other controllable medical conditions.”

Technology

Our Vision of an Ideal Consumer-Driven, Integrated System of Care

Technological advances will be utilized to integrate behavioral and somatic healthcare.

Programs/Services/Models that are Currently Working

Internet-based health information is available in English and Spanish which are the two primary languages spoken in America. Telemedicine is being used to reach people in rural areas that lack adequate health care providers. Social networking sites like Facebook are used by more individuals to access peer support and find resources. Network of Care offers access to behavioral health resources for consumers, families, providers and stakeholders. Federal and State agencies use websites to communicate key information about the health care system to the public including services available, eligibility criteria and how to access services. ValueOptions® MemberConnect Website allows consumers and families to review their personal benefits information and send and receive emails from ValueOptions® even if the person does not have an email account.

Programs exist that provide low income individuals with free or low cost cell phones. Additional services such as text messaging can be added for a nominal fee.

Veterans Administration hospitals electronic record system is viewed as a good model. Electronic health records are being used in more outpatient settings.
Barriers and Challenges

Lack of uniformity and the cost associated in health care records as systems become electronic. People don’t trust that their information will be secure and confidential.

Making Our Vision a Reality

The majority of people affected by the “lack of technology” need to organize and advocate for changes in the system that gives them greater access to technologies shown to improve coordination of services, management of one’s health situation and leads to better health outcomes.

Create pilot projects with Behavioral Health providers testing the use of Electronic Health Records (EHR) and other technology to determine what works and doesn’t work in different parts of the state.

The creation of Electronic Health Record would assist in the integration of care.

FORENSIC ISSUES

Our Vision of an Ideal Consumer-Driven, Integrated System of Care

Integrated behavioral health and somatic health care provides an opportunity to drastically improve the quality of life for consumers with forensic issues. Whether the setting is a detention center, inpatient hospital or forensic aftercare, the union of all three treatments combines for a more successful outcome than treating each one separately. Behavioral health and somatic care should be seen as integrated forensic entities. Integrated care offers the best path to enhance and improve a consumer’s quality of care, quality of life, access to care and cost effective services.

Programs/Services/Models that are Currently Working

Currently, there are many areas of integration working within the system. Treatment teams are working together for consistent patient centered care.

Mental Health Courts are increasing in number, offering options of care rather than readmitting forensic patients immediately back into the legal system. These consumers are immediately started in person-centered integrated systems of care upon admission, discharge or mental health court. The duality of substance use and mental health now allows for Narcotics and Alcoholics Anonymous meetings in jails and hospitals and provides treatment follow through in the community after discharge.

Baltimore Mental Health Systems (BMHS) is currently procuring providers to offer Integrated Dual Disorders Treatment Services (IDDT). This evidence-based practice
(EBP) provides integrated treatment for co-occurring disorders that fully support consumers in the recovery process.

**Barriers and challenges**

Forensic patients need to be included in their own treatment planning and understanding the plan before signing it. They also need better understanding of medications, their side effects, and the need for lab work. There is a fear of losing their freedom due to the lack of community centered integrated care. The stigma associated with behavioral health issues and treatment can influence the consumers follow through with their treatment once in the community.

**Making Our Vision a Reality**

Having an ideal integrated system of care for consumers with forensic issues means the coalition of person-centered, recovery oriented behavioral health and somatic treatment that is free from stigma either between healthcare providers and/or consumers with forensic issues.

Conclusion: Every person shares concerns for health, housing, education, employment, and quality of life. Some populations struggle because living with socioeconomic disparities brought on by poverty, ethnicity, or location do not enable adequate opportunities to maintain optimum health. We succeed as a society when we ensure opportunity for all, including the opportunity for equity in health and well-being. By applying our ingenuity, we can make better use of our limited resources and progress towards solving health disparities. We can develop programs and services that are well distributed and accessible. The empowerment that comes with this person-centered treatment also mitigates stigma as health care professionals and family look to the consumer as the ultimate decision maker in his/her wellness and recovery.

The concept of recovery is the cornerstone of the vision. Recovery includes universal respect as well as the belief that every consumer has hope that their life will improve and they can work toward and achieve their goals. The importance of communication between not somatic and behavioral health professionals as well as the consumer receiving treatment must be paramount.
GLOSSARY OF ACRONYMS

ACT (teams) – Assertive Community Treatment (teams)
ADAA – Alcohol and Drug Addictions Administration
ATR – Access to Recovery
BMHS – Baltimore Mental Health Systems
BRC – Baltimore Recovery Corps
BSAS – Baltimore Substance Abuse Systems
COD – Co-Occurring Disorders
DHMH – Department of Health and Mental Hygiene
DRI Dock – Dorchester Recovery Initiative
EBP – Evidence-Based Practice
EHR – Electronic Health Records
FQHC – Federally Qualified Health Center
GLBTQ – Gay, Lesbian, Bisexual, Transgender, and Questioning
ICAC – Integrated Care Advisory Council
IDDT – Integrated and Dual Disorder Treatment
LEAP – Leadership Empowerment Advocacy Project
MAPSS – Maryland Association of Peer Support Specialists
MCO – Managed Care Organization
MHA – Mental Hygiene Administration
NADA -- National Acupuncturists Detoxification Association
OCA – Office of Consumer Affairs
OETAS – Office of Education and Training for Addiction Services
PERS – Peer Employment Resource Specialist
PRCR – Peer Run Crisis Respite
PSS – Peer Support Specialist
ROSC – Recovery-Oriented Systems of Care
SDC – Self Directed Care
SAMHSA – Substance Abuse and Mental Health Services Administration
VMS – Voucher Management System
WRAP – Wellness Recovery Action Plan

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