Behavioral Health Administration
FY 25-27 State Strategic Plan

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Maryland Department of Health Secretary's Message & Call to Action

On behalf of the Maryland Department of Health's Behavioral Health Administration (BHA), it is my pleasure to present the 2025-2027 State Behavioral Health Strategic Plan. In order to strengthen partnerships with our external stakeholders, and deliver data-driven, evidence-based care to the citizens of the great State of Maryland, we are focusing on a continuum of care model that addresses disparities, inclusivity, and trauma-informed care at its center.

Our Strategic Plan will demonstrate that Maryland's Public Health Behavioral System is clinically and fiscally sound. We will continue to work with external stakeholders across the state to produce efficient outcomes, which identify gaps, and address health disparities. The Strategic Plan has been redesigned to align with the Moore-Miller Administration's priorities and the State Plan, with a commitment to "Leave no Marylander Behind."

Governor Moore has expressed a commitment to making a substantial investment in behavioral health services in the State of Maryland. Beginning with his Fiscal Year (FY) 2024 budget which included an additional $107.5 million for behavioral health initiatives. The Department is committed to making an investment in the urgent priorities that are needed for the Public Behavioral Health System, which include expanding and improving statewide crisis services. The Department also intends to address the capacity issues at our state-run psychiatric hospitals and to create additional capacity in the community.

The State Legislature and the Moore-Miller Administration have also expressed their commitment to the advancement of behavioral health through the passing of the Behavioral Health Model Legislation (HB1148 of 2023). This legislation establishes the Commission on Behavioral Health Care Treatment and Access to make recommendations to provide appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the state. The legislation also requires the Commission to jointly meet with the Behavioral Health Advisory Council to improve alignment and focus work throughout the department. Further, the Moore-Miller Administration signed into law Assisted Outpatient Treatment (AOT) Programs (SB 453) which requires statewide implementation of AOT programs by July 1, 2026. AOT is a federally recognized best practice that can improve treatment adherence and outcomes among individuals with serious and persistent mental illness (SPMI).

Following through on the 2023 legislation (SB 362), the Maryland Department of Health is applying for planning, development, and implementation grant funds related to certified community behavioral health clinics (CCBHCs) for FY2025 and inclusion in the state CCBHC demonstration program for FY2026. CCBHCs must provide nine core services either directly or through designated collaborating organizations, including crisis services. MDH will establish a Prospective Payment System for CCBHCs which is an alternative payment model.

Governor Moore's agenda also includes a focus on adolescent behavioral health planning. As a Department, we realize that solutions are needed to better address the needs of Maryland's children, youth, and families. BHA is developing a Roadmap to ensure we have the capability and capacity to provide high-quality youth and family services across the Behavioral Health Continuum of Care. Work currently underway includes renewing the 1915(i) State Plan Amendment that provides intensive care coordination to children, adolescents and their families. BHA also collaborates weekly with the Department of Human Services, Department of Juvenile Services, Developmental Disabilities Administration, and the Maryland State Department of Education (MSDE) to discuss hospital overstay cases, emergency department overstays, solutioning, and address capacity issues, oversight, and system gaps. Lastly, the Department will be focused on using data to understand needs and drive outcomes.

Thank you for your ongoing support and partnership and I invite you to join me in this call to action.

Sincerely,
Meena Seshamani, M.D., Ph.D., Secretary of Health
Alyssa Lord, MA MSc, Deputy Secretary for Behavioral Health

Executive Summary

The Maryland Department of Health (MDH), Behavioral Health Administration (BHA) is dedicated to innovation. Through ongoing community partnerships and stakeholders' collaboration, BHA strives to accomplish a commitment to excellence by cultivating a system that values and provides effective and relevant behavioral health services to all Marylanders. Last year, BHA published the 2024-26 strategic plan. This edition has been updated to reflect the Moore-Miller Administration priorities along with the goals of the Secretary of Health, Dr. Meena Seshamani. Their top priorities include strengthening the public behavioral health system by meeting the needs of residents and prioritizing continuous improvement, with a specific focus on ensuring an equitable system for all.

This three-year strategic plan outlines the current services and behavioral health needs in the state, the administration's goals, and the objectives that will be used to define and develop BHA programs. To that end, the Behavioral Health Administration has redesigned its internal structure to reflect the needs of the public behavioral health system. With the implementation of the Behavioral Health Continuum of Care we seek to establish equitable access to care and dismantling of silos that provide gaps in service. Addressing behavioral health issues is complex and requires a multifaceted whole-person approach that evolves over time. BHA intends for this plan to facilitate the activities of the public behavioral health programming.

To achieve BHA's mission, this document outlines the goals to increase access, improve quality, reduce disparities, and address trauma and adverse childhood experiences (ACEs) in the state. The individualized needs of all consumers of the public behavioral health system are addressed along the continuum of care, therefore the services and process measure of BHA are displayed along that continuum. BHA is committed to providing programs and services that address the needs of special populations and ensuring that all programs are providing trauma-informed and culturally and linguistically informed services for all Marylanders.

BHA is cultivating a system that values and provides effective and relevant behavioral health services to Marylanders. A strong behavioral health system leads to meaningful and sustainable outcomes that enhance the quality of life, health, safety, and wellness for all Marylanders. The administration is focused on evidence-based practices as well as the establishment and evaluation of performance and outcome-based metrics. The information in this document can assist governing bodies in shaping future policies, plans and programs, and allocating resources. This strategic plan expresses the standards that the state and local systems managers should be held accountable to, for the purpose of ensuring Maryland's behavioral

health services meet the expressed needs of all individuals and families served across the system.

Vision, Mission, and Cultural and Linguistic Guiding Principles

- **Vision**: To achieve optimal health outcomes and decrease avoidable health disparities for individuals across the life span, which advances an equitable behavioral health system that is integrated throughout the continuum of care.
- **Mission**: Through publicly funded, culturally informed, quality-driven services and supports, BHA will promote equity, resiliency, recovery, health and wellness for individuals who have or are at risk of behavioral health disorders (including emotional, substance, gambling and/or mental health disorders) to improve their health and well being.
- **Cultural and Linguistic Guiding Principles:** Maryland's public behavioral health system aims to ensure that all populations have equal access to quality care regardless of ethnicity, race, gender, geographical location, nationality, sexual orientation, disability or socio-economic status. Understanding the distribution of behavioral health services in Maryland is essential to effectively evaluate and address potential issues concerning access to and quality of services. Data provides the foundation for sound decision-making and serves as a guide to the design and implementation of appropriate strategies to address quality of care and equal access to the public behavioral health system. BHA recognizes that continuous data analysis is a vital part of improving the quality and effectiveness of a strong culturally and linguistically competent system. Thus, BHA will continue to explore ways to positively apply data-driven decision-making approaches to enhancing the cultural and linguistic appropriateness of services throughout the system.

State Plan Development Process

Developing this strategic plan was a comprehensive process that aimed to enhance the overall mission of BHA and outline the administration's three-year goals. With input from key BHA and jurisdictional partners, BHA built on previous efforts and identified **four priorities** along with goals and objectives aligned with each priority area. BHA then identified key strategies and metrics to achieve and measure this work. The priority goals align with the current behavioral health needs in Maryland and define SMART objectives designed to be clear, measurable, and outcomes-based. All BHA staff applied their programs and other work to the continuum of care to ensure that the public behavioral health system addressed consumer needs at every level of care.

BHA presented this process and format to all interested with input from diverse community and local stakeholders and through various means such as:

- Regional stakeholder meetings
- Maryland Association of Behavioral Health Authorities (MABHA)
- Behavioral Health Advisory Council (BHAC) Planning Committee
- BHI Learning Community (ongoing meetings, open to local jurisdictions)
- Survey to Local Behavioral Health Authorities (LBHA) on new planning process
- BHA leadership

BHA Strategic Priorities

- **Priority 1:** Increase Access
- **Priority 2:** Reduce Disparities
- **Priority 3:** Improve Quality and Outcomes
- **Priority 4:** Increase Programs Promoting Wellbeing

In concert with the strategic priorities identified through the above efforts, each Maryland State agency engages in Managing for Results (MFR). MFR is a strategic planning, performance measurement, and budgeting process that emphasizes use of resources to achieve measurable results, accountability, efficiency, and continuous improvement in State government programs. The Department of Budget and Management (DBM) publishes MFR strategic plans outlining each agency's mission, vision, goals, objectives and performance metrics. BHA has married the strategic priorities with the goals and objectives of the FY 2025 MFR plan.[1]

[1] MDH - Behavioral Health Administration Managing for Results FY 2025: https://dbm.maryland.gov/Documents/MFR_documents/2025/MDH-Behavioral-Health-Administration-MFR.pdf

Similarly, with a lens through Healthy People 2030, BHA has ensured the objectives and work across the department align. The State Plan addresses the needs across the lifespan by increasing access to behavioral health treatment, reducing emergency room usage through piloting initiatives to strengthen behavioral health services in primary care settings, expanding suicide prevention efforts, and implementing innovative programming to reach historically marginalized populations such as those experiencing homelessness, people with disabilities, and the LGBTQIA community. BHA remains steadfast in its commitment to improving the quality of life for Marylanders.

Priority 1: Increase Access

Increase access to a full continuum of behavioral health programs, services and supports through the design and implementation of a statewide integrated system of care that recognizes trauma-informed care, health disparities, and social determinants of health.

Data from FY 2024 shows that 17 percent of PBHS service recipients with a primary mental health diagnosis were readmitted within 30 days of discharge which decreased from 18.3 percent in FY 2020. The percent of PBHS service recipients with a primary substance use disorder diagnosis were readmitted within 30 days of discharge was 11 in FY 2024. The BHA dashboard also tracks the rate of overdose deaths per 100,000 population. The BHA dashboard captures the below metrics and is updated on a monthly basis.

1. **Goal: Increase the abilities of participants with behavioral health disorders to live successfully in the community.**
    1.1. The percentage of Public Behavioral Health System (PBHS) service recipients with a primary mental health diagnosis readmitted to the same or different inpatient hospital within 30 days of discharge will not exceed 18 percent.
    1.2. The percentage of PBHS substance use disorder (SUD) service recipients readmitted to the same or different SUD Residential Treatment facility within 30 days of discharge will not exceed 20 percent.

BHA shares in the collective goal across Maryland agencies to reduce overdose fatalities through the availability and distribution of naloxone and increasing the deployment of SBIRT in primary care settings.

Priority 2: Reduce Disparities

Reduce disparities in the access and delivery of behavioral health programs and services for vulnerable and underserved populations in the public behavioral health system through the development and implementation of policies, practices, programs and services that recognize and value all individuals and leaves no one behind.

The number of individuals treated in the PBHS in FY 2024 was 331,868, a 4.6 percent increase from the previous year. In FY 2024, there were 25,797 PBHS recipients who received OUD services, a decrease of 9.6 percent from FY 2022. BHA aims to improve linkages to OUD treatment. Around 50 percent or more individuals received follow-up treatment within seven days of discharge from a MH inpatient or SUD residential stay. The number of unduplicated providers actively billing the PBHS for SUD treatment services rendered to children and youth ages 0 to 17 years old sits at 278 and is projected to increase to 284 by FY 2025.

2. **Goal: Maintain and increase the number of individuals treated in the Public Behavioral Health System (PBHS).**
    - 2.1. In each subsequent year, the number of individuals receiving behavioral health services will increase by four percent.
    - 2.2. The percentage of PBHS recipients receiving Opioid Use Disorder (OUD) services will increase annually by at least three percent.
    - 2.3. The percentage of mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge will meet or exceed 45 percent.
    - 2.4. The percent of PBHS Substance Use Disorder (SUD) service recipients who receive follow-up treatment within seven days of discharge from a SUD treatment facility will meet or exceed 45 percent.
    - 2.5. Increase the percentage of SUD providers actively treating children and youth ages 0 – 17 in the PBHS by two percent each fiscal year.

The BHA dashboard captures the above metrics which are updated on a monthly basis.

BHA, in partnership with MDH's Office of Gender Specific Services and Maternal Child Health Bureau, have put forth measures to address the maternal mortality crisis that is impacting women and parents seeking recovery services in Maryland.

- Increase the number of residential treatment and recovery services for pregnant and parenting women and their children (ASAM 3.1, 3.3, and 3.5)

- Develop recovery houses for men with children
- Expand and enhance recovery supports for pregnant and parenting women in the community through existing programs and supports

Priority 3: Improve Quality and Outcomes

Improve quality and outcomes in the public behavioral health system (PBHS) through the use of evidence-informed, evidence-based and promising practices, enhanced training and workforce development, design and implementation of data and continuous performance improvement processes and the use of technology innovations.

The unduplicated number of individuals served in outpatient settings in rural areas was 89,505 in FY 2024. 49,533 individuals (55.3 percent) living in rural areas received services via tele-behavioral health in that same year. The BHA dashboard updates the metrics below on a monthly basis.

3. **Goal: Implement utilization of the latest technology to expand access to behavioral health services in the least restrictive settings.**
   - 3.1. In each fiscal year, 45 percent or more of rural outpatient service recipients receive services via telehealth.
   - 3.2. In each fiscal year, 45 percent or more of statewide outpatient service recipients will receive services via telehealth.

The BHA Office of Research and Innovation (BHRI) in partnership with the MDH Data Office has undertaken several strategic data-focused initiatives aimed at enhancing the accessibility and use of outcome data for use in program and system planning and improving overall quality and outcomes in the PBHS. This work includes the selection, development and use of a set of Behavioral Health Key Performance Indicators (KPIs) and the development of dashboard visualization tools to be used to evaluate and track performance across the PBHS. The KPIs as well as other health quality and social determinants of health indicators will be used to construct Jurisdictional and provider quality data profiles that will then be used along with behavioral health resource availability data (White Space Analysis) to inform and guide system planning and resource allocation decisions. To facilitate the effective use of results based data, BHA is also developing a Performance Management Toolkit, that will include a Performance Management and Accountability Training curriculum, a program-level Performance Management and Accountability Tool (PMAT), a performance management user manual and continuous improvement

training and tools. Together, these tools will be used to guide and inform program and planning and management.

Priority 4: Increase Programs Promoting Wellbeing

Increase programs that promote physical and behavioral health wellbeing through the reduction of adverse childhood experiences and trauma, enhancing resilience, and prevention of substance use and suicide.

In FY 2024, there were a total of 276,358 individuals who received MH services via the PBHS and 114,485 individuals who received PBHS SUD services in that same year. Of those individuals, 0.8 percent of PBHS MH service recipients had three or more behavioral health related ED visits and 1.2 percent of PBHS SUD service recipients had three or more behavioral health related ED visits. The BHA dashboard updates the metrics below on a monthly basis.

4. **Goal: Promote health and wellness initiatives in the Behavioral Health System.**
   - 4.1. The percentage of PBHS MH service recipients with three or more BH related Emergency Department (ED) visits will not exceed five percent.
   - 4.2. The percentage of PBHS SUD service recipients with three or more BH related ED visits will not exceed five percent.

Maryland passed HB 576 / SB 453 Mental Health – Assisted Outpatient Treatment Programs during the 2024 Legislative Session. The legislation requires statewide implementation of Assisted Outpatient Treatment (AOT) programs by July 1, 2026. AOT is defined as outpatient treatment for individuals with a serious and persistent mental illness (SPMI) that is ordered by the court (also referred to as “civil commitment” or involuntary commitment). Civil commitment to outpatient care combined with adequate resources for treatment and monitoring is a federally recognized best practice for improving treatment adherence and outcomes among individuals with histories of repeated psychiatric crises while reducing systemic costs through avoided hospitalization.[2,3] The legislation requires MDH to establish

[2] Munetz, M. R., Ritter, C., Teller, J. L. S., & Bonfine, N. (2019). Association Between Hospitalization and Delivery of Assisted Outpatient Treatment With and Without Assertive Community Treatment. Psychiatric services (Washington, D.C.), 70(9), 833–836. https://doi.org/10.1176/appi.ps.201800375

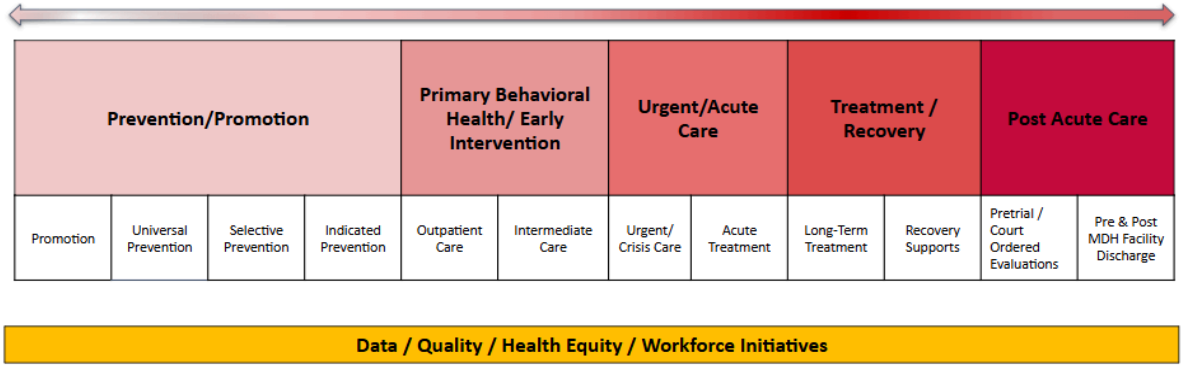
[3] Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Robbins, P. C., Steadman, H. J., McGuire, T. G., & Monahan, J. (2013). The cost of assisted outpatient treatment: can it save states money?. The American journal of psychiatry, 170(12), 1423–1432. https://doi.org/10.1176/appi.ajp.2013.12091152

operational and clinical criteria for AOT programs and Care Coordination Teams. BHA is engaged with stakeholders at the jurisdictional level to meet these requirements.

Expansion of services for children, adolescents, and families includes enhancing accessibility to 1915(i) services for youth and their families by removing barriers that interfere with their ability to access the services. Efforts are currently underway to expand the1915(i) services suite, ensuring that all regions across the state have access to adequate services. BHA/PBHEI is developing a roadmap that will offer a comprehensive vision, clear goals and recommendations for changes across the full continuum of care for children and youth. This roadmap will address everything from prevention and early intervention to serving children and youth who require high-intensity services. It will also outline the concrete implementation steps needed to address policy recommendations, how to train and expand the workforce needed to deliver high quality services, establish sustainable financing mechanisms, integrate youth and families into the process and conduct monitoring and oversight on the changes.

Behavioral Health Continuum of Care

BHA shares a vision of a state where all Marylanders have real-time access to high-quality, equitable behavioral health care. The behavioral health continuum of care must include culturally competent crisis services, address ongoing mental health and substance use needs, and support individuals who are re-entering their communities. Moreover, upstream services are essential to prevent and address trauma and to promote health and well-being for all Marylanders.



The continuum of care that BHA envisions will address all elements of Prevention and Promotion, Primary Behavioral Health and Early Intervention, Urgent/Crisis Care and Acute Treatment, and long-term Treatment and Recovery with wrap-around supports. More on BHA programs, grants, and initiatives in each division can be found in Appendix D.

Behavioral Health Continuum of Care for Children and Adolescents

Prevention/Promotion				Primary Behavioral Health			Urgent/Acute Care		Treatment / Recovery		Post Acute	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Community Care	Intensive Community Based Care	Urgent/ Crisis Care	Acute Treatment	Sub-Acute Intervention	Recovery Supports	Pretrial/ Court Ordered Evaluations	Pre & Post MDH Facility Discharge
• General Outreach • Pop Specific Outreach • Comms Campaigns	• ACE Awareness • Social and Emotional Learning modules • School Based Services (Tier 1)	• Good behavior game • SBIRT • Harm Reduction • Early childhood MH consultations w/ brief treatment	• SBIRT • Home Visiting • Mental Health First Aid • TAY • Early childhood MH consultations w/ brief treatment • DHS Prevention	• Community-Based Services • Case Mgmt • MH Client Support Services • Drug Court • Outpatient Detox • MAT • Brief intervention - PCP • School-based care	• Youth PRP • Youth TBS • DDA Youth Community Supports Services	• Partial Hospitalization • Intensive outpatient (IOP) • Intensive in home supports (EBPs) under 1915i	• 988 Hotline • Urgent Care Services • Crisis Stabilization Centers • Mobile Crisis Teams • Res Crisis • STOP • Respite	• ED • Inpatient • Inpatient Detox (ASAM 4.0, 3.7-D)	• ASAM 3.5/3.7 • Intensive in-home supports (EBPs) under 1915i • MOUD	• State Care Coor. • MDRN • START • Family Peers • Adolescent Clubhouse • Recovery schools	•Juvenile Services	• Utilization Review, Patient Discharge and Analytics
			• SATS (TCA) • Targeted Case Management			• ACT • MHSS / MRSS • Safe Stations		• Targeted Case Management • Res. Treatment				
			• BHIPP • EPSDT • EMR embedded screening • FEP									

Behavioral Health Continuum of Care for Adults and Older Adults

Prevention/Promotion				Primary Behavioral Health			Urgent/Acute Care		Treatment / Recovery		Post Acute	
Promotion	Universal Prevention	Selective Prevention	Indicated Prevention	Outpatient Care	Intermediate Community Care	Intensive Community Based Care	Urgent/ Crisis Care	Acute Treatment	Sub-Acute Intervention	Recovery Supports	Pretrial/ Court Ordered Evaluations	Pre & Post MDH Facility Discharge
•General Outreach •Pop Specific Outreach ▫ CJ ▫ TBI ▫ PW ▫ Older Adults	•ACE Awareness • Education and Training •Trauma Informed Care •Traumatic Brain Injury •Crisis Systems	•Harm Reduction	•Mental Health First Aid ▫ STOP ▫ CIT	•Community-Based Services •Case Mgmt •MH Client Support Services •Drug Court •Outpatient Detox •MAT	•Pre admission screening for older adults	•PHP •RRP	•988 Hotline •Urgent Care Services •Walk-in Services •Crisis Stabilization Centers •Mobile Crisis Teams •RCS •STOP •Respite	•ED •Inpatient •Inpatient Detox (ASAM)	•ASAM 3.5/3.7 •MOUD •Hospital State Discharge Planning	•State Care Coordination •Maryland Certification of Recovery Residences (MCORR) •Recovery Housing for Pregnant Women and Women with Children •Rental Subsidies COC PATH PSH	• Adult Pretrial • Central Admissions Office •Justice Services	• Forensic DDA •Community Forensic Aftercare Program •Firearms Rights Restoration Program •Utilization Review, Patient Discharge and Analytics
			•Targeted Case Management			•ACT •Safe Stations		•Targeted Case Management •Residential Treatment				

Access to Services by Jurisdiction

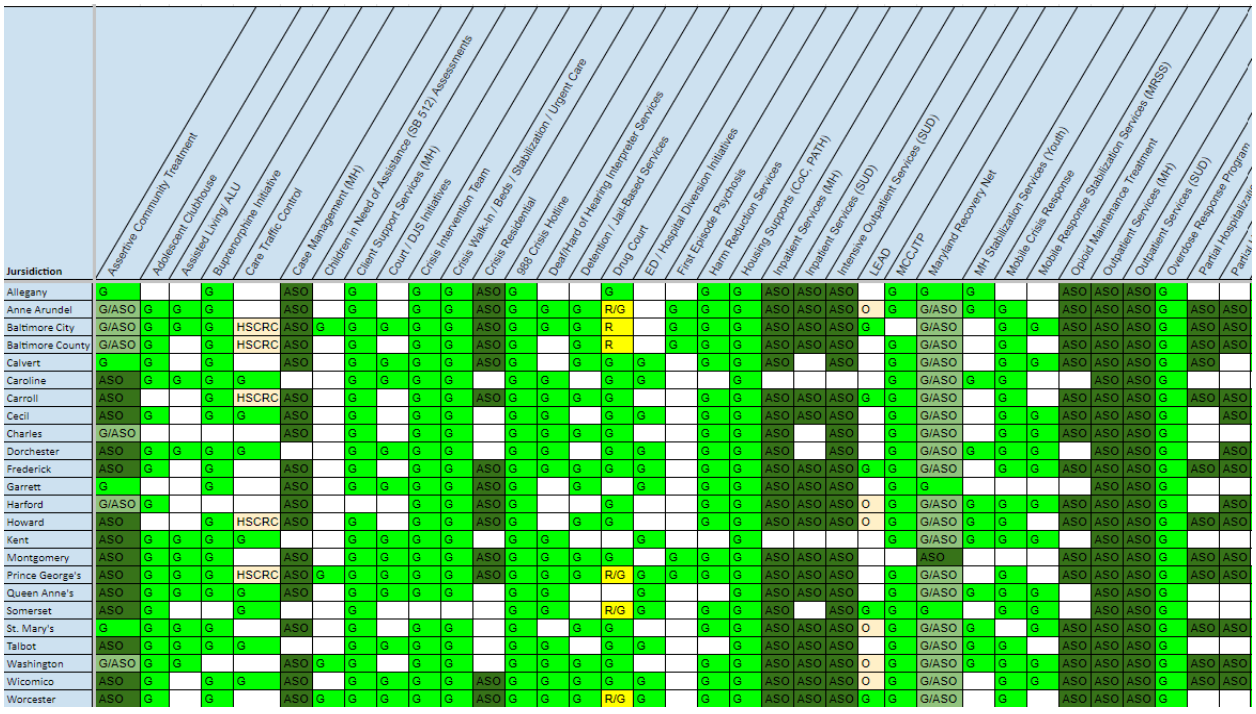
BHA developed a White Space analysis through collaboration with local jurisdictions (LBHAs, LAAs, and CSAs) and data sources. This point in time analysis from April 2024 shows the services in each jurisdiction and the funding streams. Data comes from the 2022 ASO data and 2024 LBHA grant data. ASO denotes at least one provider billing the ASO for a respective service based on provider location. Residents are able to access ASO services across jurisdictional boundaries, so if there are no ASO

providers providing the services within the jurisdiction, residents must go to another jurisdiction.

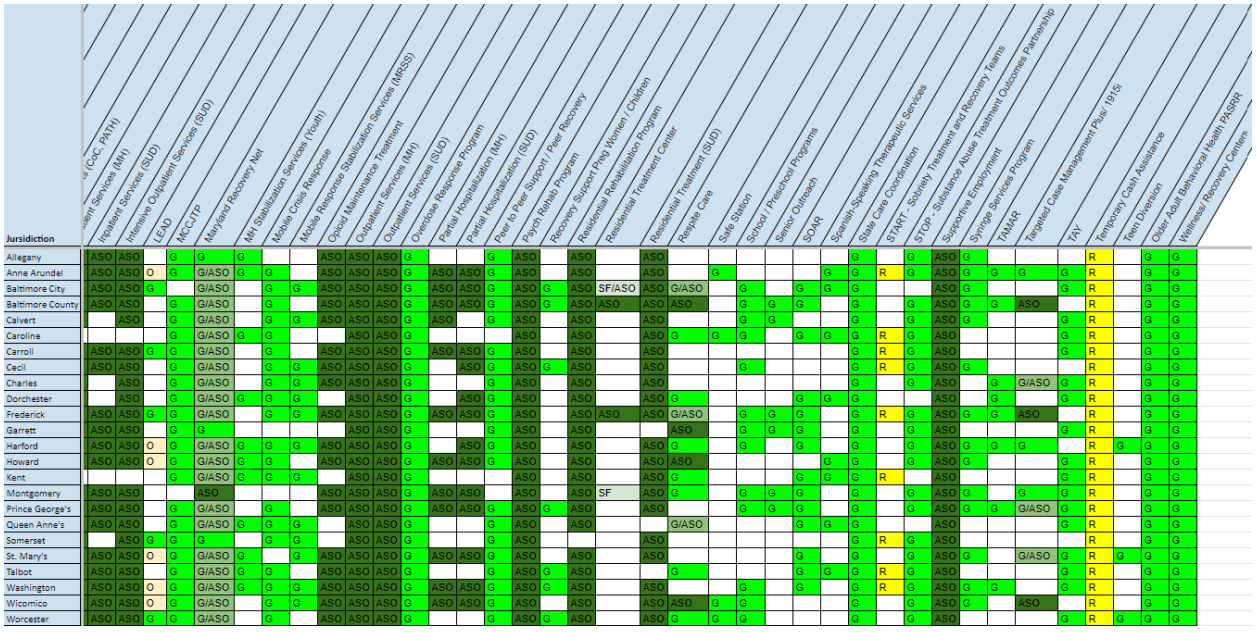
Legend:

- G - MDH Grant funded service
- ASO - Provider in Jurisdiction billing for service through the ASO
- HSCRC - Projects funded through HSCRC
- O - Funded by an outside organization
- R - Reimbursable Service
- SF - State Facility (RICA)

The purpose of this undertaking is to understand where services are located and where there may be gaps and/or barriers for utilizing services. BHA is committed to using data to understand needs and drive outcomes. Services span from Assertive Community Treatment to Wellness/Recovery Centers. A program glossary can be found in Appendix C.



Jurisdiction	Assertive Community Treatment	Adolescent Clubhouse	Assisted Living/ ALU	Buprenorphine Initiative	Care Traffic Control	Case Management (MH)	Children in Need of Assistance (SB 512) Assessments	Client Support Services (MH)	Court / DJS Initiatives	Crisis Intervention Team	Crisis Walk-In / Beds / Stabilization / Urgent Care	Crisis Residential	988 Crisis Hotline	Deaf/Hard of Hearing Interpreter Services	Detention / Jail-Based Services	Drug Court	ED / Hospital Diversion Initiatives	First Episode Psychosis	Harm Reduction Services	Housing Supports (CoC, PATH)	Inpatient Services (MH)	Inpatient Services (SUD)	Intensive Outpatient Services (SUD)	LEAD	MCCJTP	Maryland Recovery Net	MH Stabilization Services (Youth)	Mobile Crisis Response	Mobile Response Stabilization Services (MRSS)	Opioid Maintenance Treatment	Outpatient Services (MH)	Outpatient Services (SUD)	Overdose Response Program	Partial Hospitalizati	Partial
Allegany	G			G		ASO		G		G	G	ASO	G			G			G	G	ASO	ASO	ASO		G	G	G			ASO	ASO	ASO	G		
Anne Arundel	G/ASO	G	G	G		ASO		G		G	G	ASO	G	G	G	R/G		G	G	G	ASO	ASO	ASO	O	G	G/ASO	G	G		ASO	ASO	ASO	G	ASO	ASO
Baltimore City	G/ASO	G	G	G	HSCRC	ASO	G	G	G	G	G	ASO	G	G	G	R		G	G	G	ASO	ASO	ASO	G		G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO
Baltimore County	G/ASO	G		G	HSCRC	ASO		G		G	G	ASO	G		G	R		G	G	G	ASO	ASO	ASO		G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO
Calvert	G	G		G		ASO		G	G	G	G	ASO	G		G	G	G		G	G	ASO		ASO		G	G/ASO		G	G	ASO	ASO	ASO	G	ASO	
Caroline	ASO	G	G	G	G			G	G	G	G		G	G		G	G			G					G	G/ASO	G	G			ASO	ASO	G		
Carroll	ASO			G	HSCRC	ASO		G		G	G	ASO	G	G	G	G			G	G	ASO	ASO	ASO	G	G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO
Cecil	ASO	G		G	G	ASO		G		G	G		G	G		G	G		G	G	ASO	ASO	ASO		G	G/ASO		G	G	ASO	ASO	ASO	G		ASO
Charles	G/ASO					ASO		G		G	G		G	G	G	G			G	G	ASO		ASO		G	G/ASO		G	G	ASO	ASO	ASO	G		
Dorchester	ASO	G	G	G	G			G	G	G	G		G	G		G	G		G	G	ASO		ASO		G	G/ASO	G	G	G		ASO	ASO	G		ASO
Frederick	ASO	G		G		ASO		G		G	G	ASO	G	G	G	G	G		G	G	ASO	ASO	ASO	G	G	G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO
Garrett	G			G		ASO		G	G	G	G	ASO	G		G		G		G	G	ASO	ASO	ASO		G	G					ASO	ASO	G		
Harford	G/ASO	G				ASO				G	G	ASO	G			G			G	G	ASO	ASO	ASO	O	G	G/ASO	G	G	G	ASO	ASO	ASO	G		ASO
Howard	ASO			G	HSCRC	ASO		G		G	G	ASO	G		G	G			G	G	ASO	ASO	ASO	O	G	G/ASO	G	G		ASO	ASO	ASO	G	ASO	ASO
Kent	ASO	G	G	G	G			G	G	G	G		G	G			G			G					G	G/ASO	G	G	G		ASO	ASO	G		
Montgomery	ASO	G	G	G		ASO		G	G	G	G	ASO	G	G	G	G		G	G	G	ASO	ASO	ASO			ASO				ASO	ASO	ASO	G	ASO	ASO
Prince George's	ASO	G	G	G	HSCRC	ASO	G	G	G	G	G	ASO	G	G	G	R/G	G	G	G	G	ASO	ASO	ASO		G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO
Queen Anne's	ASO	G	G	G	G	ASO		G	G	G	G		G	G			G			G	ASO	ASO	ASO		G	G/ASO	G	G	G		ASO	ASO	G		
Somerset	ASO	G			G			G					G	G		R/G	G		G	G	ASO		ASO	G	G	G		G	G		ASO	ASO	G		
St. Mary's	G	G	G	G		ASO		G		G	G		G		G	G			G	G	ASO	ASO	ASO	O	G	G/ASO	G		G	ASO	ASO	ASO	G	ASO	ASO
Talbot	ASO	G	G	G	G			G	G	G	G		G	G		G	G			G	ASO	ASO	ASO		G	G/ASO	G	G		ASO	ASO	ASO	G		
Washington	G/ASO	G	G			ASO	G	G		G	G		G	G	G	G			G	G	ASO	ASO	ASO	O	G	G/ASO	G	G	G	ASO	ASO	ASO	G	ASO	ASO
Wicomico	ASO	G		G	G	ASO		G	G	G	G	ASO	G	G	G	G	G		G	G	ASO	ASO	ASO	O	G	G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO
Worcester	ASO	G		G		ASO	G	G	G	G	G	ASO	G	G	G	R/G	G		G	G	ASO	ASO	ASO	G	G	G/ASO		G		ASO	ASO	ASO	G		



Jurisdiction	(CoC, PATH)	Inpatient Services (MH)	Inpatient Services (SUD)	Intensive Outpatient Services (SUD)	LEAD	MCCJTP	Maryland Recovery Net	MH Stabilization Services (Youth)	Mobile Crisis Response	Mobile Response Stabilization Services (MRSS)	Opioid Maintenance Treatment	Outpatient Services (MH)	Outpatient Services (SUD)	Overdose Response Program	Partial Hospitalization (MH)	Partial Hospitalization (SUD)	Peer to Peer Support / Peer Recovery	Psych Rehab Program	Recovery Support Preg Women / Children	Residential Rehabilitation Program	Residential Treatment Center	Residential Treatment (SUD)	Respite Care	Safe Station	School / Preschool Programs	Senior Outreach	SOAR	Spanish-Speaking Therapeutic Services	State Care Coordination	START - Statewide Treatment and Recovery Teams	STOP - Substance Abuse Treatment Outcomes Partnership	Supportive Employment	Syringe Services Program	TAMAR	Targeted Case Management Plus/ 1915i	TAY	Temporary Cash Assistance	Teen Diversion	Older Adult Behavioral Health PASRR	Wellness/ Recovery Centers
Allegany	ASO	ASO		G	G	G			ASO	ASO	ASO	G			G	ASO		ASO			ASO							G		G	ASO	G			R		G	G
Anne Arundel	ASO	ASO	O	G	G/ASO	G	G		ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO		G				G	G	R	G	ASO	G	G	G	G	R		G	G
Baltimore City	ASO	ASO	G		G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	SF/ASO		ASO	G/ASO		G		G	G	G			ASO	G			G	R		G	G
Baltimore County	ASO	ASO		G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO	ASO		ASO	ASO		G	G	G		G		G	ASO	G	G	ASO		R		G	G
Calvert		ASO		G	G/ASO		G	G	ASO	ASO	ASO	G	ASO		G	ASO		ASO			ASO			G	G			G		G	ASO	G			G	R		G	G
Caroline				G	G/ASO	G	G			ASO	ASO	G				ASO		ASO			ASO	G	G	G		G	G	G	R	G	ASO				G	R		G	G
Carroll	ASO	ASO	G	G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO							G	R	G	ASO				G	R		G	G
Cecil	ASO	ASO		G	G/ASO		G	G	ASO	ASO	ASO	G		ASO	G	ASO	G	ASO			ASO			G				G	R	G	ASO	G				R		G	G
Charles		ASO		G	G/ASO		G	G	ASO	ASO	ASO	G			G	ASO		ASO			ASO							G		G	ASO		G	G/ASO	G	R		G	G
Dorchester		ASO		G	G/ASO	G	G	G		ASO	ASO	G		ASO	G	ASO		ASO			ASO	G				G	G	G			ASO		G		G	R		G	G
Frederick	ASO	ASO	G	G	G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO	ASO		ASO	G/ASO		G	G	G		G	R	G	ASO	G	G	ASO		R		G	G
Garrett	ASO	ASO		G	G					ASO	ASO	G			G	ASO		ASO				ASO		G	G	G		G		G	ASO				G	R		G	G
Harford	ASO	ASO	O	G	G/ASO	G	G	G	ASO	ASO	ASO	G		ASO	G	ASO		ASO			ASO	G		G		G		G		G	ASO	G	G	G		R	G	G	G
Howard	ASO	ASO	O	G	G/ASO	G	G		ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO	ASO					G	G		G	ASO	G				G	R		G	G
Kent				G	G/ASO	G	G	G		ASO	ASO	G				ASO		ASO			ASO	G				G	G	G	R		ASO				G	R		G	G
Montgomery	ASO	ASO			ASO				ASO	ASO	ASO	G	ASO	ASO		ASO		ASO	SF		ASO	G		G	G	G		G		G	ASO	G		G	G	R		G	G
Prince George's	ASO	ASO		G	G/ASO		G		ASO	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO			ASO			G	G	G		G		G	ASO	G	G	G/ASO	G	R		G	G
Queen Anne's	ASO	ASO		G	G/ASO	G	G	G		ASO	ASO	G			G	ASO		ASO				G/ASO				G	G	G			ASO				G	R		G	G
Somerset		ASO	G	G	G		G	G		ASO	ASO	G			G	ASO					ASO						G	R	G	ASO					R		G	G
St. Mary's	ASO	ASO	O	G	G/ASO	G		G	ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO					G		G		G	ASO	G		G/ASO	G	R	G	Q	Q
Talbot	ASO	ASO		G	G/ASO	G	G		ASO	ASO	ASO	G			G	ASO	G	ASO				G			G	G	G	R	G	ASO					R		G	G
Washington	ASO	ASO	O	G	G/ASO	G	G	G	ASO	ASO	ASO	G	ASO	ASO	G	ASO	G	ASO			ASO			G		G		G	R	G	ASO	G	G		G	R		G	G
Wicomico	ASO	ASO	O	G	G/ASO		G	G	ASO	ASO	ASO	G	ASO	ASO	G	ASO		ASO			ASO	ASO	G	G				G		G	ASO	G		ASO		R		G	G
Worcester	ASO	ASO	G	G	G/ASO		G		ASO	ASO	ASO	G			G	ASO	G	ASO			ASO	G	G	G				G		G	ASO				G	R	G	G	G

The partnership between the BHA and the LBHA, Local Addiction Authority (LAA), and the Core Service Agency (CSA) plays a crucial role in executing state strategies funded by federal block grants. These grants empower local entities to implement impactful programs that align with state and federal goals.

Through fostering these relationships, BHA ensures that resources are effectively used to meet the diverse needs of marginalized communities. One of these examples is that Garrett County's partnership with BHA has been transformative for its community particularly through Substance Use Block Grant funds. The Healthy Families Garrett County initiative is rooted in evidence-based home visiting practices to drive meaningful change in the lives of high-risk families. The Healthy Families program is designed to deliver tailored support directly to families and children. This approach ensures that families receive guidance on child development and engage in parent-child activities that are crucial for healthy early growth.

Under the Mental Health Block Grant, Anne Arundel County's Signing Therapist Services program works with individuals who are deaf and hard of hearing providing one-on-one services. The program is staffed by professionals who share the same primary mode of communication, sign language. The program ensures that clients receive culturally and linguistically appropriate care.

The Baltimore County Sexual Health in Recovery Program is an innovative initiative that unites members of the health workforce from infectious disease and behavioral health sectors to address the complex intersection of mental health, substance abuse, and sexual health. Through fostering collaboration among healthcare

professionals, the program aims to enhance understanding and improve the quality of care for individuals facing sexual health challenges during recovery. It provides targeted education and training to public health workers, equipping them with the skills to engage effectively with this community by reducing stigma and promoting holistic, stigma-free care.

Several jurisdictions that have implemented programming targeting individuals in jails or detention centers that are reintegrating into the community. Reentry programs provide an opportunity to connect individuals to services and support their transition. The Substance Abuse Treatment Outcome Partnerships (S.T.O.P.) funds programming in Anne Arundel, Cecil, Frederick, St. Mary's, and Talbot counties where services such as case management, vocational coaching, peer support, recovery housing, reentry coordination, distribution of narcan kits, and community based treatment are made available. Somerset County's reentry services include assertive outreach, transportation to treatment, and assistance obtaining vital documents. Carroll County has detention center based services and reentry ASAM Level 2.1 that provides structured outpatient evaluation and treatment to individuals who need substance use services.

BHA Supporting Divisions

A summary of BHA's Supporting Divisions across the continuum of care is provided below. More about programs, grants, and initiatives can be found in Appendix D: BHA Division Highlights.

Prevention and Promotion

The Prevention and Promotion division is responsible for improving access to behavioral health services. This includes consumer affairs, public awareness campaigns, family peer support, suicide prevention, family peer support and navigation. Newly integrated into the division is the Center for Harm Reduction Services.

The Center oversees the Overdose Response Program, Syringe Services Program, naloxone distribution, harm reduction grants, and various workforce development, training, and technical assistance activities.

Primary Behavioral Health and Early Intervention

The Primary Behavioral Health and Early Intervention division is charged with developing a system of care for young people and their families ranging from early childhood to when young people reach the age of majority and legally become

adults. The system of care is designed to meet the needs of individuals within this age range who have mental health conditions, substance-related disorders, and those who have both.

This division evaluates the network of services that the Behavioral Health Administration (BHA) funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. The division also manages special projects and is responsible for working with all other child serving agencies at both the state and local levels to assure a highly coordinated and individualized approach to care.

Urgent and Acute Care

The Behavioral Health Administration works with and funds jurisdictions and providers to develop a statewide continuum of integrated, comprehensive, and equitable urgent and acute behavioral health care services.

We want to ensure that everyone across the state has:

1. Someone to contact when they need urgent behavioral health care services;
2. Someone to respond to help them in that moment; and
3. Somewhere safe to get help, stabilize, and get connected to ongoing support.

Treatment and Recovery

BHA's Treatment and Recovery division is responsible for developing and managing an integrated system of care for adults and older adults. This includes:

- Developing policies and regulations related to clinical services for adults and older adults
- Developing conditions of awards and co-developing with the Local Authority statements of work for monitoring service deliverables and network adequacy
- Providing administrative oversight of clinical treatment, recovery supports, evidence-based practices, and housing supports
- Providing technical advice and guidance to the local jurisdictions
- Designing and implementing state and federally funded services and specialized programs
- Identifying gaps in services and best practices to enhance access and quality of care

- Designing, developing, and implementing specialized, culturally sensitive, and responsive initiatives to address the needs of individuals who are deaf and hard of hearing, have limited English proficiency, mental illness or both
- Directing, administering, and overseeing the statewide continuum of community-based outpatient behavioral health treatment services, including outpatient mental health centers, outpatient substance use treatment (outpatient, intensive outpatient), withdrawal management, mental health and substance use partial hospitalization programs, group practices, private licensed behavioral health practitioners, and residential substance use disorder treatment
- Designing, planning, directing, implementing, and evaluating care management services, recovery supports, and community resources.

Policy and Planning

The Policy and Planning division oversees provider licensing and certification, compliance and monitoring for community behavioral health programs. This includes oversight of Local Behavioral Health Authorities, site visits, leading BHA's State Strategic Plan as well as cultural and linguistic competency strategic planning. This division also oversees grants, co-manages the Administrative Services Organization contract with Maryland Medicaid.

Diversity in Maryland

Maryland's population is ethnically and racially diverse. State-level demographics that describe Maryland's population are used to identify cultural and linguistic groups and their service utilization rates. According to the Census.gov 2020 Diversity Index, which illustrates the chance that two people chosen at random will be from different racial and ethnic groups, Maryland was the fourth most diverse state in the United States, with 67.3% out of one. For a visual representation of the distribution of ethnic and racial minorities in Maryland's counties see Appendix B Map 1.

Data Summary and Analysis

Based on 2020 population estimates, ethnic and racial minorities represented nearly one-half (49.4%) of the state's population. Minorities are defined as everyone other than the "non-Hispanic White" population. African Americans account for one-third (31%) of the state's population and 63% of communities of color. Individuals of Asian and Hispanic or Latino origin account for 14.5% and 22.2% of the population respectively. As shown in Map 1, the proportion of minorities varies substantially across the state's 24 jurisdictions, ranging from a low of 3.2% in Garrett County to a high of 87.7% in Prince George's County. Baltimore City and those jurisdictions

bordering the Baltimore and Washington metropolitan areas have the highest concentration of minorities.

Ethnic and Racial Distribution of Individuals Served in PBHS

Maryland's PBHS provides a comprehensive array of mental health and substance use disorder treatment and support services to adults, children and adolescents experiencing behavioral health challenges. In FY 2024, a total of 331,868 individuals received public behavioral health system services in Maryland at a total cost of $2.5 billion. Individuals from communities of color accounted for nearly one-half (43.6%) of the total population served as well as the behavioral health expenditures (see Appendix B, Figure 1). It is important to note that due to a Centers for Medicare & Medicaid Services (CMS) parity ruling in 2019, providers are no longer required to enter an individual's race. An individual's racial category is captured using Medicaid's Eligibility file in which the racial field is often left blank, therefore 23.3% of individuals served in the public behavioral health system during FY 2024 fall under the "Unknown" race category.

Limited English Proficiency (LEP) Individuals served in the PBHS

The Maryland Department of Health, in accordance with applicable State and Federal law, seeks to make programs, services, and benefits accessible to all eligible individuals, including those with Limited English Proficiency (LEP) due to national origin and/or ancestry. The efforts to make programs and services accessible to LEP persons is in line with the obligations outlined in Title VI of the Civil Rights Act of 1964 and Annotated Code of Maryland State Government Article, §§10-1101—10-1105[4]. In Maryland, the Baltimore Metropolitan Region, which comprises Baltimore City, Anne Arundel, Baltimore, Carroll, Harford and Howard counties, is where the majority of individuals who speak a language other than English at home and who speak English at a level considered less than "very well" mostly reside compared to the entire state. As recipients of federal funding, the Maryland Department of Health and BHA are required by law "to take reasonable steps to create meaningful access to information and services provided[5]" for LEP persons living in Maryland. The Office of Public Awareness constantly monitors current demographic data to determine trends regarding LEP needs. All public awareness campaigns provide information in Spanish for video, audio, digital, and print materials. These materials are made available for any jurisdiction or stakeholder for use. Determining reasonable steps to be taken to provide behavioral health services to the LEP population involve four factors: 1) the number and proportion of individuals identified as LEP persons in the

[4]Maryland Department of Health (2016). *Limited English Proficiency Policy*- Office of Equal Opportunity Programs; Policy # 01.02.05.
[5]Ibid.

eligible public behavioral health system service area, 2) the frequency with which LEP persons come in contact with the public behavioral health system programs, 3) the importance of the public behavioral health system services provided to the LEP population, and 4) the resources available to the LEP recipients of public behavioral health system services.[6]

Deaf and Hard of Hearing Population

Lack of funding and access to behavioral health services as well as the limited availability of local, culturally competent mental health providers who are fluent in American Sign Language (ASL), have been a growing concern for providers to deaf and hard of hearing individuals. To help close the gap and increase direct mental health services provided by providers who are culturally and linguistically competent, the Governor's Office of the Deaf and Hard of Hearing (GODHH) worked closely with the Maryland Department of Health in FY 2016 to increase the availability of mental health providers who are fluent in ASL to deaf and hard of hearing individuals through telehealth. Medicaid participants usually would have to travel to use telehealth services with a culturally competent provider fluent in ASL. Medicaid only reimbursed for psychiatrists despite the fact that there are no psychiatrists in the state of Maryland who know ASL. [7]

GODHH and Maryland Department of Health drafted changes to regulations in the Code of Maryland Regulations (COMAR 10.09.49 Telehealth Services) and in FY 2017, the changes were proposed and adopted. Maryland is now the first state where Medicaid specifically permits and reimburses qualified providers such as psychologists and social workers who are fluent in ASL for clinically appropriate telehealth services for deaf and hard of hearing Medicaid participants. Furthermore, the GODHH serves on the Behavioral Health Advisory Council and Co-Chairs the Cultural and Linguistic Competency Committee, which works on promoting and advocating for a culturally competent and comprehensive approach to Maryland's public behavioral health system. GODHH also actively connects individuals in need of behavioral health services to local providers, organizations, and resources, and also helps connect community organizations with appropriate state entities to ensure that treatment is accessible and funding is available.[8]

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[6] Ibid.

[7] Governor's Office of the Deaf and Hard of Hearing, Annual Report, Fiscal Year 2017, July 1, 2016-June 30, 2017. Retrieved from https://odhh.maryland.gov/wp-content/uploads/sites/13/2017/12/ODHH-FY2017-Annual-Report.pdf

[8] Ibid.

Data Summary and Analysis

As shown in Figure 2, there were a total of 2,615 deaf and hard of hearing individuals who received behavioral health services in FY 2024 of whom 43.6% were Caucasian, followed by 34% African Americans. Although there were no significant observations made among the other racial/ethnic groups, it is important to note that the data on the deaf and hard of hearing is based solely on individual responses. There is a large portion of the public behavioral health services population for that this information is Unknown, due to the fact that deaf and hard of hearing is no longer a required data element for collection and providers have the opportunity to "opt out" of completing this question-as shown by the data 50% have chosen to do so.

Veterans

Data Summary and Analysis

The racial distribution among veterans served in the public behavioral health services shows almost 40 percent Caucasians are the predominant group served in Maryland's public behavioral health services followed by African Americans at 39.3%. The percentage of other ethnic minority veterans who seek public behavioral health service are slightly more than 2 percent, and the largest percentage among these groups are those who identified themselves as Asian (1 percent) and Native Americans (0.6 percent).

Figure 3 shows the number of veterans who have received behavioral health services from 2019 to 2024 has decreased by 29.7 in mental health treatment and 40.7 percent for substance use disorder treatment services. Based on available data, veterans make up less than 1.3 percent of the total number of individuals who received behavioral health service in fiscal years 2019 through 2024. The reason for the decrease can be directly linked to the 2019 CMS Parity ruling in which providers are no longer required to enter an individual's veteran status for data collection and providers have the opportunity to "opt out" of completing this question; the data shows that a large percentage have chosen to do so.

Homelessness

For FY 2024, the estimated count of individuals experiencing homelessness in Maryland was 21,489. Due to changes in the delivery of services in response to COVID-19 and the changing funding environment, it is not possible to compare the data from 2021 to prior years. COVID-19 has impacted individuals experiencing homelessness, while there has been increased funding opportunities to serve more individuals, the lack of available affordable housing has decreased. The cost of rental units has increased above Fair Market Rent making it hard for individuals with a

rental subsidy to find a unit and there is also increased competition for available units. The majority of homeless individuals counted in FY 2024 were residents of Baltimore City, Baltimore County, Montgomery County and Prince George's County (see Appendix B, Figure 4).[9] The largest number of individuals who were experiencing homelessness were in Baltimore City, 6,395 individuals. In the 2024, Point In Time Count, 6.1% percent of the individuals statewide were veterans. Of the counted homeless, 61% were African Americans and 7% Latino or other.

Current Services and Needs Landscape

Social Determinants of Health

Healthy People 2030 defines social determinants of health as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[10] Healthy People 2030 has categorized social determinants of health into five domains, which are: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, Social and Community Context. Research has shown that 90% of the determinants of health are derived from our lifetime experiences in the social and physical environment.[11] An individual's response to their social and physical environment drives risk behaviors and habits, such as smoking, drug use and addiction, poor eating habits and physical inactivity, driving nearly 40 percent of health issues and premature mortality. In addition, it should be recognized that up to 30 percent of health outcomes are driven by our genetics. Through the new science of epi-genetics, it is now known that genes can be turned on and off by our exposure to environmental/social stressors and that these predispositions can be transmitted across generations[12]. In order to improve behavioral and health outcomes, it is essential that the public behavioral health system, in addition to providing high quality, evidence informed treatment and recovery services, recognize and refocus efforts to address social determinants of health.

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[9] The Maryland Interagency Council on Homelessness, *2020/2021 Report on Homelessness*. Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://dhcd.maryland.gov/HomelessServices/Documents/2021AnnualReport.pdf

[10] Office of Disease Prevention and Health Promotion. (n.d.). Social Determinants of Health. Social Determinants of Health - Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

[11] Sederer L. I. (2016). The Social Determinants of Mental Health. Psychiatric services (Washington, D.C.), 67(2), 234–235. https://doi.org/10.1176/appi.ps.201500232

[12] McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. Health affairs (Project Hope), 21(2), 78–93. https://doi.org/10.1377/hlthaff.21.2.78

The BHA is dedicated to improving the quality of life for all Marylanders. Enhancing the awareness and developing strategies to effectively address the impact of social determinants of health is critical to achieving our mission and improving health outcomes for individuals who receive public behavioral health system services. Social determinants of health will be addressed through the delivery of quality and evidence informed programs and services, a focus on reducing health disparities, and advancing a trauma informed and healing centered culture throughout BHA and the public behavioral health system. In collaboration with the Maryland Department of Health and other state partners, BHA will research, adopt and implement a behavioral health vulnerability index. The tool will assess three key factors: 1) Community-level Behavioral Health Burden, including behavioral health factors that put an individual at increased risk and place a burden on health and behavioral health resources and service delivery; 2) Availability and Access to Behavioral Health Resources; and 3) Social Vulnerability, those community-level characteristics or social determinants of health that are known to be associated with poor health and behavioral health outcomes. The Vulnerability Index will be used as an essential decision support tool to inform targeted outreach and assessment, resource allocation, program planning and policy development and direction. BHA will also look to systematically capture SDOH through increased utilization of Z codes[13] amongst providers.

Current Services

Some of the current services that Clinical Services oversee that fall under this category are 1) SSI/SSDI, Outreach, Access and Recovery (SOAR) Initiative. Gap/Need: SOAR dedicated positions in every jurisdiction or region. 2) Supported Employment. BHA can work to increase efforts statewide. 3) Encourage local authority and provider participation in the local continuum of care, housing and homeless round tables, as well as efforts by local government to increase affordable housing. The goal is to increase access to affordable housing opportunities. 4) Increase the number of certified Recovery Residences. 5) Recovery Capital with Recovery Residences.

Gaps in Service

1. SOAR dedicated positions in every jurisdiction or region and for every state hospital to assist individuals transitioning from state hospital level of care to community level of care.
2. Increased number of providers offering evidenced-based levels of supported employment services.
3. Increase affordable housing opportunities.

[13] ICD-10-CM Z codes are a set of diagnosis codes that identify factors that affect a patient's health or reasons for seeking health services that are not classifiable elsewhere as diseases, injuries, or external causes.

Workforce Needs

Workforce development aims to provide skills for individuals, communities, and businesses by offering training, development opportunities, and continuing education programs to maximize career success.

Current Services

The Office of Workforce Development (referred to as the Office) conducted a 2019 Survey of the current behavioral health workforce to collect data regarding workforce shortage issues, recruitment and retention concerns and barriers to employment, pay scale barriers to employment, as well as staff burnout. Findings indicate that providers do not have adequate staff to provide quality care across the continuum of care. Staff turnover due to burnout and low pay were also reported as the two highest retention indicators. Legislation to address workforce shortage crisis includes **SB283/HB418: Mental Health - Behavioral Health Workforce Investment Fund** (passed during 2023 legislative session), requiring the Maryland Health Care Commission, in coordination with certain other agencies, to conduct a comprehensive behavioral health workforce needs assessment by October 1, 2024. Based upon this report, funds are to be provided to reimburse for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals.

HB625/SB440: Commission to Study the Health Care Workforce Crisis was created to examine the extent of the workforce shortage, to recommend short-term solutions to the workforce shortage, identify future health care workforce needs, and to examine the current relationship between the Maryland Department of Health and the health occupations boards.

Gaps in Services

- Increase the amount and quality of primary data collected by Maryland's professional licensure boards.
- Health care worker shortages are most pronounced in rural parts of the state.
- Sustainable funding. Establish a behavioral health workforce investment fund to sustain workforce expansion efforts.
- Need to examine the effect reimbursement has had on workforce shortages.

Trauma Informed Care Background and Initiatives

Unaddressed adversity and trauma has been shown to have cumulative and lifelong negative consequences for children, families, and communities, including chronic health problems, early mortality, increased risk of suicide, as well as higher risk of

mental health and substance use challenges. Research has demonstrated a clear dose response relationship between exposure to adverse childhood experiences (ACEs) and a number of adverse risk behaviors and negative health outcomes. Individuals who experience ongoing or sustained exposure to trauma and adversity are more likely to experience negative consequences on their physical and emotional development. Data from the Maryland Youth Risk Behavior Survey (YRBS) shows that Maryland high school youth, who experience three or more adverse childhood experiences were nearly three times as likely to experience significant mental health challenges, use substances, and engage in sexual intercourse and more than twice as likely to attempt suicide compared to students with no ACEs.[14] According to the 2018-2019 Behavioral Risk Factor Surveillance Survey (BRFSS), Maryland adults who experienced four or more ACEs are more than twice as likely to experience poor physical health (14 or more days in a month), nearly five times more likely to experience major depression, and nearly seven times more likely to misuse illicit drugs.

In July 2022, BHA partnered with the University of Maryland School of Medicine and Bowie State University to launch the Building Healing Systems Initiative (BHS). The goal of this multi-year initiative is to advance trauma-informed organizational change at all levels of the public behavioral health system. The BHS initiative includes three core components including: 1) Targeted Training and Technical Assistance, 2) Enhanced Adverse Childhood Experiences (ACEs) and Trauma Informed Care Data Analysis and Reporting, and 3) development and implementation of a Trauma Informed Organizational Assessment Tool (TIOA).

Strategic Priorities

In 2023, the Trauma-Informed Care Commission (TICC) adopted the Maryland Way - Trauma Informed, Resilience Oriented, and Equitable Care Framework (TIROE) and a set of trauma informed guiding principles. This framework is intended to provide the foundation and direction for trauma-informed culture change across Maryland. In order to meet the requirements of the Healing Maryland's Trauma Act and the Moore-Administration's vision to "Leave No One Behind, lead with compassion and make Maryland a Leader in Trauma Informed Care", the Maryland Department of Health convened a Cross Administration Trauma-Informed Care Action planning Team. This planning group was charged in developing the first ever MDH Trauma Informed Care Action plan for the Department.

System change efforts to advance trauma-informed and resilience-oriented care policies and practices is a priority across the behavioral health continuum of care. This change requires a paradigm shift and reframing of the system from a focus on

[14] YRBS estimates may not represent youth who have disenrolled from high school or who are chronically truant.

symptoms and asking, *"What's wrong with you?"* to ask *"What has happened to you?"* This is essential to fully understand an individual's needs and to provide effective individualized services. The following strategic activities will be implemented to advance Trauma-Informed Care across the public behavioral health system.

- Develop a logic model that depicts theory of change for the MDH trauma informed care transformation effort.
- Design and implement a Department-wide TIC action plan to provide a framework and roadmap for TIC organizational change efforts across MDH.
- Conduct introductory training, titled Agencies Working for Everyone"developed in collaboration with the Trauma-Informed Care Commission to MDH leadership and staff.
- Develop and implement a comprehensive TIC training and technical assistance plan, including curriculum development, mandatory training, onboarding training for new staff, requirements for ongoing and refresher training sessions and providing ongoing technical assistance to MDH Administrations to support their TIC organizational change efforts.
- Identify and develop Statewide ACEs and TIC Metrics to evaluate and monitor progress on Statewide TIC initiatives.
- Administer the Trauma Informed Organizational Assessment (TIOA) Tool across BHA and other MDH Administrations and use the results to target training and technical assistance efforts and monitor progress with Trauma Informed organizational change efforts.
- Design and conduct annual learning collaboratives and provide targeted technical assistance to BHA staff, local behavioral health partners and provider organizations to facilitate the development of TIC organizational Action plans.
- Design and perform focused data studies on the prevalence and impact of ACEs and trauma exposure on behavioral health populations and disseminate findings to state and local behavioral health partners.

Quality Assurance and Compliance

Licensing

The State of Maryland continues to identify opportunities to build quality and equitable care through the lens of regulatory, statutory and compliance frameworks. At the time of writing of the FY 25-27 State Plan, the State is currently undertaking a process to revise the 10.63 COMAR regulations.

The office of licensing is dedicated to overseeing the licensure of providers under COMAR 10.63 and improving the quality of behavioral health services provided to

individuals within the Public Behavioral Health Systems(PBHS). Improvement of the licensing infrastructure will significantly enhance the administration's ability to provide comprehensive system oversight to the PBHS. These improvement efforts will include upgrading the licensing database to ensure that there is accurate data handling capacity through automated provider application submission. This will allow for reduction in provider error and missing documentation thus allowing the administration to maintain a turnaround time of less than 8 weeks for licensing providers. Continued development of a robust and sufficient IT infrastructure will allow for the ability to generate real time reporting of licensing information and a searchable database for the public.

Compliance

The Mental Health and Substance Use Disorder compliance offices are committed to ensuring that all providers under the authority of the Administration are in compliance with regulation, Federal and State laws and improving quality of services through providing technical assistance and training. The compliance offices seek to increase the percentage of provider compliance reviews conducted annually by 25 percent with the addition of new compliance reviewer staff and training the Local Behavioral Health Authorities (LBHA) on effective auditing techniques. The compliance offices are in the process of revising procedures for complaints, critical incidents, and other compliance investigations. Through the use of data mining through the BHASO, the department has begun analyzing compliance trends and using this information to publish quarterly compliance provider alerts for PBHS providers. These alerts give targeted information for providers to use to improve the quality of their program by addressing common compliance trends. The compliance office is working with the licensing department to improve the IT infrastructure. The improvement of the IT capabilities within the compliance offices will allow the administration to identify providers with chronic compliance concerns and take necessary disciplinary action, develop targeted training programs for ongoing implementation of quality assurance, and improved service delivery.

Regulation and Accreditation

The Accreditation and Regulation workgroup is responsible for ongoing periodic reviews of the Administrations regulations in COMAR 10.63. The workgroup is currently conducting a comprehensive review and revision of the current regulations to ensure that the administration has met all requirements outlined in the legislation, outlined clear comprehensive compliance requirements for all existing and new licensed providers. The updated regulatory requirements will re-establish standard floor requirements and align with the changes made by the American Society of Addiction Medicine (ASAM) for the treatment of individuals with substance

use disorders. The Accreditation and Regulation workgroup continues to partner with the five administration approved Accreditation Organizations to educate providers, stakeholders, other state organizations about the accreditation process and its role in quality improvement for providers licensed by the administration.

Behavioral Health Administrative Service Organization (ASO) Contract Implementation & Monitoring

As the largest funded program at $2.5 million, the effective contract implementation and monitoring for the Behavioral Health Administrative Services Organization (ASO) is integral to the administration's ability to provide oversight, quality assurance, and continuous performance improvement practices for providers within the PBHS. The ASO is responsible for overseeing the authorization of services, data collection,claims submission, the payment of claims, as well as the performing clinical quality audits of providers in the PBHS. BHA clinical subject matter experts in partnership with the Medicaid Behavioral Health Division oversee the implementation and ensure that contractual requirements are met by the selected ASO vendor. Effective contract oversight will result in improved clinical care for individuals within the Public Behavioral Health System, leading to better health outcomes for some of Maryland's most vulnerable citizens.

Future Initiatives

Certified Community Behavioral Health Clinics

SAMHSA's Certified Community Behavioral Health Clinics (CCBHC) Model is designed to ensure access to coordinated, comprehensive behavioral healthcare. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age, including developmentally appropriate care for children and youth.

CCBHCs are responsible for providing nine services, which can be provided directly or through formal relationships with Designated Collaborating Organizations (DCOs):

1. Crisis Services
2. Treatment Planning
3. Screening, Assessment, Diagnosis and Risk Assessment
4. Outpatient Mental Health and Substance Use Services
5. Targeted Case Management
6. Outpatient Primary Care Screening and Monitoring
7. Community Based Mental Health Care for Veterans
8. Peer, Family Support and Counselor Services
9. Psychiatric Services

Legislative Authorization

Maryland Senate Bill 362 (2023): Certified Community Behavioral Health Clinics - Planning, Grant Funds, and Demonstration Application took effect July 1, 2023. The bill requires the Maryland Department of Health to apply to SAMHSA at the Center for Mental Health Services for (1) federal planning, development, and implementation grant funds related to certified community behavioral health clinics for fiscal 2025 and (2) inclusion in the state CCBHC demonstration program for fiscal 2026. The Medicaid Administration and the Behavioral Health Administration was awarded the 2025 CCBHC Planning Grant from SAMHSA, and have begun preliminary research and planning work.

Value Based Purchasing (VBP)

A brief entitled “Exploring Value-Based Payment to Encourage Substance Abuse Disorder Treatment in Primary Care” developed by CHCS and the Technical Assistance Collaborative and supported by the Melville Charitable Trust explores how states and health plans are using financial levers to encourage SUD treatment in primary care. The Medicaid Administration in collaboration with the Behavioral Health administration are working to draft a Medicaid Waiver to develop a pilot program that will demonstrate better provider outcomes and look at prospective payment.

Data Innovation

Increase Statewide Use of Information Technology Innovations

Expanding the uptake and use of technology innovations specifically designed to enhance the efficiency and effectiveness of service delivery within the Public Behavioral Health System is a priority for the Behavioral Health Administration. The administration has a number of technology enhancement initiatives that are underway or planned over the next three years. An electronic Statewide Inpatient Psychiatric Bed Registry combined with a Care Coordination and Referral function was launched in February 2022 that provides discharge planners in hospitals across Maryland, visibility into all available, staffed, inpatient psychiatric beds across the state. A hotline, operated in partnership with Sheppard Pratt was also established to provide telephonic support for referrals. In July 2022, an Outpatient Care Coordination and Referral Pilot was launched in partnership with MD 211, press 1.

This hotline was established to provide discharge planners in hospitals across Maryland an access point for supporting patients in need of community based behavioral health services. Additionally, a Behavioral Health Hospital Coordination team has been established within the Behavioral Health Administration for case

escalation when services are not readily identified for community based behavioral health services. Work is currently underway, through the development of a Request for Proposals (RFP) to combine the psychiatric bed registry and referral system with a comprehensive statewide crisis Care Traffic control data solution. The application will have the capability to track individuals throughout their experience with the crisis system, from their first contact to final disposition, capture comprehensive service level and individual outcome metrics, and enable real time look-up and referral to stabilization and acute care beds and other community services and resources. Over the past 12-months, BHA has worked with crisis system stakeholders to identify and select a core set of crisis system data elements for statewide use; has identified and initiated the use of uniform crisis assessment tools (CAT) for use by mobile crisis and crisis stabilization providers. Both a Child CAT and an Adult CAT tools were developed and training and system wide implementation is anticipated over the next 12-months. The selected crisis data elements and the assessment tools will be incorporated in the Statewide crisis data solution. This technology is essential to effectively monitor and coordinate care delivery in the crisis system and to effectively evaluate service effectiveness.

BHA Quality Metrics and Performance Monitoring Program

The identification, selection and implementation of core behavioral health quality metrics is essential in order to evaluate the effectiveness of PBHS services, inform policy decisions and continuous improvement efforts. The Department has several ongoing initiatives focused on the development and implementation of Core Performance/Quality Metrics. The BHA Quality Metrics and Performance Monitoring System established a set of core behavioral health quality metrics and a dashboard tool for use by BHA leadership and local behavioral health partners. The system includes a continuous improvement review process to regularly monitor progress on selected quality metrics to determine improvement priorities and actions. The system will be used to:

- Assess the quality and effectiveness of the Public Behavioral Health System (PBHS);
- Align and focus state and local behavioral health program development, planning, monitoring and policy direction on key measures of success; and,
- Establish a continuous learning and improvement culture at BHA and in the PBHS.

An initial set of more than 30 measures were identified based on a review conducted by the BHA Data and IT and ARE Offices. Measure selection was informed by previous work by BHA, including a JCR review of behavioral health quality measure, Moore-Miller Administration behavioral health metrics, State Health Improvement

Plan (SHIP) Measures,and State Opioid Response (SOR) core metrics , among other sources. Measures were selected that best aligned with PBHS goals, prioritizing the Moore-Miller Administration core metrics and BHA MFR reporting measures. A Power BI dashboard tool has been developed and is now operational. Quality measures have been built into the tool and other measures are being phased in as the data work is completed. The dashboard is updated monthly. The identified measures were reviewed and vetted with BHA program directors and leadership. Annual targets are established for each measure based on a modified Achievable Benchmarks of Care (ABC) methodology where feasible.

Increase the Adoption and Use of Rapid Cycle Continuous Performance Improvement Processes

The effective use of data to drive program change and system improvements remain a significant challenge for State and local PBHS partners. Over the next twelve months, BHA will work to enhance data driven decision-making in the PBHS through the adoption and implementation of focused data to action strategies and the use of the Plan Do Study Act (PDSA) rapid cycle Improvement methods and process. BHA has convened an Evaluation and Continuous Quality Improvement (ECQI) workgroup that is charged with identifying improvement opportunities, developing and implementing improvement actions plans, and studying the impact of these actions. Based on the results of the plans, the workgroup will recommend ongoing program and system changes.

MDH Initiatives

Preventing Gun Violence

Center for Firearm Violence Prevention and Intervention, a public health program created by the 2024 Maryland State Legislature (HB 583) with a broad scope and major impact on Maryland Department of Health's missions and operations. The Center's purpose is to reduce firearm violence, harm from firearm violence, and misuse of firearms in the state by partnering with Federal, State, and local agencies and affected communities to implement a public health approach to firearm violence reduction.

Effective October 1, 2018, Maryland has extreme risk protective orders (ERPO – also referred to as a "red flag" law), which is a court order that temporarily requires a person to surrender any firearms or ammunition to law enforcement and not purchase or possess firearms or ammunition. The court may also refer the person for an emergency evaluation. Red Flag laws combat gun violence such as mass shootings or suicide by firearm by temporarily removing firearms from individuals who are at risk of harming others or themselves.

Access to Care for Undocumented Immigrants

As of July 1, 2023 through the Healthy Babies Equity Act, undocumented pregnant individuals living in Maryland have access to all Medicaid services. This new benefit includes coverage for all of pregnancy and four months after the baby is born as well as dental services. Medicaid will pay for:

- Doctor visits
- Prenatal visits – doctor visits to check you and baby before baby is born
- Hospital care
- Hospital stay – when you have baby
- Dental care
- Lab work and tests
- Prescription drugs – medicine from your doctor
- Mental health care
- Behavioral health care - help to stop smoking, drinking alcohol or using drugs
- Transportation services - a ride to and from medical care through Non-Emergency Medical Transportation (NEMT)

The Maryland Refugee Mental Health Program connects humanitarian immigrants with culturally and linguistically appropriate mental health services. The program is funded by the Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, Refugee Health Promotion Grant. Refugees can access mental health services such as early detection and screening by using the refugee health assessment (RHA) and the Strengths and Difficulties Questionnaire (SDQ). Humanitarian immigrants who screen positive on the RHS-15 or SDQ are offered a referral for further assessment and treatment, if needed.

The PBHS also provides time-limited coverage of behavioral health services for non-citizens who meet eligibility criteria.

Conclusion and Next Steps

Maryland has been at a significant crossroads regarding the behavioral health needs of residents over the last several years. Since 2020 with the advent of the COVID-19 pandemic, mental health needs have been on the rise. This has been compounded by the opioid epidemic. Opioids accounted for 90% of all intoxication-related deaths in Maryland in 2020.

It is crucial to understand that person-centered approaches that consider the wide diversity of individuals, families, and communities in Maryland are necessary to

address the behavioral health needs in the State as comprehensively as possible. Building a behavioral health system based on a continuum of care model that offers top-notch care and services to those who need them most is a major step toward a more effective and efficient process. The new mission and vision statements from the Maryland Behavioral Health Administration make it very evident that everyone should have the opportunity to flourish and experience improved outcomes.

Although the task at hand will be difficult, success is ultimately achievable with the help of this Strategic Plan, numerous partners, efforts, and extensive networks of stakeholders with a wide range of backgrounds, specialties, and life experiences. The plan will focus on four main areas to: increase access to behavioral health services; increase the quality of the services delivered through the public behavioral system; reduce disparities in the public behavioral health systems services for underserved populations; and expand behavioral health programs that promote mental well-being and reduce high-risk experiences such as Adverse Childhood Experiences (ACEs) and toxic stress and prevent high-risk behaviors such as substance use and suicide.

Reflecting on the enormous responsibility to re-imagine the behavioral health system within the State of Maryland, it is important to create an equitable, accessible, flexible, and long-lasting process that demonstrates the commitment to individuals with behavioral health needs.

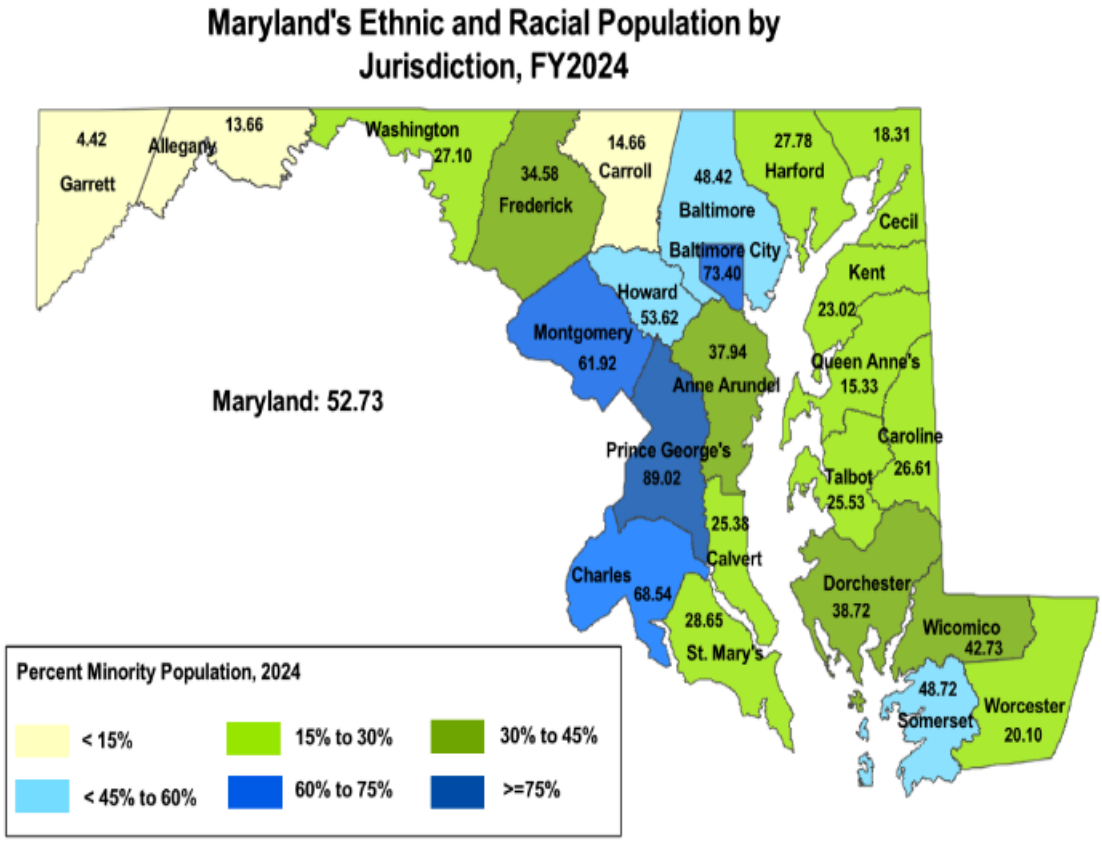
Appendix A: Managing for Results Metrics

Metrics: BHA Strategic Priorities
Priority 1: Increase Access
1. Goal: Increase the abilities of participants with behavioral health disorders to live successfully in the community. 1.1. Percent of PBHS service recipients with a primary mental health diagnosis who are readmitted to the same or different mental health inpatient hospital within 30 days of discharge Total number of PBHS service recipients with a primary mental health diagnosis discharged from an inpatient hospital following an admission for a mental health related condition 1.2. Percent of PBHS SUD service recipients readmitted to the same or different SUD Residential Treatment facility within 30 days of discharge Total number of PBHS SUD service recipients discharged from Residential Treatment
Priority 2: Reduce Disparities
2. Goal: Maintain and increase the number of individuals treated in the PBHS 2.1. Number of individuals treated in the PBHS in the fiscal year Change in the number of individuals treated from previous fiscal year Percent change from previous fiscal year 2.2. Percent change in the number of PBHS recipients receiving OUD services Number of PBHS service recipients receiving PHBS OUD services in the current fiscal year Changes in number of PBHS service recipients receiving PBHS OUD services in previous fiscal year 2.3. Percent of PBHS mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge from an inpatient facility Total number of PBHS service recipients discharged from mental health hospital treatment facilities 2.4. Percent of PBHS SUD service recipients who received follow-up treatment within seven days of discharge from SUD Residential Treatment facility Total number of PBHS SUD service recipients discharged from SUD Residential Treatment 2.5. Number of unduplicated providers actively billing the PBHS for SUD treatment services rendered Number of unduplicated providers actively billing the PBHS for SUD treatment services rendered to children and youth ages 0-17 years old Percent of SUD providers in the PBHS actively billing the PBHS for SUD treatment services rendered to children and youth ages 0-17 years old
Priority 3: Improve Quality and Outcomes
3. Goal: Implement utilization of the latest technology to expand access to behavioral health services in the least restrictive settings

Metrics: BHA Strategic Priorities
3.1. Unduplicated number of individuals served in outpatient setting in rural areas Number of individuals that received tele-behavioral health services in rural areas Percent receiving tele-behavioral health services in rural areas 3.2. Unduplicated number of individuals served in outpatient setting statewide Number of individuals that received tele-behavioral health services statewide Percent receiving tele-behavioral health services statewide
Priority 4: Increase Programs Promoting Wellbeing
4. Goal: Promote health and wellness initiatives in the Behavioral Health System 4.1. Percent of PBHS MH service recipients with three or more behavioral health related ED visits Total number of PBHS MH service recipients 4.2. Percent of PBHS SUD service recipients with three or more behavioral health related ED visits Total number of PBHS SUD service recipients

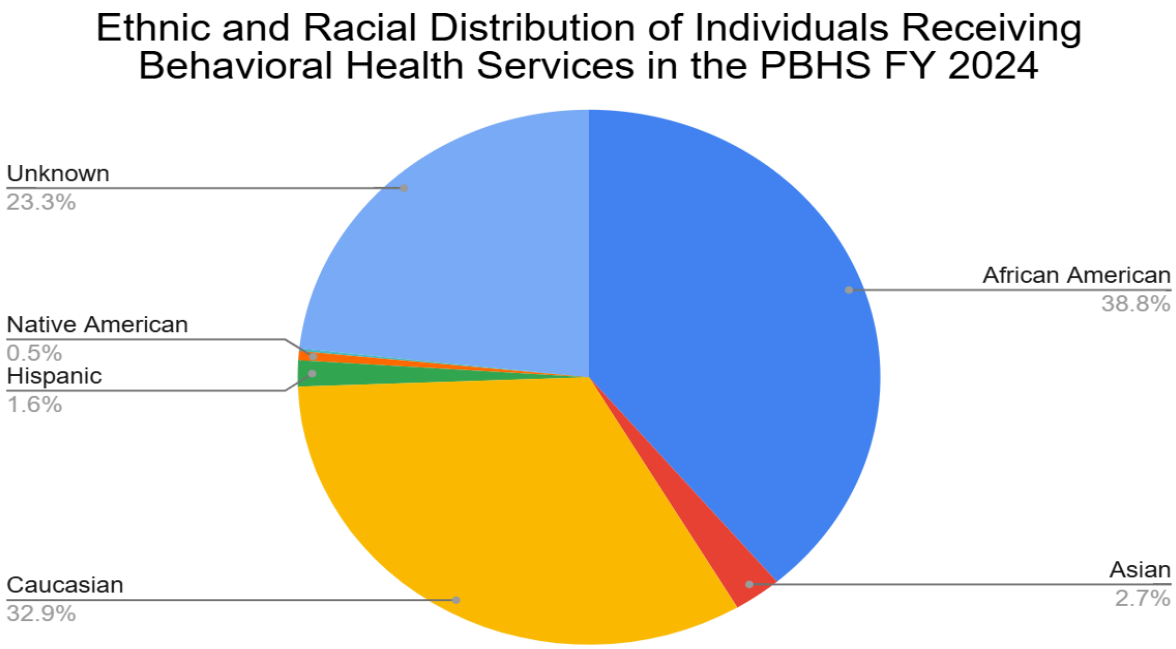
Appendix B: Diversity in Maryland: Maps and Figures

Map 1: Maryland's Ethnic and Racial Population by Jurisdiction, FY 2024



***Data Source**: Maryland estimated population data for July 1, 2023, Maryland Vital Statistics Administration.*

Figure 1: Ethnic and Racial Distribution of Individuals served in the PBHS, FY 2024



African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Total
128,910	8,806	109,321	5,237	1,824	488	77,282	331,868

Data Source: *ASO behavioral health service claims data. Data based on claims paid through December 31, 2024.**FY 2024 data are not complete as providers have 12 months from the time of service in which to submit a claim for payment. However, by the date of the data run, approximately 95% of all FY 2024 claims have been submitted for reimbursement.

Figure 2: Deaf and Hard of Hearing Individuals Served in the PBHS by Race, FY 2024

	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Total
Total Served in PBHS	128,910	8,806	109,321	5,237	1,824	488	77,282	331,868
Number of Deaf/HOH Served in PBHS	888	42	1,141	26	13	<11	502	2,615
Percentage of Deaf/HOH by Race	33.96%	1.61%	43.63%	0.99%	0.50%	0.11%	19.20%	100.00%

Data Source: *ASO behavioral health service claims data. Data based on claims paid through December 31, 2024.*
*FY 2024 data are not complete as providers have 12 months from the time of service in which to submit a claim for payment. However, by the date of the data run, approximately 95% of all FY 2024 claims have been submitted for reimbursement.
Deaf/HOH are those individuals who reported that they had replied "Yes" to the question: "Are you deaf?"
CMS Suppression rules require any numbers between 1-10 to be represented by "<11".

Figure 3: Number of Veterans who received Behavioral Health Services (Mental Health or SUD), FY 2019-2024

Fiscal Year	# Veterans Served MH	MH Veteran Expenditures		# Veterans Served SUD	SUD Veteran Expenditures
2019	4,597	$39,447,274		4,197	$24,787,523
2020	4,047	$36,583,125		3,687	$22,975,160
2021	3,794	$33,761,963		3,058	$21,071,517
2022	3,544	$31,788,746		2,806	$22,849,077
2023	3,441	$33,769,525		2,608	$27,083,035
2024*	3,233	$33,214,406		2,487	$30,857,641

Data Source: ASO data based on claims paid through December 31, 2024. *FY 2024 data are not complete as providers have 12 months from the time of service in which to submit a claim for payment. However, by the date of the data run, approximately 95% of all FY 2024 claims have been submitted for reimbursement. Data based on those individuals served in the PBHS who self-reported "Yes" to the question: "Are you a Veteran?"

Figure 4: Maryland's Four Jurisdictions with the Largest Homeless Population Count based on the Annual Count of those Experiencing Homelessness

Counties	FY 2024	FY 2023	FY 2022
Total	21,489	19,989	18,680
Baltimore City	6,395	6,454	6,605
Baltimore County	2,817	2,324	1,928
Montgomery County	2,786	2,451	2,322
Prince George's County	1,323	1,034	1,136

Source: Partially adapted from the Maryland Interagency Council on Homelessness; April 8, 2025.

Appendix C: Access to Services by Jurisdiction Program Glossary

Program / Service	Definition
Assertive Community Treatment	Provide Assertive Community Treatment (ACT) services to individuals with complex mental health and other secondary diagnoses. Provided through the ASO for Medicaid eligible clients. ACT with housing subsidy is also provided as a limited service through LBHAs for non-Medicaid eligible clients.
Adolescent Clubhouse	The Adolescent Clubhouse programs are expected to serve adolescents ages 12-17 (18 if still in HS) who are at high risk of an Opioid Use Disorder (OUD) and/or stimulant use disorder. These are not treatment programs but are rather a resource to help prevent escalation of opioid experimentation, use and/or promote recovery in our youth.
Assisted Living/ ALU	Behavioral Health Assisted Living Pilot programs are intended to support adults or older adults diagnosed with serious mental illness, and needing assistance with activities of daily living (ADL), instrumental activities of daily living (IADL), or other somatic problems requiring nursing assessment and/or delegation, to prevent unnecessary institutionalization.
Buprenorphine Initiative	The purpose of these funds is to address and alleviate access barriers to Buprenorphine treatment.
Case Management (MH)	Connects individuals to community services and resources
Children in Need of Assistance (SB 512) Assessments	The purpose of the legislation was to identify newborns exposed to drugs/alcohol and offer the mother and birth father drug treatment as well as support.
Client Support Services (MH)	The purpose of these funds is to enable an adult or youth to access or retain community-based mental health services and shall be linked to the client's treatment, rehabilitation, or recovery plan goals
Court / DJS Initiatives	Variety of initiatives based in the court system, including court assessments/court-ordered substance use services for the Department of Juvenile Services (DJS),

Crisis Intervention Team	The Crisis Intervention Team (CIT) program is a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families, and other advocates. It is an innovative first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness-related behaviors. It also promotes officer safety and the safety of the individual in crisis.
Crisis Walk-In / Beds / Stabilization / Urgent Care	Variety of initiatives to increase the availability of Crisis Walk In / Stabilization services and/or Urgent Care that can serve clients in need of immediate psychiatric care, but are not experiencing an emergency or other life-threatening situation, rather than utilizing Emergency Department services
Crisis Residential	Short-term, intensive mental health services and support to prevent unnecessary psychiatric inpatient admissions.
988 Crisis Hotline	The funding is intended to support Maryland's 988 Crisis Hotline System services - State-wide 24-hour crisis intervention and supportive counseling hotline for SUICIDE, family and relationship problems, shelter needs, violent or threatening domestic situations, loneliness, depression, chemical dependency issues, and others.
Deaf/Hard of Hearing Interpreter Services	Provision of services to individuals who are Deaf or Hard of Hearing utilizing American Sign Language (ASL) as their primary mode of communication to provide one-on-one supervision and behavioral support to an individual who is Deaf or Hard of Hearing, meets the target definition of having a severe or persistent mental illness (SPMI), or Supportive Living services.
Detention / Jail-Based Services	Programs and initiatives offered through the BHA Office of Crisis and Criminal Justice Services to provide diversion from incarceration related to low level substance use disorder offenses, administration for certain jail/detention center based treatment services, and program and services to support successful re-entry into the community following incarceration
Drug Court	Supports fixed price contract agreements with various vendors to provide case management for the purpose of the preparation of documents for court, time spent in court, non-reimbursable clinic case management associated with SUD treatment services
ED / Hospital Diversion Initiatives	Various programs for the provision of mental health treatment services which reduce unnecessary hospitalizations and/or prevent/divert future ED visits and inpatient admissions
First Episode Psychosis	Serve individuals with a diagnosis of a schizophrenia spectrum disorder, diagnosed in accordance with DSM- 5 criteria, for whom

	the current episode of psychosis is within two years of the first onset of psychotic symptoms
Housing Supports (CoC, PATH)	Housing programs, such as PATH and Continuum of Care, link a vulnerable population of individuals experiencing serious mental health disparities to mainstream and other supportive services
Inpatient Services (MH)	Psychiatric Treatment is provided in hospitals
Inpatient Services (SUD)	SUD Treatment is provided in hospitals
Intensive Outpatient Services (SUD)	SUD Treatment is provided in an outpatient setting, but with more programming/support than an outpatient service
LEAD	Law Enforcement Assisted Diversion (L.E.A.D.) is a voluntary diversion program that connects eligible participants to intensive case management and diverts them away from law enforcement. LEAD participants are linked to trauma-informed intensive case management and peer support.
MCCJTP	Maryland Community Criminal Justice Treatment Program (M.C.C.J.T.P.) brings treatment and criminal justice professionals together to screen individuals with mental health concerns while they are confined in local jails, prepare treatment and aftercare plans for them, and provide community follow-up after their release. The program also offers services to probationers and parolees with mental health concerns and provides enhanced services to offenders with mental health concerns who are homeless and/or have co-occurring substance use disorders.
Maryland Recovery Net	The purpose of these funds is to enable an individual to access or retain community-based behavioral health services and shall be linked to the client's clinical and/or recovery support plan goals. Any requests for MDRN funding must demonstrate the relationship between the requested MDRN service or support and the individual's identified clinical treatment or recovery goal.
MH Stabilization Services (Youth)	Provides Mental Health Stabilization Services to youth involved with the Department of Social Services to improve the stability of family placements and divert youth from requiring additional services.
Mobile Crisis Response	Provides Mobile Crisis Services to individuals experiencing a behavioral health crisis.
Mobile Response Stabilization Services (MRSS)	Implementing child specific mobile response teams in alignment with the enhanced Mobile Response and Stabilization Services (MRSS) model promoted by BHA, as well as supplementing existing mobile crisis teams in this same area.

Opioid Maintenance Treatment	The use of medications in combination with counseling and behavioral therapies for the treatment of opioid use disorders
Outpatient Services (MH)	Community clinics or group practices with mental health professionals providing outpatient treatment
Outpatient Services (SUD)	Group and individual counseling services less than 9 hours a week
Overdose Response Program	Overdose Response Programs provide overdose prevention education and dispense naloxone to the community.
Partial Hospitalization (MH)	Intensive, non-residential MH treatment for more than 20 hours per week consisting of outpatient group, individual, and family therapy
Partial Hospitalization (SUD)	Intensive, non-residential SUD treatment for more than 20 hours per week consisting of outpatient group, individual, and family therapy
Peer to Peer Support / Peer Recovery	Peer to Peer services are unique in that the delivery of these services are facilitated exclusively by individuals who identify as having lived experience in behavioral health recovery.
Psychiatric Rehabilitation Program	Services to improve or restore skills needed to live, work, learn, and participate in the community.
Recovery Support Pregnant Women / Children	Provides recovery housing, and access to supportive services, for pregnant women and women with children who are in the early stages of recovery from a substance related disorder.
Residential Rehabilitation Program	Individuals live in a supportive environment that enables them to develop daily skills for independent living.
Residential Treatment Center (MH)	Campus-based intensive treatment setting; Children may be admitted when services available in the community cannot meet their needs.
Residential Treatment (SUD)	Campus based intensive SUD treatment. Programs provide low-, medium-, and high- intensity services including withdrawal management.
Respite Care	A person with behavioral health needs stays briefly away from home with specially- trained individuals, or someone comes into the home to give the caregivers a break and provide the person with behavioral health needs with enhanced support.

Safe Station	Safe Stations is an innovative new program that shifts barriers to treatment for those members of our community who are eager to recover from drug addiction. Persons seeking treatment for addiction can visit any police or fire station across the county, day or night, to dispose of any paraphernalia and find assistance gaining access to care.
School / Preschool Programs	Various programs for the provision of mental health treatment services for preschool aged and/or school aged children
Senior Outreach	Senior Mental health Outreach services are designed to prevent or reduce psychiatric hospitalization by improving access to mental health services for older Adults / Adults with disabilities who are unable to access mental health services within traditional treatment settings.
SOAR	This program aims to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or who are at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder.
Spanish Interpretation Services	Provision of a Maryland licensed Spanish Speaking Psychiatrist and/or therapist to provide on-site language interpretive services and support to Spanish speaking consumers only.
State Care Coordination	The purpose of State Care Coordination services is to expand access to a comprehensive array of community-based behavioral health services for Maryland residents in varying stages of recovery. It is designed to improve recovery outcomes for individuals identified as at high risk for relapse.
START - Sobriety Treatment and Recovery Teams	The Sobriety Treatment and Recovery Teams (START) model is an intensive child welfare/peer support and integrated service delivery model.
STOP - Substance Abuse Treatment Outcomes Partnership	Funding is requested via the submission of proposals that outline strategies to provide substance-related disorder treatment services to one or more eligible populations; or to provide funding for eligible functions within the requesting jurisdiction or jurisdictions as defined in MD Code, Health General Article, Title 8, Subtitle 6C,.
Supportive Employment	In a Supported Employment situation, people with disabilities are given on-going support after they begin working, through activities such as training, supervision, and help with adjustment to the work environment, to ensure an employer's satisfaction with the new employee's work performance.
Syringe Services Program	Syringe services programs (SSP) are harm reduction programs that provide a wide range of services to people who inject drugs.

TAMAR	The purpose of the TAMAR program is to identify individuals with trauma histories through the use of approved screening and assessment instruments and invite eligible candidates to participate in the TAMAR project. In addition to trauma, an eligible candidate will present with a history of mental illness and/or substance use
Targeted Case Management / 1915i	Targeted Care Management (TCM) Plus is a program designed to support youth and families with a combination of risk factors and intensive mental health or substance use issues.
TAY	Services such as supported employment or supported education assist youth and young adults with behavioral health needs to gain independence and transition to adulthood.
Temporary Cash Assistance	The provisions of the Welfare Innovation Act require that a substance use disorder counselor designated as an Addiction's Specialist be on site at the Local Department of Social Services. The SATS Specialist will work with all customers that are referred to them by the Local Department of Social Services to screen, assess and refer to treatment any individual that needs substance use disorder treatment. The Specialist will also provide/refer for urinalyses services and case manage all individuals that are in the SATS program by providing follow up on all individuals monthly.
Teen Diversion	This program will offer youth a diversion for an out of home placement program that will provide assessments, supports and referrals to ongoing mental health services.
Older Adult Behavioral Health PASRR	Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long term care. PASRR requires that Medicaid-certified nursing facilities: 1. Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID); 2. Offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); 3.Provide all applicants the services they need in those settings
Wellness/ Recovery Centers	Provides for the development/maintenance of a site that allows individuals living in or seeking behavioral health recovery to meet at least 48 hours per week. This site will offer peer support services and provide individuals with the ability to connect with others in behavioral health recovery while navigating local support services and overcoming barriers to their own personal recovery.

Appendix D: BHA Division Highlights

Prevention and Promotion

Suicide Prevention Training

The Office of Suicide Prevention works to inform, educate, train, and connect behavioral health and medical professionals, and the public on the scope and magnitude of the causes and effects of suicide among individuals, families, communities, and populations. The initiatives focus on vital issues related to suicide prevention, intervention, and postvention. These approaches cover responses to signs of concern, risk, and protective factors, maintaining safety, and approaching those struggling across the continuum of care through culturally appropriate and evidence-based practices. The Office of Suicide Prevention integrates state-wide evidence and community-level insights to address mental health stigma, increase data transparency, engage with diverse stakeholders, and educate providers and the public both in-person and online. The Office serves as a hub for resources. Office highlights include:

- Suicide Fatality Review Committee
- Hosting the annual Suicide Prevention Conference with topics ranging from post-traumatic growth to a School-Aged Youth Toolkit
- Statewide Suicide Prevention Coalition
- Suicide Data Surveillance regional meetings
- Together We Care umbrella emphasizes collaborative campaigns supporting at-risk populations, such as:
    - Taking Care of Us (Black Mental Health Alliance)
    - Caring Out Loud (Trevor Project)
    - Caring for Champions (Alston Athletics)
- Launched a robust digital presence: social media campaigns on Twitter and Instagram, the MD Mind Health and MD Young Minds Texting Project, an ever-growing monthly Scoop newsletter, and plans to overhaul our years-old state website
- Offers ongoing trainings, facilitated through external collaborators, tailored for special populations provided to local jurisdictions and providers
- Current issues being researched are suicide amongst specific populations such as postpartum, construction workers, veterinarians, correction workers, prisoners, Deaf & Hard of Hearing, elderly and aging, and refugees and immigrants. Other research areas are incidences of murder/suicide, problem gambling and suicide, and overdoses – accidental vs. suicide.

Maryland Commitment to Veterans

Maryland's Commitment to Veterans provides a comprehensive system of treatment and recovery support services for individuals who are currently serving or have served in the U.S. Uniformed Services and their families seeking wellness in Maryland. The program coordinates with national, state and local organizations in efforts to improve services and empower individuals throughout their recovery. In addition, the program provides referral services and peer support to Maryland US Uniformed Service members, veterans and their families and training/educational opportunities for behavioral health and medical providers, peers, first responders, and community partners. Two of our ARPA initiatives are highlighted below:

- *Trained Military Assistance Provider* (TMAP) Program - An advanced training in military culture, risk assessment and safety planning provided to Maryland-based nurses, doctors and all primary care staff. It is a free, online and on-demand set of evidence-based and trauma-informed courses. Practices completing the courses will receive the TMAP identifier, physical and virtual resource kits, and access to free suicide assessment consultation services.
- *Crisis Intercept Mapping* (CIM) for Service Members, Veterans and their Families (SMVF) - Grant-funded technical assistance that guides stakeholders through the continuum of care in their particular jurisdiction, identifies strengths and weaknesses, and provides support in creating an action plan to strengthen crisis care for the SMVF.

Public Awareness

All public awareness campaigns from the Office of Public Awareness follow a similar plan when being developed; consulting content experts regarding subject matter, reviewing current data to see which demographics are being most affected (gender, race, age, region, etc.), designing a campaign to show Maryland's diverse demographics (images reflecting people and state locations), strategizing with media vendors to target specific areas regarding each of the campaigns. All campaigns have a Spanish component that mirrors the deliverables created in English.

Campaigns cover multiple substance use disorder-related topics such as naloxone, Good Samaritan Law, stigma, fentanyl/xylazine, "How to talk to your doctor" if being prescribed an opioid, and safe drug disposal. The office also promotes 988, and problem gambling. The campaigns appear on multiple media platforms, including but not limited to TV, OTT, streaming, radio, digital platforms, movie theaters, print, sports venues, video games, retail stores, and print. Spokespersons from the Ravens and local radio have been incorporated into campaigns for 988, stigma, and

fentanyl/xylazine. Each campaign rollout has both broad and target audiences. Data guides specific media platform use through information on locations and demographics (age, gender, race, economic status) most affected by campaign purpose. Use of ads in Latin Opinion, Baltimore Beat, Urban One radio, Ravens, Orioles, video games, school posters, and small independent community stores are some examples. The Office of Public Awareness tracks the number of impressions (persons reached through the above-listed media platforms) and targeted campaign impressions while researching new ways to reach specific audiences/populations.

Harm Reduction

Harm Reduction Services centers its attention on the promotion of accessible and compassionate care for individuals using psychoactive substances. These services include but are not limited to workforce development, increase in statewide drug testing through Rapid Analysis of Drugs (RAD)[15], distributing of fentanyl and xylazine test strips, engagement in overdose prevention, and linkage to comprehensive care and housing. Program priorities include:

- Targeted outreach to community members who have an interest in becoming an SSP in a given jurisdiction
- Connecting potential local programs to their Local Health Departments,
- Focus efforts to increase the number of Peers involved – Peers allow outreach to participants *where they are,* to access services free of stigma
- Expand targeted distribution of naloxone to achieve saturation of naloxone distribution
- Outreach to new locations for ORPs through the STOP ACT expansion requiring all hospitals, correction facilities, homeless shelters, and opioid treatment programs to become ORPs by June 2024
- Continue with the Regrounding our Response (RoR) training efforts, training master presenters statewide to continue expanding training thus reducing stigma statewide

The metrics collected from grantees' quantitative monthly reporting, include: individuals served, service encounters, individuals receiving care coordination services, individuals receiving peer support, and referrals to other community services. These measures will undergird the efforts to reduce stigma and improve harm reduction efforts across the state.

[15] Rapid Analysis of Drugs (RAD)

Buprenorphine Expansion Initiatives

Buprenorphine expansion services assist local health departments with funding for expanding access through engaging in approved projects that are limited to services and initiatives specific to opiate use disorders. Expansion of the system involves increasing the number of providers who are eligible and willing to prescribe buprenorphine, as well as increasing the number of patients being treated by an eligible prescriber.

Buprenorphine has been recognized as an effective tool in combating opioid use disorder, and efforts have been made to expand its availability to address the opioid epidemic. Expansion initiatives generally focus on increasing access to buprenorphine through various means:

- Expanding access often involves efforts to train more healthcare professionals, such as primary care physicians, nurse practitioners, and physician assistants, to prescribe buprenorphine.
- Efforts to expand buprenorphine access also involve raising awareness about its effectiveness in treating opioid addiction and dispelling myths or misconceptions. Education campaigns target both healthcare providers and the general public.
- Integrating buprenorphine treatment into primary care settings helps reduce stigma associated with seeking addiction treatment. This approach also makes it more convenient for individuals struggling with opioid addiction to access the necessary care.

Nineteen local jurisdictions currently receive funding through the BUP Initiative. Quarterly meetings have been established to encourage collaborative efforts between jurisdictions in conjunction with BHA. Jurisdictions have used these funds to expand treatment access to patients, conduct population-focused public awareness campaigns with anti-stigma messaging, and provide educational opportunities, outreach, and technical assistance related to buprenorphine and MOUD for potential and active prescribers. Metrics under consideration to track progress include:

- Percentage of individuals who remain engaged in buprenorphine treatment over a specified period of time
- Monitoring the extent to which the expansion increases access to buprenorphine treatment, particularly in underserved populations
- Reduction in stigma associated with OUD medication-assisted treatment, contributing to improved treatment-seeking behavior
- Assessing the number of healthcare providers adopting buprenorphine prescribing practices and their capacity to meet the demand for treatment

Hub and Spoke

The Hub and Spoke Model is designed to support buprenorphine prescribers serving individuals with an opioid use disorder (OUD). The primary goals are to increase the number of community-based prescribers, the number of OUD patients they are willing to treat and facilitate the transfer of an OUD patient from a community-based prescriber (Spoke) to a SUD treatment program (Hub) as needed. This goal will be accomplished by linking prescribers into a continuum of care for the treatment of opioid use disorder. Prescribers can transfer a patient to a higher level of treatment, including any ancillary support, if necessary.

The Hub and Spoke program was implemented in Maryland in FY21. The program enrolled over 100 participants and engaged 21 Hubs and 30 Spokes. The funding from this project assisted St. Mary's County with implementing community ADA-compliant telehealth booths. The telehealth booths are housed in their local libraries and provide community access for OUD patients to access virtual appointments with Primary Care and other treatment and support related to their recovery. The program ended FY23 with increases in provider engagement and had approximately 200 participants.

The Early Intervention Team will track the operating costs of Hub and Spoke to ensure that the model remains cost-efficient, measure the efficiency of the Hub and Spoke by assessing the capacity being utilized, measure the quality of services provided by the Hub and Spokes, ensuring they meet or exceed customer expectations, and evaluate the effectiveness of communication channels between the Hub and Spokes.

Maryland Addictions Consultation Services (MACS) – Early Intervention

The Maryland Addictions Consultation Service (MACS) provides addiction consultation and outreach services. The consultation service is a "warm line" operated by the University of Maryland School of Medicine Department of Psychiatry. Addiction Medicine physicians provide expert consultation to community physicians and other prescribers about buprenorphine induction and maintenance and assist with patient resource identification. MACS is also available to consult on general questions related to substance use disorder. MACS performs outreach to encourage physicians, nurse practitioners, and other eligible prescribers to prescribe buprenorphine and is available to support them as new prescribers. Outreach is targeted to areas of the state that have a high rate of opioid overdose deaths and/or have a shortage of treatment providers. MACS also proposes to expand its services further addressing prescribing disparities in Maryland. MACS conducts online

webinars and continuing medical education (CME) events regarding substance use disorders.

MACS has enrolled over 3,000 providers in all 24 counties. MACS has responded to over 1,480 clinical consultations. Conducted 388 trainings with over 7,400 participants, and hosted 88 ECHO Clinics for primary care, maternal health, and opioid treatment program providers and teams. In addition to providing consultation, education, and technical assistance to healthcare providers and teams across the state, MACS has developed campaigns and materials to educate providers about legislative changes to buprenorphine prescribing, new DEA-required training, guidance on cannabis legalization, and more.

MACS tracks Participation in educational activities and their impact on prescribers with follow-up surveys on all educational activities and consultations.
The efficiency of the Program will be measured by assessing program utilization and engagement patterns. The operating cost of the Maryland Addiction Consultation service will continue to be tracked to ensure that the model remains cost-efficient.

Alcohol, Tobacco, and Drug (ATODs) and the Opioid Misuse Prevention Program

Alcohol, Tobacco, and Drug Prevention Centers (ATODs) are funded by the Substance Use Block grant and are located in universities across four regions in Maryland: Towson University (Central Maryland), Frostburg State University (Western Maryland), University of Maryland Eastern Shore, and Bowie State University (Central Maryland). These ATODs focus on substance use prevention efforts through training, education, and implementing constructive alternatives for college students with the goal of preventing and reducing substance misuse and risk-taking behaviors among students. The ATOD Centers apply evidence-based approaches at both the individual level (e.g., screening and brief intervention) and the environmental level (e.g., strengthening policies to reduce substance misuse) that actively supports, educates, and empowers students to make healthy choices. The ATOD Centers engage students in developing leadership and critical thinking skills that create campus environments supportive of academic success and wellness, resulting in a reduction of student drinking and other substance use. In addition, the ATOD Centers collaborate with agencies and organizations in the community surrounding the campus.

The Opioid Misuse Prevention Program (OMPP) provides funding to 18 jurisdictions in Maryland (one is regionally based, which is the mid-shore) to implement primary prevention and intervention strategies utilizing SAMHSA's Strategic Planning Framework in order to prevent and reduce opioid misuse, overdoses, and overdose

fatalities. These strategies can be targeted to the general population, or to those who are at increased risk of misusing opioids or already misusing opioids.

Opioid Misuse Prevention Program (OMPP), for participating jurisdictions- Review of the Total number of: jurisdictions implementing Narcan Distribution and/or Narcan Training, Academic Detailing, Storage and Disposal Strategy, Community-based process strategy, social marketing campaigns, information dissemination strategy, and Prevention Education Strategies.

Primary Behavioral Health and Early Intervention

Screening, Brief Intervention, & Referral to Treatment (SBIRT) Programs

Screening, Brief Intervention, & Referral to Treatment is a universal screening program that has been a part of BHA's work for over thirteen years. The target population for these projects includes patients of all races and ethnicities identified through the universal SBIRT screening processes at the facility implementing these services. This work is currently funded by the State Opioid Response III grant. SBIRT programs include the following services:

- Universal screening for SUD to all patients at a given facility using evidence-based screening tool(s)
- Motivational Interviewing Brief Interventions to address substance use for those patients who screen positive
- Referrals to treatment for appropriate patients
- Statewide training on SBIRT for peer recovery coaches, nurses, and social workers

SBIRT work over the next few years includes the following:

1. SBIRT in Hospital Emergency Departments. This work combines SBIRT, the Overdose Survivor Outreach Project (OSOP), and Hospital Based Medication for Opioid Use Disorders Prescribing efforts.
2. SBIRT Fidelity & Quality Assurance Program. This work involves going back to hospital emergency departments that previously implemented SBIRT, OSOP, MOUD prescribing to address issues of training and drift from evidence-based practice.
3. SBIRT, OSOP, and MOUD prescribing in Crisis Stabilization Centers
4. Statewide SBIRT training for Nurses, Social Workers, and Peer Recovery Specialists
5. SBIRT in primary care settings through MDPCP (Maryland Primary Care Program)

First Episode of Psychosis

The Maryland Early Intervention Program (MEIP) operates with state funding to provide services for young people experiencing a first episode of psychosis. MEIP is a specialized program with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with psychotic disorders. The program has three components: 1) Outreach and Education Services, 2) Clinical Services, and 3) Training and Implementation Support. Research is integrated into these components and focuses on developing objective methods for early detection and prediction of disease emergence, progress or recovery; and intervention development to enhance efficacy and effectiveness. All MEIP activities are guided by a multi-disciplinary Advisory Council, including youth, family, and consumer advocacy membership.

BHA uses the 10% Set-Aside Federal Block Grant funds to support three teams utilizing the RAISE-IES Coordinated Specialty Care (CSC) model – OnTrack Maryland at Family Services, Inc. in Montgomery County, OnTrack Maryland at Family Services, Inc. in Prince George's County, and the Johns Hopkins Bayview Early Psychosis Intervention Clinic in East Baltimore. In addition, funding for first episode psychosis includes fidelity efforts to further promote recovery support services such as person-centered planning, peer involvement, and a combined model of evidence-based supported employment and supported education for individuals served by these three teams. These support services enable individuals to choose, obtain, maintain or advance within a community-integrated work and education environment consistent with their interests and preferences.

The goals of the MEIP are to:

- Serve individuals with a diagnosis of a schizophrenia spectrum disorder, diagnosed in accordance with DSM-5 criteria, for whom the current episode of psychosis is within two years of the first onset of psychotic symptom
- Utilize interventions to promote transition to a lower level of care
- Technical Assistance and Supports eg: 24/7 access to support staff

Behavioral Health Integration and Pediatric Primary Care

The Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) supports the efforts of primary care and emergency medicine professionals to assess and manage the mental health needs of their patients from infancy through the transition to young-adulthood. This is achieved through a consultation warmline with child mental health specialists; training & education for primary care & emergency medicine professionals; telemental health services which includes psychological

evaluations, record review and consultation, and complex care coordination; as well as, social work co-location which is a partnership with Salisbury University providing regionally specific social work co-location in primary care settings. BHIPP is supported by funding from the Maryland Department of Health-Behavioral Health Administration through general funds and operates as a collaboration between the University of Maryland School of Medicine, the Johns Hopkins University School of Medicine, Salisbury University and University of Maryland Eastern Shore.

BHIPP program goals:

1. Provide training for primary care providers, and office staff/mental health consultants working with primary care providers. This may include technical assistance to primary care providers interested in increasing their mental health evaluation and treatment capacity, including helping to implement systems for screening and tracking patients and for co-location of mental health services.
2. Develop and maintain a mechanism for responding to requests from primary care providers for informal consultation about children and adolescents with mental health problems.
3. Collaborate with all partners to maintain a data collection and monitoring system to track program activities and provide quality monitoring, and to develop and execute plans for evaluation of the clinical and fiscal impact of the program.
4. Provide Outreach and Training

Early Periodic Screening Diagnosis and Treatment (EPSDT)

While oversight of EPSDT lives in Medicaid, the BHIPP initiative incorporates EPSDT requirements and screening recommendations into training around specific diagnoses or mental health topics (e.g., developmental, autism, substance use, depression). BHIPP also shares information on EPSDT with social work interns who are trained on how to administer, score, and interpret the results as well as appropriate next steps. A library of free, validated tools that meet the EPSDT requirements are available on BHIPP's website.[16] BHIPP sends clinically appropriate screening tools, instructions, and provides technical assistance in how to interpret and respond to screening results to pediatric Primary Care Physicians who call for consultation about the developmental, behavioral, and mental health of their patients.

[16] https://mdbhipp.org/

Urgent and Acute Care

The crisis system vision is a statewide continuum of integrated, comprehensive, equitable mental health and substance use services for Marylanders across the lifespan - to prevent crisis, support people experiencing a crisis as they define it, and help them heal and thrive. Care must be compassionate, culturally sensitive, and trauma-responsive.

BHA aims to achieve this objective by:

- Regulating mobile crisis team and Behavioral Health Crisis Stabilization Center services,
- Increasing the number of mobile crisis teams and expanding the hours to 24/7 to improve access,
- Establishing Behavioral Health Crisis Stabilization Centers,
- Increasing awareness of 988 and crisis services across populations,
- Leveraging Medicaid reimbursement to support sustainability,
- Standardizing training for the Crisis System workforce,
- Implementing a comprehensive data collection system to monitor Crisis System outcomes and assess for quality improvement opportunities, and
- Implementing a Care Traffic Control (CTC) system statewide for coordination of care throughout the Urgent & Acute Care continuum, including Bed Registry and Referral.

Additionally, BHA supports jurisdictions utilizing the Mobile Response and Stabilization Services (MRSS) model for children, adolescents, and their families. MRSS is a family-specific intervention model that provides rapid response and intervention to help families stabilize with youth experiencing behavioral health challenges.

These efforts will have a positive impact on the behavioral health landscape, ensuring better care for individuals in need throughout the state.

Hospital Care Coordination

BHA's Hospital Care Coordination Team aims to create initiatives to resolve the psychiatric hospital overstay and emergency department boarding crisis in Maryland. The team provides technical assistance for the most complex behavioral health cases, which involves collaborative problem solving with other state agencies, including the Department of Human Services, Department of Juvenile Services, and Developmental Disabilities Administration, as well as with Local Behavioral Health Authorities and Local Departments of Social Services.

BHA has also piloted the first residential crisis program in Maryland for youth who are overstays at inpatient hospital units or emergency departments. This is a bridge care program for youth to step-down from the hospital environment while waiting for their placement.

BHA is also creating a state-wide Bed Registry and Care Traffic Control System. The pilot efforts while this system is being built include the Behavioral Health Care Coordination Dashboard, which updates inpatient bed availability daily and also includes crisis beds and urgent care facilities, and the 211 Press 4 referral system to aid emergency department staff with complex cases and track data on behavioral health needs in the State.

9-8-8 Statewide Crisis Hotline System

Maryland currently supports, through funding to certain Local Behavioral Health Authorities (LBHA) and Core Service Agencies (CSA), nine 9-8-8 call centers across the state. These nine centers are part of a national 9-8-8 crisis hotline network that includes over 200 call centers nationally. The 9-8-8 system provides help-seekers with the ability to reach out through calls, texts, and chats. The Maryland call centers handle in-state calls with backup coverage provided by national backup centers. At this time, over 90% of Maryland calls are handled by our nine call centers with an average speed to answer of 22 seconds. BHA has been funding for our in-state 9-8-8 centers including braided funding for both State General Funds and several federal grants. Currently, the focus for 9-8-8 in Maryland is on expanding Marylander's awareness of the resource, increasing our in-state answer rate, and cooperation between 9-8-8 and Maryland 9-1-1 system so that appropriate behavioral health calls are transferred to 9-8-8.

Crisis Peer Training and Expansion

The Behavioral Health Crisis Walk-In/Urgent Care Centers Peer Expansion (Crisis Peer Expansion) is designed to support Peer Recovery Specialist (PRS) positions within Behavioral Health Crisis Walk-In/Urgent Care Centers. The primary goal of this funding is to increase the availability of recovery support services for individuals served through crisis services and simultaneously expand the Peer Recovery Specialist Workforce across Maryland. This goal will be accomplished by incorporating Peer Recovery Specialists into the organizational structure of Behavioral Health Crisis Walk-In/Urgent Care Centers and expanding peer-recovery support services for individuals utilizing these centers.

The Crisis Peer Model is designed to provide for but is not limited to:

1. One-on-one and/or group peer support for individuals engaging in crisis services;
2. Peer recovery support services for individuals engaging in crisis services;
3. Connection to local resources, supports, and organizations that help prevent future behavioral health crisis events and offer stable treatment and recovery supports;
4. Assisting individuals to navigate crisis support services while identifying and activating healthy life skills which support long-term increases in wellness and reduce future behavioral health crises;
5. Organizational infrastructure to support the professional development of Certified Peer Recovery Specialists within programs that support individuals utilizing crisis services.

BHA tracks the total number of individuals served annually and the total number of services provided to individuals served.

Treatment and Recovery

Office of Consumer Affairs:

The PBHS Service Programs offer Evidence Informed Care Coordination and Recovery Support Services to individuals with behavioral health disorders. Recipients also receive Evidence Informed Care Coordination and Recovery Support Services under Optum Maryland and the Administrative Service Organization (ASO). These services are provided by Behavioral Health Professionals who have been trained on Evidenced Informed Treatment, Promising Treatment or Service Delivery Approaches. There are several funding sources and initiatives the Office of Consumer Affairs oversees.

Opioid Workforce Innovation Fund

The Opioid Workforce Innovation Fund (OPWIF) is a statewide grant funded by the Department of Labor with the intended purpose of creating equitable employment opportunities for individuals affected by opioid addiction. The grant awards funding to local organizations to assist with the development of job recruitment as well as allocating funds to carry out the Recovery Friendly Workplace model.

- Peer Training Expansion Fund (SOR 2)
    - The SOR 2 Grant facilitated three Certified Peer Recovery Specialists (CPRS) Training programs: A total of 11 training offerings consisting three different curriculums for individuals who are currently seeking employment, volunteering, or working as a Peer Recovery Specialists (PRS) or CPRS in the Public Behavioral Health System, were used.
- Opioid Treatment Program (OTP) Peer Positions Expansion (COVID)

    - COVID Supplemental funding was used to expand the availability of CPRS services for individuals being served by OTPs across Maryland. This allowed programs to develop the needed infrastructure for this workforce prior to the launch of Fee for Service (FFS) reimbursement in this setting effective FY24.
- Opioid Treatment Program (OTP) Peer Training Cohorts (COVID)
    - This training collaboration supported the workforce being hired through the "OTP Peer Expansion" project. Training tailored to peers working in OTP settings was facilitated and allowed the peers funded through the OTP Peer Expansion, the opportunity to obtain all required CEU training hours to meet the CPRS credentialing requirements.
- Recovery Friendly Workplace (SOR 3)
    - SOR 3 funding was used to hire Certified Peer Recovery Specialists who will implement the Recovery Friendly Workplace model in three Local Workforce Development Areas. These CPRS will onboard a number of local business partners to become official Recovery Friendly Workplaces. The CPRS will serve as both an intake specialist for people who disclose their direct or indirect impact by opioid and/or stimulant use disorder and seek to utilize American Job Center (AJC) services and need job placement services, as well as, a “Recovery Friendly Advisor” to local employers looking for a new employment stream.

- Peer Certification Fund (SOR, SOR 2, ARPA)
    - This project provides the funding support needed to create a partnership between the Maryland Addiction and Behavioral-health Professional Certification Board (MABPCB) to offset the cost associated with the CPRS credential recognized for peers in Maryland.
- CPRS Credentialing Staff Infrastructure (MABPCB Funding)
    - This funding will be used to hire an Executive Director to oversee peer credentialing for the MABPCB. Additional staff will be recruited via Indeed, LinkedIn, etc. Workforce training for the staff is also provided and includes: position roles and responsibilities; educational requirements; computer skills; knowledge or certification, licensing and credentialing; and specialized skills pertaining to the position hired.

Office of Evidence-based Practices, Housing and Recovery Supports

This office explores opportunities to fund recovery residences beyond treatment programming, such as opportunities for vocational support, and promotes transparency and coordination for the recovery housing certification and funding process. Office highlights include:

- Pilot projects for evidenced-based vocational service provision in Cecil County,

Baltimore City, and Midshore.
- ACT Expansion – awarded supplemental block grant funds to expand ACT in Southern and Western Maryland by using a population-based formula to determine need in combination with geo-mapping to show areas/jurisdictions of need.
- Block grant funding for University of Maryland Evidence-based Practice Center Person-Centered Care Planning Trainer-Consultant.
- SSI/SSDI Outreach, Access, and Recovery (SOAR) program – assists individuals experiencing homelessness or at risk of homelessness and diagnosed with a mental illness and/or co-occurring disorder to apply for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

State Opioid Response Grant (SOR)

BHA is now in its third iteration of the SOR grant. The purpose of this funding is to address the opioid overdose crisis by:

- Providing resources to states and territories for increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD),
- Supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders, and
- Supporting the continuum of care for stimulant misuse and use disorders, including for cocaine and methamphetamine.

The SOR grant began in 2018 as a continuation of the State Targeted Response Grant (STR) which began with the Maryland Overdose Rapid Response Grant (MORR).

- SOR-I
    - 2018: Prime $33,169,207 each year for 2 years (2018 - 2020)
    - 2019: Supplemental $17,314,430
- SOR-II
    - 2020: $50,751,132 each year for 2 years (2020 - 2022)
- SOR-III
    - 2022: $51,384,298 each year for 2 years (2022 - 2024)

The following goals were established for the Maryland SOR grant to address the opioid overdose crisis.

- Goal 1: Individuals seeking access to services for OUD will receive access to Medication Assisted Treatment (MAT) and other clinically appropriate services
    - Increase referral of individuals (adults and adolescents) with OUD to MOUD services.

        - Percent of individuals enrolled in SOR funded services determined to be in need of MOUD services who are referred to and enrolled in services.
    - Increase enrollment of individuals (adults and children) in evidence informed OUD/Stimulant Use Disorder (STUD) prevention, treatment and recovery services.
        - Percent of SOR recipients who are enrolled and receiving one or more evidence informed prevention, treatment or recovery services.
        - Percent of SOR funded service recipients who are enrolled in MOUD services and who remain active in MOUD for 30 days or more.
    - Invest in the services provided by regional OTPs to ensure timely access to intake, assessment, inductions and ongoing medication and psychosocial services for MOUD services.
        - Percent Opioid Treatment Programs (OTPs) that make service delivery and operational enhancements to improve the quality and effectiveness of services provided.
        - Percent of OTPs recipients who receive psychosocial services in addition to medication treatment.

- Goal 2: Reduce Opioid Overdose Related Deaths (OORD) through prevention, treatment and recovery using evidence-based practices.
    - Enhance public awareness efforts regarding opioid and stimulant use disorders and the availability of prevention, treatment and recovery services through targeted media campaigns.
    - Increase naloxone distribution to decrease opioid deaths.
    - Increase access to recovery support services by sustaining and expanding the OUD/STMUD community-based treatment and recovery support.

Behavioral Health Assisted Living Model of Care

Resources for older adults with behavioral health conditions are sparse in general within Maryland and the rural counties are particularly challenged. PBHS System utilization data indicates that older adults are underrepresented among those served taking into account the percentage of Medicaid recipients who are over age 65. Hospitals report extended stays for this population, which has been further exacerbated by the pandemic. The rates of suicide and overdose among this population continues to increase. Healthcare for the Homeless reports an increase in older adults experiencing homelessness for the first time in their lives.

Residential Rehabilitation Program (RRP) providers continue to report a growing aging population and on-going challenges with providing services to older adults as their medical needs and their need for accessible housing increases. There are few community options that provide an alternative to nursing facility services for older adults with behavioral health conditions who require assistance with activities of daily living and or have medical conditions that require nursing assessment and delegation. Maryland's long-term services and support lack behavioral health expertise and Maryland public behavioral health system lacks services that are accessible and or meet the needs of older adults.

BHA is creating a Behavioral Health Assisted Living Model of care to fill these unmet needs. This model consists of assistance with activities of daily living and instrumental activities of daily living provided by a licensed assisted living facility with behavioral health wrap-around services and care coordination to support both the somatic and behavioral healthcare needs of this population and prevent unnecessary institutionalization.

BHA also collaborates with the Maryland Department of Aging, the Department of Human Services, and other agencies within the Department of Health such as Medicaid's Office of Long Term Services and Supports through a variety of interagency efforts. These efforts include:

- Standing monthly coordination meetings to share information, resources, and trends around aging and behavioral health and cognitive health;
- Participation in the legislatively mandated Oversight Committee on Quality of Care in Nursing Homes and Assisted Living;
- Participation in Longevity Ready Maryland multi sector planning;
- Participation on the Geriatric Behavioral Health subcommittee of the Commission on Behavioral Healthcare Treatment and Access.

There remain opportunities for building an understanding and capacity for serving Medicare and dual-eligible populations through the intersection of funding streams.

Post Acute Care

The Post Acute Care Unit comprises nine units that fall under the umbrella of the Office of Court Ordered Evaluations and Placements. The Post Acute Care unit spans the continuum of health care from the entry point to one of our state psychiatric hospitals, through the discharge and aftercare phases of treatment.

- The **Adult Pretrial Unit** is the office that handles the 3-105, 3-111, 11-727, and Psycho-sexual evaluations. It is staffed by contracted community evaluators, and by Court Medical. This office does approximately 3500 evaluations per year.

- The **Central Admissions Office**- CAO is the office that receives all of the Orders for placement when they come in. This office is responsible for managing our Waitlist, for arranging transport from detention centers to our hospitals, for determining acuity through medical record review, and for providing vital information to our legal team regarding defendants who are in the hospitals and for those who are awaiting beds.
- The **Justice Services** office is the unit that handles all of our 8-505 and 8-507 orders. These orders are for evaluation and placement in our Addictions Treatment Early Release Programs. This office is responsible for vetting and sourcing all of the Providers that are in the program, for education to the Judiciary about the Program, for doing the 8-505 evaluations, and for the transport of the individuals from detention to the program.
- **Juvenile Services**, similar to our Adult Pretrial, does competency evaluations but for Juveniles. This team is responsible for providing attainment services for youth who are forensically involved. This team does approximately 150 evaluations per year.
- The **Forensic Developmental Disabilities Administration Team** works to provide both attainment services as well as create plans for individuals who are leaving our hospitals and re-entering the community.
- The **Firearms Rights Restoration Program** is for individuals who have been committed to a psychiatric hospital in their past, have had their firearms removed, and would like to have the ability to own firearms again. This team is responsible for facilitating the background checks, the psychiatric evaluations, and decisional review board.
- The **Community Forensic Aftercare Program** (CFAP) is responsible for monitoring individuals who are conditionally released from our psychiatric hospitals. This team is responsible for ensuring that the individual does not break their conditions, keeps their appointments, and does not decompensate while in the community. This program also has a weekly Review Board that makes decisions regarding travel requests, and requests for early release from conditions, to which the team would then make recommendations to the Judiciary. The team currently monitors approximately 700 individuals in the community.
- The **Utilization Review** Team is composed of RNs who review patient charts to ensure that they are receiving the proper level of care and that our quality measures are being met. This team also reviews complex cases to help our discharge team in getting the patient prepared for discharge. This team is responsible for ensuring that we are meeting the requirements of CMS, as well as COMAR 10.07.01.13.
- The **Patient Discharge** Team is composed of Housing Specialists who support the case managers at our five state hospitals. They help fill out complex paperwork to help patients receive ID cards and birth certificates, they are all certified to transport, and often take patients out to visit potential home placements.
- The **Patient Analytics Team** is responsible for data collection as well as they are specialized in working with older adults, and DDA individuals for placement in the community. Additionally, this unit has a community liaison program to ensure that patients who are discharged from the hospital not on

conditional release do not fall through the cracks and wind up back in the hospital again.

Appendix E: Acronyms

ACE	Adverse Childhood Experiences
AJC	American Job Center
ASAM	American Society of Addiction Medicine
ARE	Applied Research and Evaluation
ARPA	American Rescue Plan Act
ASL	American Sign Language
ASO	Administrative Services Organization
BHA	Behavioral Health Administration
BHI	Behavioral Health Integration
BHAC	Behavioral Health Advisory Council
CAP	Corrective Action Plan
CAT	Crisis Assessment Tools
CAYAS	Children Adolescent Young Adult Services
CCBHC	Community Behavioral Health Clinics
CHCS	Center for Health Care Strategies
CLAS	Culturally and Linguistically Appropriate Services
CIM	Crisis Intercept Mapping
CMS	Centers for Medicare and Medicaid Services
CoC	Continuum of Care
COMAR	Code of Maryland Regulations
CPRS	Certified Peer Recovery Specialists
CSA	Core Service Agency
CTC	Crisis Care Traffic Control
CY	Calendar Year
DBM	Department of Budget and Management
DHH	Deaf and Hard of Hearing
DORM	Data Informed Opioid Risk Mitigation
EBP	Evidence Based Practices
ECQI	Evaluation and Continuous Quality Improvement
FEP	First Episode Psychosis Programs

FY	Fiscal Year
GODHH	Governor's Office of the Deaf and Hard of Hearing
HSRI	Human Services Research Institute
LAA	Local Addictions Authority
LBHA	Local Behavioral Health Authorities
LEP	Limited English Proficiency
MABHA	Maryland Association of Behavioral Health Authorities
MABPCB	Maryland Addiction & Behavioral-Health Professionals Certification Board
MACS	Maryland Addiction Consultation Service
MAT	Medication Assisted Treatment
MDH	Maryland Department of Health
MORR	Maryland Overdose Rapid Response
MOUD	Medications for Opioid Use Disorder
NDC	National Drug Code
OD2A	Overdose Data to Action
OOCC	Opioid Operational Command Center
OMHC	Outpatient Mental Health Clinics
OMPP	Opioid Misuse Prevention Program
OPWIF	Opioid Workforce Innovation Fund
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PIP	Performance Improvement Processes
PBHS	Public Behavioral Health Systems
PDSA	Plan, Do, Study, Act
PMAT	Program Measurement and Account Tool
PSA	Public Service Announcement
QI	Quality Improvement
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SBIRT	Screening, Brief Intervention, and Referral to Treatment

SE	Supported Employment
SMI	Serious Mental Illness
SMVF	Service Members, Veterans, and their Families
SOAR	SSI/SSDI Outreach, Access, and Recovery
SOR	State Opioid Response
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STR	State Targeted Response
STUD	Stimulant Use Disorder
SUD	Substance Use Disorder
TCM	Targeted Case Management
TIC	Trauma Informed Care
TICC	Trauma Informed Care Commission
TIOA	Trauma Informed Organizational Assessment
TMAP	Trained Military Assistance Provider Program
UOM	University of Maryland
YARH	Young Adult Recovery House