Maryland

UNIFORM APPLICATION
FY 2026/2027 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 06/30/2026 11.57.07 AM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State Unique Entity Identification

Unique Entity ID	FZNNFD4RF5Y9

I. State Agency to be the Grantee for the Block Grant

Agency Name	Maryland Department of Health
Organizational Unit	Behavioral Health Administration
Mailing Address	Spring Grove Hospital Center - Vocational Rehab Building 55 Wade Avenue
City	Catonsville
Zip Code	21228

II. Contact Person for the Grantee of the Block Grant

First Name	Alyssa
Last Name	Lord
Agency Name	Behavioral Health Administration-Maryland Department of Health
Mailing Address	Spring Grove Hospital Center 55 Wade Avenue/Voc. Rehab Building
City	Catonsville
Zip Code	21228
Telephone	443-651-0181
Fax	
Email Address	alyssa.lord@maryland.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	8/29/2025 9:41:17 AM
Revision Date	4/6/2026 1:06:19 PM

VI. Contact Person Responsible for Application Submission

First Name	Sherone
Last Name	Lewis

Telephone 2404445642
Fax
Email Address sherone.lewis@maryland.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Alyssa Lord

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary of Health, Maryland Department of Health

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

STATE OF MARYLAND

OFFICE OF THE GOVERNOR

Wes Moore

July 14, 2025

Grants Management Officers
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Grant Management Officers:

Federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign office grant documents. To expedite the processing of the federal Substance Use Treatment Prevention and Recovery Services Block Grant (SUPTRS) and Mental Health Block Grant (MHBG), I designate the Secretary of Maryland's Department of Health (MDH) or the Secretary's designee to make future assurances, sign applications and agreements, and perform any similar act relevant to the SUPTRS and MHBG for the Maryland Department of Health before your agency.

Sincerely,

Wes Moore
Governor

CC: Meena Seshamani, M.D., Ph.D., Secretary of Health, Maryland Department of Health

100 State Circle, Annapolis, Maryland 21404
(410) 974-3400
TTY Users Call via MD Relay
governor.maryland.gov

Maryland Department of Health, Behavioral Health Administration (BHA)
Title of Project: Bipartisan Safer Communities Act (BSCA)
Mental Health Block Grant Supplement
Budget Detail and Narrative
Total Amount of the Federal Award including Approved Cost
this Project Period: $1,308,300
Project Period: 9/30/2026 - 9/29/2028
Due Date for Proposal: 9/01/2025

Residential Crisis Pilot Program for Youth (90% of the grant) - $1,177,470

Justification:
The Behavioral Health Administration (BHA), in collaboration with Brook Lane, a non-profit mental health facility in Western Maryland, has launched a pilot residential crisis stabilization program for youth ages 8-17 who meet inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The focus population is youth with serious emotional distress who are exhibiting symptoms or behaviors of thought or mood disorders and have an IQ of 70 or higher.

The program serves as an interim placement to stabilize youth who have remained in an emergency department or on a hospital unit longer than clinically necessary while waiting for a long-term placement. These youth are typically unable to return to their homes because their symptoms present barriers to the safety or wellness of themselves and their families.

The program has been successful until this date:

- Since February 2024 to present, twenty five youth have transitioned into the program from an ED or inpatient unit that was unable to further serve their clinical and therapeutic needs. This opened up valuable ED or hospital inpatient beds that were bottlenecked by placement issues.
- Eighteen youth have successfully transitioned from an inpatient unit or an ED to the program, and then to their bed at a Residential Treatment Center.
- Case workers have reported that the youth who are stabilized at the Residential Crisis Pilot Program are more receptive to treatment at their Residential Treatment Center, and are more likely to successfully transition back to the community.
- Youth at the program are able to attend school, receive psychiatric services, individual therapy, and recreational therapy. These essential services are not available in inpatient units or EDs, risking further decompensation.

The program continues to be voluntary so the youth and their families/caregivers/guardians can consent to participating in treatment. The length of stay for this program can be variable due to external factors that can delay placement, but the average length of stay for this program is 168 days.

Budget:

BSCA funding will be used to support the program's daily rate of $1,247 per bed, which allows them to serve these high acuity youth. This daily rate is all-inclusive, and accounts for clinical and therapeutic services, ancillary services, and staff salaries and benefits.

Brook Lane will send BHA an invoice for $1,247 per bed per day. These invoices will separate the costs for clinical and therapeutic services, ancillary services, and staff salaries and benefits from any room and board costs. Room and board costs will not be funded via the BSCA grant, and will be reimbursed with State dollars.

Item	Rate/Description	Cost
$1,247 per day x 7 beds x 134.89 days	$1,177,470	
Total Cost of Project	$1,177,470	
	Total	**$1,177,470**

Resilience Project: Community Outreach (10% of the grant) $130,830

Justification:

The Resilience Project is a collaboration among:

- University of Maryland, Department of Psychiatry Maryland Early Intervention Program (EIP)
- Maryland Central Area Health Education Center (MCAHEC)

For this next phase of the project, we have refined our scope of work to better target outreach to clinical programs that serve youth and young adults experiencing first episode psychosis, and to also more specifically focus training on Coordinated Specialty Care (CSC) care and resources for outreach recipients. The Community Health Worker (CHW) will support clinician outreach. We are not requesting any change to the current budget.

Proposed Outreach and Education to:

- Mental health crisis programs that are not hospital-based (e.g. Baltimore Crisis Response Inc.)
- County "warm-line" crisis programs through the State Core Service Agencies

- School mental health programs for higher-risk teenagers (e.g. non-public day programs, special education programs)
- Parent and Peer Support specialist providers (e.g. On Our Own)
- Primary care providers (family medicine and pediatrics) – outreach through our existing Behavioral Health in Pediatric Primary Care State Network (BHIPP)
- Homeless shelters for teenagers and young adults who have case management/mental health referral workers
- Addiction treatment programs

Proposed Training Topics:

- Introduction to Coordinated Specialty Care Services (CSC) – develop personalized trainings for mental health and primary care personnel
- Strategies to engage youth and young adults to utilize CSC services
- CSC resources in Maryland
- Recovery goals that can be supported by CSC services

Additional Grant Activities:

- The MCAHEC's website will maintain CSC information and resources easily accessible to any CHW in the state who needs information on CSC services.
- Transportation vouchers will be distributed to support access of youth and " young adults to health services (primary care and specialty) to support further evaluation and CSC referral/support.

Outcomes:

- Trainings (Goal is a minimum of 2 per quarter, approx. 8/year)
- Outreach and education, on-site/virtual, by CHW and/or our Resilience Project clinicians (Goal is a minimum of 3 sites monthly, approx. 36/year)
- CHW contacts for CSC referral questions/assistance (Goal is a minimum of 25 referrals/year)
- Transportation (bus token) vouchers distributed to clinical programs to support access to clinic visits with primary or mental health care appointments for further assessment of mental health symptoms or referral to CSC care.

Budget:

Item	Rate/Description				Cost
Personnel	**Salaries**	**Fringes 28.5%**			
.05 FTE Gloria Reeves, PI	$17,748	$5,058			
.02 FTE Jill RachBeisel	$4,438	$1,265			
.02 Robert Buchanan	$7,146	$2,037			
.02 Kristin Bussell	$6,336	$1,806			
	Salaries	**39.1%**			
.1 Kathryn McDonald	$5,403	$2,112			
Total Salary	$41,071	$12,278			
Subcontracts					
MCAHEC (Maryland Central Area Health Education Center)	$68,173				
MCAHEC would support both initiatives of this proposal					
Task 1-Fund a Community Health Worker for community outreach					
Task 2-Monthly FIT check and follow up					
Staffing model includes Supervisor, Paula Blackwell and 1-.75FTE Community Health Worker					
Other Direct Costs					
Transportation Vouchers (eg: bus tokens)	$3,612				
	$3,612				
Total Direct Costs	$125,134				
Total Modified Direct Costs	$56,961				
IDC @ 10%	$5,696				
Total Direct and Indirect Costs	**$130,830**				
				Total 10% Set-Aside	**$130,830**

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

TO: Alyssa Lord, MA MSc
Deputy Secretary for Behavioral Health
Behavioral Health Administration

FROM: Meena Seshamani, MD., Ph.D.,
Secretary of Health
Maryland Department of Health

CC: Sherone Lewis, MHSS
Director of Special Projects
Policy and Planning
Behavioral Health Administration

DATE: July 17, 2025

SUBJECT: Delegation of Signatory Authority for the Mental Health Block Grant (MHBG) and Substance Use Treatment Prevention and Recovery Services Block Grant (SUPTRS)

Pursuant to the Public Health Service Act, Title XIX Block Grants, Part B, Subpart I, Block Grants for Community Mental Health Services and Part B, Subpart II, Block Grants for Substance Abuse Prevention, Treatment and Recovery Services, I hereby delegate authority to you as the Deputy Secretary for Behavioral Health to sign funding agreements and certifications, to provide assurances of compliance to the Secretary, Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) and the Substance Use Treatment Prevention and Recovery Services Block Grant (SUPTRS). This delegation is subject to an annual renewal so long as the referenced grant remains in effect or said delegation of authority is otherwise rescinded.

The Community Mental Health Services Block Grant (MHBG) program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions.

Grantees use the funds to provide comprehensive, community –based mental health services to adults with serious mental illnesses (SMI), to children with serious emotional disturbances (SED) and to monitor progress implementing a comprehensive, community-based mental health system.

Grantees use the block grant funded programs for prevention, treatment, recovery support, and other treatment services to supplement Medicaid, Medicare, and private insurance services. Specifically, providers who receive block grant awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health, prevention, treatment, and recovery support services.

The MHBG funding supports the following services throughout Maryland:

- Crisis Response Systems/Services (5% Set-Aside)
- Implementation of Evidence Based Practices (including Assertive Community Treatment (ACT),
- Supported Employment (SE), and Family Psychoeducation (FPE)
- Early Intervention/First Episode Psychosis (10% Set-Aside)
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- School-Based Mental Health
- Housing Supports
- Public Awareness/Education/Training & Outreach
- Planning Council Technical Assistance

The (SUPTRS) supports the following services in Maryland:

- Substance Use Disorder (SUD) treatment across all ASAM levels of care
- Primary Prevention
- Tobacco Use Prevention – SYNAR Amendment
- Women's Services (Pregnant Women and Women with Dependent Children)
- Overdose Prevention
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- Recovery Support Services
- Tuberculosis Services

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Alyssa Lord

Signature of CEO or Designee[1]: Signed by: Alyssa Lord 379120299D8440B...

Title: Deputy Secretary of Health, Maryland Department of Health

Date Signed: 11/7/2025

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Not applicable

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

OVERVIEW OF THE STATE'S CURRENT BEHAVIORAL HEALTH SYSTEM
The Behavioral Health Administration (BHA) is a division of the Maryland Department of Health (MDH) that is responsible for overseeing the delivery of behavioral health services through the Public Behavioral Health System (PBHS). The top priority of Maryland includes strengthening the PBHS by meeting the needs of residents and prioritizing continuous improvement. In order to strengthen partnerships with our external stakeholders, and deliver data-driven, evidence-based care to Marylanders we are implementing a behavioral health continuum of care model that increases access and centers trauma-informed care.

Maryland continues to promote the goal of behavioral health integration, building on the existing strengths of the public behavioral health programs in order to:
- Improve services for individuals with co-occurring conditions;
- Create a system of care that ensures a "no wrong door" experience;
- Expand access to appropriate and quality behavioral health services;
- Enhance cooperation and engagement;
- Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
- Expand public health initiatives; and
- Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

BHA's work is carried out through six overarching divisions: Prevention and Promotion; Primary Behavioral Health and Early Intervention; Urgent and Acute Care; Policy and Planning; Treatment and Recovery, and Post Acute Care. Together, these divisions support a comprehensive, wrap-around system designed to improve the health and well-being of all Marylanders across the lifespan.
Child and Young Adult Behavioral Health System. The Primary Behavioral Health, Early Intervention (PBHEI) division of the BHA is responsible for developing and overseeing a comprehensive system of care for children, adolescents, young adults up to age 25, and their families. This system addresses the behavioral health needs of young people with mental health challenges, substance use disorders, and co-occurring conditions.

BHA funds and provides oversight for fourteen Adolescent Clubhouses (ACH). This statewide recovery oriented support is designed for youth ages 12 – 17, (18 if still in High School) receiving treatment for substance use disorders, including Opioid Use Disorders (OUD), or following discharge from treatment. Each unique clubhouse uses evidence- based and promising practices to provide screening, intervention, and recovery support to adolescents. Through various approaches to substance use intervention and recovery, to include the use of Young Adult Peer Specialists on staff, the clubhouse's recovery-oriented model supports diminishing triggers and cues that led to past substance misuse and uses youth driven activities to engage adolescents in more enriching and healthy ways.

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.

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.

Adults Behavioral Health and Substance Use Services System. The system is structured to support prevention, early intervention, treatment, recovery, and crisis services for adults and older adults with mental health and substance use needs. A team of division directors and clinical, policy, and operational leaders work together to ensure the delivery of high-quality, integrated care across the state. The behavioral health continuum of care must include 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.

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.

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 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 BHA works with and funds jurisdictions and providers to develop a statewide continuum of behavioral health care services.

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 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.

The Office of Behavioral Health Services is housed within MDH's Public Health Services, Prevention and Health Promotion Administration; it directly supports the behavioral health needs of adult women, particularly pregnant women and women with dependent children. This office oversees residential and transitional substance use treatment programs, peer support services, recovery housing, and services connected to the START program. It also manages compliance with the state's requirement that pregnant women must receive access to treatment services within 24 to 48 hours of requesting care.

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 . This division also oversees grants, co-manages the Administrative Services Organization contract with Maryland Medicaid.
Administrative Services Organization (ASO). The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the Administrative Services Organization (ASO), including inpatient, outpatient, residential treatment (for children and adolescents), and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. Residential crisis services are also paid through the ASO. BHA and Medicaid works collaboratively to design an integrated system of mental health and substance use disorder (MH/SUD) services. BHA is the lead for clinical and systems management matters, whereas Medicaid's Behavioral Health Unit is the lead regarding payment rates, compliance matters, the development of State Medicaid regulations,

and the Medicaid State Plan. Maryland primarily provides or funds public behavioral health services in two ways, directly through its State psychiatric hospital system or by funding its managed fee-for-service (FFS) system. However, implementation of PBHS is co -monitored by BHA and Maryland Medicaid. 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.

The ASO's responsibilities include provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving behavioral health services; providing data collection, analysis and management information services; offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

ROLE OF THE SMHA, SSA, AND OTHER STATE AGENCIES IN THE DELIVERY OF MH/SUD SERVICES
The Single State Authority (SSA). BHA is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance use prevention, intervention, treatment and recovery support services. The Single State Authority (SSA) for Maryland resides within the BHA and is responsible for planning, developing, and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families, and communities. BHA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and recovery support services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates "science to service" information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, misuse, and dependence, and support services to sustain the recovery beyond the treatment/rehabilitation episode.

The Division of Policy and Planning. Supports the development of the statewide public behavioral health system (PBHS,) through planning, monitoring, compliance and licensing. The division also serves as the BHA liaison with all Local Behavioral Health Authorities (LBHAs).
Scope of Responsibility:
Co-manages the ASO contract with Medicaid
Leads the state strategic plan and systems planning for BHA
Oversee the Federal Block Grants - Community MH BG (MHBG) and Substance Use Prevention Treatment and Recovery Services BG (SUPTRS)
Compliance monitoring for providers, and LBHA compliance
Leads the effort centered around population health improvement

Prevention and Promotion. This division's purpose is the prevention of behavioral health related problems through public and behavioral health best- and evidence-based practices, strategies, and interventions. The responsibility of this division includes responsible for promoting mental health services and resources, preventing substance misuse, suicide, and problem gambling. The division works to reduce stigma through public awareness campaigns and connects individuals to needed care and resources. Peer support is a vital component, with services available for individuals and families, alongside efforts to strengthen the peer workforce. Additionally, specialized linkages are provided for veterans, service members, and their families to ensure access to behavioral health and other supportive services.

Public Awareness. The Public Awareness Office develops, creates, and implements statewide, BHA related, public awareness campaigns through multiple media platforms. Subjects covered by the Public Awareness Office include SUDs, Maryland's Crisis Helpline, Maryland's Good Samaritan Law and special projects. The Public Awareness Office works closely with BHA divisions, to include Leadership, Treatment, Prevention & Promotion, advocates and stakeholders, to identify need, demographics and messaging that best convey BHA specific information. Among the lessons learned from the opioid crisis has been the vital importance of expanding and deepening public awareness about public health and the necessity of all citizens to be kept informed regarding a health crisis. As part of the MDH, BHA in conjunction with the LBHAs, CSAs, and LAAs has worked to develop creative ways to keep the public informed and aware of the most effective ways to reduce harm. Current data consistently shows that when there is an active campaign regarding SUDs, 988 lifeline, and problem gambling, there is a sharp uptick in people clicking to the specific webpages to learn more.
Consumer Affairs (embedded within the Office of Community Based Access and Support). The BHA prides itself on our comprehensive system of treatment and recovery support services for individuals seeking wellness in our State. This recovery oriented system of care was designed utilizing ongoing and valuable input from individuals with lived experience in behavioral health recovery. Consumer Affairs coordinates with local peer support chapters, individuals, and advocacy groups in efforts to improve services, and empower individuals throughout their recovery. In addition, in conjunction with LBHA, can assist individuals with their concerns and/or complaints regarding services received or treatment provided.

Maryland's Commitment to Veterans (MCV). MDH continues to prioritize efforts to address the behavioral health needs of service members, veterans and their families. Maryland's Commitment to Veterans is a program under BHA that collaborates with the VA

Maryland Health Care System and the Maryland Department of Veterans and Military Families as well as other state agencies and community providers. MCV assists service members, veterans and their families with coordinating behavioral health services, including MH/SUD services, and other supportive services - with the VA, BHA and community providers. In addition, MCV provides training and education opportunities for behavioral health providers, peers, health care staff, law enforcement, and community organizations. MCV leads the Maryland Governor's Challenge to Prevent Suicide Among Service Members, Veterans and their Families team collaborating with federal, state and local agencies and organizations to build and coordinate suicide prevention efforts in Maryland. As well, MCV staff participate in a variety of military- and veteran-focused boards, commissions, coalitions, and collaboratives across the state. MCV manages the Sheila E. Hixson Behavioral Health Services Matching Grant Program, a competitive grants program for local nonprofit organizations to establish and/or expand community behavioral health programs that serve the behavioral health needs of eligible service members, veterans and their family members.

Treatment and Recovery. The Treatment and Recovery Services Division's mission is to ensure that adults and older adults facing mental health and substance use challenges receive the highest quality care. This is done by implementing evidence-based practice models that address co-occurring disorders, supporting access to safe and effective recovery housing, and strengthening the continuum of services and supports. The division's work is driven by the belief that integrated, person-centered care leads to better outcomes and lasting recovery. The scope of work and programs within the office include:
Offices Evidence Based Practice Housing and Recovery Support: This office provides oversight of evidence-based practices, housing and homeless initiatives, and recovery supports. This includes the BHA Continuum of Care Housing programs, Projects for Assistance in Transition from Homelessness (PATH), Residential Rehabilitation Programs (RRP), Psychiatric Rehabilitation Programs (PRP), the DLA-20 assessment and Data Mart, Maryland's SSI/SSDI, Outreach, Access and Recovery (SOAR) Initiative, state hospital benefits project, homeless identification project, Maryland RecoveryNet (MDRN), Maryland Certification of Recovery Residences (MCORR), Assertive Community Treatment (ACT), Supported Employment (SE), Person-Centered Care Planning (PCCP), and Critical Time Intervention (CTI).

Office of State Hospital Initiative: Provide transitional programs from State Hospital Discharge into community programs.
Community Integration and Program Planning: This division provides statewide leadership, direction, and oversight to the design, development, implementation, and continuous refinement of an actionable, data-informed statewide strategic and operational plan to facilitate the community placement of individuals being discharged from the state psychiatric hospitals and to expand the community capacity to serve this population. This includes but is not limited to Assertive Outpatient Treatment (AOT), all State hospital discharge initiatives within the department and developing stand operation procedures across divisions.

Office of Older Adults and Long-Term Care Services and Support: Responsible for developing and managing an integrated system of care for adults and older adults. Some of the functions of this division include developing policies and regulations related to clinical services for adults and older adults, identifying gaps in services and best practices to enhance access and quality of care, and directing, administering, and overseeing the statewide continuum of community-based outpatient behavioral health treatment services, including outpatient mental health centers, outpatient substance use treatment, withdrawal management, substance use intensive outpatient treatment, mental health and substance use partial hospitalization programs (PHP), group practices, private licensed practitioners, and residential substance use treatment.

Office of Treatment Services: The OTS provides oversight for adults and older adults for behavioral health treatment (mental health, substance use, or co-occurring MH/SUD, state care coordination, targeted case management, behavioral health homes, behavioral health services to individuals who are deaf, deaf-blind, hard of hearing, late-deafened (DDBHH/LD), and Limited English Proficient (LEP), and the State Opioid Response (SOR) federal grant. This office also monitors community-based grant funded services and provides technical assistance (TA) to local jurisdictions and constituents.

A primary focus of this technical assistance is narrowing the service delivery gap in underserved areas. For example, current data indicates that of the 92,000 adults living with a Serious Mental Illness (SMI) in rural counties, only 31% (29,000) are currently receiving PBHS services. Closing this penetration gap remains a critical benchmark for OTS-monitored programs. The following programs are examples on how Maryland leverage programs to expand access for Individuals with Serious Mental Illness (SMI) in underserved areas:

- Adults with SMI receive support through Targeted Case Management, Residential Rehabilitation Programs, LEAD, and Behavioral Health Court.
- Recognizing that formal clinical settings can sometimes be a barrier in rural areas, peer support is integrated across crisis, recovery, and school settings, which is use to promote long-term engagement and empowerment.

BHA is also funding programs for Rural Psychiatric Mental Health Services and Emergency Department Care Coordination. The Rural Psychiatric Mental Health Services program supports access in the State's rural areas for individuals to Outpatient Mental Health Centers (OMHC), coordinating linkages to care for adults diagnosed with SMI or co-occurring mental illness and SUD. OMHC provides Care Coordination between community providers, stakeholders, individuals, family members, and behavioral health care advocates.

Urgent and Acute Care. The Office of Urgent and Acute Care provides oversight of all urgent and acute behavioral health care services - including the 988 Suicide and Crisis Lifeline call/text/chat centers, mobile crisis intervention teams (CIT), mobile crisis, mental health residential crisis, SOR residential crisis for individuals with opioid use disorders, This office also oversees criminal

justice services related to jail-based, trauma-informed care; and criminal justice services, including Maryland Community Criminal Justice Treatment Program (MCCJTP), Trauma, Addiction, Mental Health And Recovery (TAMAR), Substance Abuse Treatment Outcomes Partnership (STOP), medications for opioid use disorder (MOUD) in jails and detention centers, Drug Court, and DataLink. This office also oversees care coordination and is also responsible for implementation of a statewide care traffic control system to include a bed registry and referral system.

Primary Behavioral Health & Early Intervention. BHA's Primary Behavioral Health, Early Intervention (PBHEI) division is charged with developing a system of care for children, adolescents, young adults, and their families. This system of care covers those from early childhood up to age 25. It is designed to meet the needs of individuals within this age range who have mental health, substance-related disorders, and those who have co-occurring conditions. PBHEI evaluates the network of services that 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. It also manages a number of 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. These include:
- Development and implementation of an integrated and coordinated system of care
- Oversight and guidance for all behavioral health services provided to children, adolescents and young adults and their families consistent with BHA's Vision and Mission
- BHA's liaison to all child serving agencies in the State: Children's Cabinet, Department of Human Services, Department of Juvenile Services, Maryland State Department of Education, Governor's Office on Children, and others as applicable
- Oversight and problem resolution for local behavioral health authorities in matters related to the target population
- Leadership for demonstration projects to improve service delivery approaches to population and special needs groups within the child and adolescent population.

Translating these high-level objectives into rural accessibility remains a primary focus, particularly for vulnerable youth who currently fall outside the reach of traditional service networks. In FY2024, an estimated 44,000 children in rural counties were diagnosed with a Serious Emotion Disturbance, but only 35% (15,400) were served in the PBHS. The following services are deployed to support Children with Serious Emotional Disturbance (SED):

- School-Based Mental Health Services are embedded in school systems through programs such as Sources of Strength (SOS) and peer recovery support, building protective factors and promoting early intervention.
- Youth and Adolescent Care Coordination is facilitated by Center for Children, Inc., connecting families to services and support systems.
- Family-Centered Services are emphasized through the Family OPTIONS Program, which supports pregnant and parenting teens and connects them to outpatient mental health services. Programs like Guiding Good Choices (GGCs) strengthen family resilience and behavioral health literacy.
- Residential rehabilitation programming is available for youth when needed, along with short-term stabilization services through MHSS.
- Youth suicide prevention is a major priority, with campaigns such as "It's Ok to Ask" raising awareness and promoting help-seeking behaviors.
- Maryland Early Intervention Program (MEIP) has a Centralized Line designated to assist the public with guidance on FEP treatment to assist with consumers who are at risk for Early Serious Mental Illness. The program has three components: 1) Outreach and Education Services, 2) Clinical Services, and 3) Training and Implementation Support.

An office within the MDH's Public Health Services, Prevention and Health Promotion Administration, provides oversight of prevention, treatment and recovery services for pregnant women and women with dependent children. These services include residential SUD treatment services, legislatively mandated services for child welfare-involved families that need SUD treatment, recovery support for pregnant women and women with dependent children and prevention services for families involved with SUDs.

This includes oversight of residential treatment and transitional services for pregnant women and women with children, Pregnant Women and Women with Children MOUD Prescription Drug Opioid Addiction (PDOA) federal grant, Sobriety Treatment and Recovery Teams (START), childcare during withdrawal management initiative, recovery support specialist in pregnancy/postpartum project, recovery supports for women and women with children, and several legislatively mandated initiatives. BHA approved Residential Treatment Programs for Pregnant Women and Women with Children (PWWC), are required to provide a service for pregnant women within 48 hours of presenting to the program. This office also oversees recovery services for women with children, including Recovery Supports Housing for Pregnant and Parenting Women and Recovery Support for Pregnant and Postpartum Women's (RSPPW) Program, which provides wrap-around recovery support for women in early recovery.

BHA required, as a condition of Grant Award, that all publicly funded programs develop policies and procedures to address the sex needs of this priority population to ensure that all pregnant women gain access to treatment services within 24 hours of request for services. These services can include screening, assessment, interim services, admission or referral for treatment. The conditions are monitored by BHA's Treatment Compliance Unit. Compliance monitors residential treatment programs either quarterly or yearly, depending on the type of funding, to ensure adherence to the 24-hour requirement. If the program is not in compliance with the conditions of award, then they are required to submit a Plan of Correction to the Administration within 30

days of the site visit.

Currently, MDH has treatment services at the following Levels of Care: Level 3.1-Low Intensity Residential Treatment Services, and Level 3.3/3.5- Medium/High Intensive Co-Occurring Capable Residential Treatment Services and various recovery support services for the population including peer support services.. These services are for pregnant women and women with dependent children. The Level 1 MOUD programs are the medication treatment for OUD programs that can induce and maintain pregnant women and women with dependent children on MOUD.

The Maryland Center for Tuberculosis Control and Prevention is part of the Public Health Services Prevention and Health Promotion Administration Infectious Diseases Bureau of the MDH. It provides leadership, policy development, and technical assistance to local health departments (LDHs), health care providers, and other partners who contribute to the control and prevention of tuberculosis in Maryland. The Maryland TB Center is also an active member of a national Center for Disease Control-funded Tuberculosis Epidemiologic Studies Consortium which conducts research toward the goal of eliminating tuberculosis in the United States.

In addition to internal stakeholder, BHA work with college/university and sister agencies include but not limited to: University of Maryland, Department of Human Services, Department of Juvenile Services, and Developmental Disabilities Administration, Maryland Department of Aging, Maryland State Department of Education, Maryland Overdose Rapid Response, and the Governor's Office of the Deaf and Hard of Hearing (GODHH) that contributes to the delivery of mental health and substance use services.

In addition, efforts are underway to plan for an expansion that would offer statewide technology transfer and technical assistance (TT), leverage telemedicine technology to increase access to rural areas and provide strategies for educating an emerging workforce.
Statewide expansion efforts are underway to increase rural access via telemedicine, provide specialized technical assistance (TT), and implement workforce development strategies to support the behavioral health field.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Maryland's PBHS is overseen by the BHA within the MDH, in collaboration with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), Local Behavioral Health Authorities (LBHAs), and the ASO. The State ensures uniform oversight and policy guidance while empowering local entities to manage planning, implementation, and coordination of services. At the local level, each of Maryland's 24 jurisdictions (23 counties and Baltimore City) is responsible for managing services across both mental health and substance use services. The CSAs, LAAs, ASO and LBHAs are entities at the local level that have the authority and responsibility to develop and manage a coordinated network of Maryland's public behavioral health services in a defined service area. These local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations.

They vary in size, needs, budgets, and budget sources. They are the administrative, program, and fiscal authority that are responsible for assessing local service needs and planning the implementation of a comprehensive local MH/SUD delivery system that meets the needs of eligible individuals of all ages. They conduct jurisdiction-level needs assessments, monitor providers, and develop strategic plans that align with that state's priorities and goals. The CSAs, LAAs, and LBHAs are important points of contact for consumers, families, and providers in the PBHS and develop partnerships with other local, State, and federal agencies, including law enforcement, housing authorities, educational systems, and hospitals. They provide numerous public education events and training. Additionally, local mental health advisory committees, CSA boards, and local alcohol and drug abuse councils have the opportunity and responsibility to advise the CSAs/LAAs/LBHAs regarding the PBHS and to participate in the development of local MH/SUD plans and budgets.

BHA works with local jurisdictions and other stakeholders to effectively integrate systems management. BHA partners with local authorities to standardize systems integration by hosting Learning Community Collaboratives. Each local jurisdiction completes an annual self-assessment ongoing their systems management integration status. A training on change management was conducted, and plans are set to do another one next year. The Integration Plan was built on an analysis of experiences in all 24 local jurisdictions, plus financial data that indicated opportunities to increase value from systems management. BHA has partnered with a few of the local authorities to form a workgroup that will update the Integration Tool and offer feedback about the local strategic planning process. BHA is assisting with working through challenges such as the separate funding streams, blending separate advisory councils for mental health and substance use, and limited local staff and budgeting to address integration in addition to their daily job tasks.

Maryland counties are typically organized by:
- Single LBHA structures, where one agency manages both mental health and substance use services (e.g., Baltimore City, Anne Arundel County, Allegany County), or

- Dual structures, where a CSA oversees mental health and an LAA oversees substance use services (e.g., Harford County, Baltimore County).

These entities are key collaborators with state and local partners across sectors such as:
- Healthcare providers (e.g., hospitals, crisis centers, outpatient and residential programs)
- Educational institutions (e.g., school-based mental health services, behavioral health training)
- Judicial and Public Safety (e.g., specialty courts, crisis intervention teams, reentry programs)
- Social service agencies (e.g., housing, benefits assistance, family preservation)
- Community-based organizations and peer-led recovery centers
- Local Management Boards (LMBs), Drug and Alcohol Councils (DACs), and Mental Health Advisory Committees (MHACs)

Below are examples illustrating how counties are organized and the entities that provide or contribute to mental health and substance use services:

Howard County Health Department's Bureau of Behavioral Health (HCHD BBH), which serves as the Local Behavioral Health Authority (LBHA). The LBHA is responsible for the development, oversight, and integration of prevention, intervention, treatment, and recovery services.The LBHA supports a broad network of services tailored to meet the needs of Howard County residents.

The Grassroots Crisis Intervention Center provides 24/7 crisis support, including hotline and mobile response services, while also delivering peer support to enhance recovery. The 988 Crisis Line is actively promoted by the LBHA, and regional collaboration through the Central Maryland Regional Crisis System strengthens mobile response capacity and reduces reliance on emergency departments and law enforcement during behavioral health crises.

For individuals with Substance Use Disorders (SUD), Howard County offers a continuum of care. Naloxone training and the provision of Life-Saving Overdose Prevention and Response Services are led through the Opioid Overdose Response Program, supported by partners such as HC DrugFree, Johns Hopkins Howard County Medical Center, and the Maryland Pharmacists Association (MPhA). The Howard County Detention Center also delivers SUD treatment, including MOUD, while Maryland Recovery Net provides benefits to support recovery. Mental health services are delivered through key community providers. Center for Children, Inc. offers Youth Targeted Case Management, and Therapeutic Connections provides Mental Health Stabilization Services (MHSS) for youth and adolescents. Other mental health partners include NAMI Howard County, On Our Own of Howard County, and providers like Way Station and Ellie Mental Health.

The LBHA's commitment to care coordination is reflected in programs such as Behavioral Health Navigation (BHN), State Care Coordination (SCC), and Consumer Support Services (CSS), which provide access to behavioral health treatment, psychiatric medications, and transportation for individuals with limited resources.
Howard County's behavioral health system is deeply embedded in its legal and social services landscape. Through partnerships with the Howard County Courts, Police Department, Public Defender's Office, and State's Attorney's Office, the LEAD program diverts individuals from arrest and connects them with services. The Behavioral Health Court Liaison and Recovery Court further provide case management and treatment referrals for justice-involved individuals.

Collaborations extend to agencies such as the Howard County Department of Social Services, Howard County Public School System (HCPSS), and the Howard County Library System, supporting efforts like Temporary Cash Assistance screenings, school-based mental health programs, and literacy and wellness promotion. The LBHA also partners with public benefit programs such as WIC, MCHP, and the Administrative Care Coordination Unit (ACCU).

Additional collaborators include the MDH, Maryland's Office of Overdose Response (MOOR), and national partners like the National Association of Counties (NACo). The Horizon Foundation, BHIPP, and The Steven A. Cohen Military Family Clinic further expand access through training, public campaigns, and outreach to veterans.
Howard County's behavioral health system is structured to address the needs of MHBG and SUPTRS BG priority populations, including:

Individuals with SUD:
- The county delivers a robust mix treatment, and recovery support, including MAT, and peer navigation.
- Recovery housing, behavioral health court support, and expanded 988 crisis services ensure a comprehensive response to the opioid crisis.
- Stigma reduction is embedded in outreach and training, increasing access and encouraging help-seeking.

Pregnant Women and Women with Children:
- Family OPTIONS Program
- Serves first-time mothers aged 19 or younger who are pregnant or parenting a child under age 2 and reside in Howard County.
- Focuses on helping participants thrive academically and connects high-risk mothers to outpatient mental health services.
- Offers in-person services, including home visits and group sessions.

Military personnel (active, guard, reserve, and veteran) and their families:
- Hosting community engagement events: "Good Vibes and Voices: Concert and Event"

- This helped to promote engagement of the Service Members, Veterans, and their Families (SMVF). HCHD shared suicide prevention materials and other behavioral health resources at this event.
- HCHD BBH and CIM also held a “Safe Firearm Storage” workshop, to educate attendees about safe firearm storage to reduce the risk of firearm tragedies within homes of attendees.

Maryland’s mid-shore region, which includes Caroline, Dorchester, Kent, Queen Anne’s, and Talbot Counties is coordinated through a regionally integrated and collaborative approach led by the Mid Shore Planning Collaborative (MSPC). MSPC is a partnership among the five county-level Local Addictions Authorities (LAAs) and Mid Shore Behavioral Health, Inc. (MSBH), the region’s Core Service Agency (CSA). MSPC works to strengthen behavioral health programs with a focus on prevention, and the development of innovative services across the region. This collaboration promotes a unified regional approach to managing mental health and substance use challenges. The mid-shore region is primarily rural and has health care delivery system challenges driven by economic challenges, high poverty rates among children and adults as compared to Maryland statewide averages, transportation challenges, inadequate healthcare and behavioral health workforce, internet and broadband access challengess, and limitations with capacity with service providers and range of services available by age and need.

Mid Shore Behavioral Health, Inc. (MSBH) plays a critical coordinating role, overseeing regional planning, managing grant funds, and spearheading key initiatives such as the Eastern Shore Crisis Response System (ESCRS) and the Hub Pilot Program. MSBH also manages Drug Free Caroline, Caroline County’s Local Drug and Alcohol Abuse Council (LDAACThe Regional Behavioral Health Advisory Committee (RBHAC) serves as a vital feedback mechanism for the collaborative, providing guidance on system integration, local needs, and state–local partnerships.

One of the region’s flagship programs, the Eastern Shore Crisis Response System (ESCRS), is managed by MSBH and delivers comprehensive mobile crisis services across eight counties, including all five in the Mid-Shore region, ensuring access to behavioral health crisis support regardless of jurisdiction.
Each Mid-Shore county operates a LAA responsible for managing the PBHS locally, while participating in MSPC’s regional planning and implementation efforts.
LDHs are essential partners in delivering evidence-based services such as naloxone distribution, and public health education. They also support programs targeting youth substance use and coordinate directly with schools on behavioral health initiatives.

Local Management Boards (LMBs) collaborate on community engagement and training efforts, including initiatives like the "No Such Thing as a Bad Kid" training for professionals working with youth.

Each county also maintains an active Local Drug and Alcohol Abuse Council (LDAAC), with MSPC leadership engaged on all councils to align local strategies with regional priorities. Additionally, Opioid Intervention Teams (OITs) and Overdose Fatality Review Teams (OFRTs) operate at the county level to address opioid misuse and conduct case reviews to guide prevention and intervention efforts.

Counties like Queen Anne’s also run Problem Solving Courts, such as Adult Drug Court, to provide specialized support for individuals involved with the criminal justice system and experiencing behavioral health challenges.

Mental Health Services:
Individuals with SMI or SED in rural areas and among those experiencing homelessness: Dorchester County also has several individuals that identify as homeless, which makes Mobile Treatment a most appropriate referral for services to support these individuals in the community.
Individuals with mental health and substance use disorders involved in the adult or juvenile justice systems: State Initiatives such as the State Hospital Discharge Initiative help transition individuals from state hospitals into assisted living settings with coordinated care.
Individuals in need of behavioral health crisis services (BHCS): The Eastern Shore Crisis Response System (ESCRS) manages crisis services for eight counties, aiming to expand funding and improve reimbursement structures for mobile crisis teams. The 988 crisis line is also monitored and coordinated to ensure residents receive necessary services.

Substance Use Services
Persons experiencing homelessness: Dorchester County continues to be one of the poorest counties in the state. The ACCESS Program implements Infectious Disease Prevention Services and Life-Saving Overdose Prevention and Response Services as essential points of engagement to facilitate linkage to SUD treatment and long-term recovery. These activities include distributing approved wound care supplies and hygiene kits. Furthermore, the program offers STOP the Bleed training to respond to trauma and address the infectious disease consequences linked to drug use, mental illness, and homelessness.
Individuals new in their recovery who require additional recovery support services, as appropriate, to maintain their recovery: Peer Support Specialists serve in multiple settings including detention centers, health departments, recovery centers, hospitals, and substance use clinics.
Individuals with mental health and substance use disorders involved in the adult or juvenile justice systems: Detention Centers support behavioral health by implementing MOUD programs, offering peer support, and coordinating post-release care.

To serve the Tuberculosis priority population, it is the responsibility of the LHDs to identify cases of TB and to provide treatment and community outreach. LHDs may utilize private providers but LHDs are responsible for ensuring that basic standards of care are

met.

Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Maryland's Public Behavioral Health System (PBHS) aims to ensure that all populations have access to quality care. Understanding how behavioral health services are distributed in Maryland is an essential part of a needs assessment to effectively evaluate and address potential issues concerning access to and quality of services. Data is the foundation for identifying unmet needs and gaps in care and it serves to guide Maryland's PBHS' design and implementation of new, appropriate strategies to address increasing access to treatment.. Continuous data analysis is vital to improving the quality and effectiveness of a strong system. The Behavioral Health Administration (BHA) uses several data platforms to determine the service needs of consumers who are part of Maryland's PBHS.

Administrative Services Organization (ASO) Data

The Behavioral Health ASO collects required data for all Mental Health (MH) and Substance Use Disorder (SUD) services for which it makes reimbursement, whether or not it manages those services. The ASO manages and reimburses both Medicaid services as well as services to uninsured individuals, who, based on income, family size, and severity of need, may be covered with State only funds by the PBHS. The system is driven by a combination of authorizations and claims for behavioral health services. All required mental health Client Level Data (CLD) and substance use disorders Treatment Episode Data Set (TEDS) data elements have traditionally been built into the ASO. Due to parity concerns, Maryland was informed that providers had to be given the choice to "Opt Out" of reporting these data elements. It is anticipated that due to system changes and data collection issues, the state is unable to report on approximately 50% of all required data fields that constitute the CLD and TED files. A small percentage, approximately 20%, of providers are reporting some of the additional reporting data requirements which renders the data

unrepresentative of the larger system. One of the challenges of not having this data from the ASO, to deliver quality care services, is that the local health departments are not able to synthesize data from the demographics of the individuals accessing services from the local service providers. With the transition to a new BHASO vendor (Carelon) on January 1, 2025, the parity ruling has not changed; however, Carelon has engaged with Maryland Medicaid to continue to submit parity reporting to CMS. The system also manages services not covered under Medicaid that are reimbursed with state funds. During FY24 over 330,000 individuals (mental health and substance use disorder treatment services) were served through a network of over 3,500 individual, group, agency, and institutional service providers.

University of Maryland- Systems Evaluation Center (SEC) and SoftTech, Inc.
BHA works closely with SoftTech, Inc., a technology solution company that specializes in data architecture, database management, data warehousing, and Business Intelligence (BI) solutions. Key data support efforts include provision of data analysis and programming activities with various State and local partners such as Maryland Medicaid, the local system authorities and the SEC, and provide appropriate support and consultation as required. SoftTech provides support to database design needs and ASO system requirements.

The work of the SEC helps to identify key gaps in the delivery of quality services. The SEC, which is funded by Mental Health Block Grant funding, performs a wide range of activities, including:
- Designs and conducts required evaluations for Mental Health and Substance Abuse Block Grants. Provides technical support for federal data reporting requirements.
- Performing Program Evaluations and Data Analyses to support BHA priority programs and initiatives.
- Performs program effectiveness evaluations and focused data studies of federal grant programs, collecting and reporting data and responding to inquiries from grant managers related to data and evaluations.
- Provides technical assistance and data analysis to support behavioral health integration efforts and state reporting requirements, such as conducting research on system capacity.

Recurring Behavioral Health Needs Assessment
In addition to the primary role of the University of Maryland SEC and BHA have collaborated on the design of a statewide Behavioral Health Recurring Needs Assessment (BH-RNA) process and methodology. The BH-RNA will be used to: 1) Meet SAMHSA requirements and inform Block Grant planning and development efforts; 2) Inform the allocation of State and Federal resources where they are most needed; 3) Support local (LBHA) planning, monitoring and management decisions; 4) Identify gaps in services and access to increase treatment for behavioral health risks, service access and use for priority subpopulations; and 5) Derive estimates of behavioral needs in Maryland broken down by subpopulation (e.g., jurisdictions and demographic characteristics). The BH-RNA will incorporate multiple federal and state data sources and include measures relating to population demographics (e.g., age, geographic location), prevalence of behavioral health disorders, fatal and non-fatal overdoses, suicides, behavioral health need estimates and associated risk factors, service utilization, treatment capacity and behavioral health issues related to somatic health. Four behavioral health need estimates will be derived including overall SUD need, OUD need, overall mental health/mental illness need, and SMI/SED need. Four primary data sources, including: NSDUH data, data on individuals experiencing a fatal overdose, individuals with MH or SUD diagnoses represented in ASO claims data, individuals who receive buprenorphine prescriptions in PDMP and individuals who received hospital inpatient or outpatient treatment services in the HSCRC case mix data will be used to derive need estimates. The use of multiple data sources allows for a more accurate representation of the total population with behavioral health treatment needs in Maryland. The BH-RNA will be conducted every three years with key metrics updated on an annual basis. The assessment design, implementation plan and protocols was completed in May 2025 with the first assessment for the Summer and Fall of FY2026. The BH-RNA is another device that will be used to determine key gaps and challenges in service delivery for Maryland's PBHS.

Use of Epidemiological Data to Inform Prevention
The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/misuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements.
Maryland has taken many steps to attempt to track and prevent both suicides and deaths from unintentional overdoses (OD). Suicide and overdose death records have been matched to PBHS service utilization, and the characteristics of those who have died have been examined and shared with many groups, including the majority of BHA staff as well as the staff members of the local system authorities. Demographically, those who were active in the PBHS were very similar to the population of all overdose deaths. Those decedents who received both specialty mental health and substance use disorder services were more likely to experience a fatal overdose. Maryland has also used its real time reporting system that was established to provide early identification of community-based epidemics, reports that are available to LBHAs, to identify overdose admissions as well as suicide attempts. Peers have been hired by hospitals and the LBHAs to work with those individuals who have gone to the emergency department as a result of an overdose and work with the individual to engage in treatment. All overdose deaths are reviewed by Local Overdose Fatality Review Teams (LOFRTs). These are multi-agency groups composed of experts from many disciplines that review all overdose fatalities to identify possible risk factors and potential interventions that might have changed the outcome of the overdose. Over the past year, the MDH launched an interactive, public facing Opioid Overdose Dashboard tool that contains

current data on fatal and non-fatal overdose events and other opioid related indicators. This dashboard tool is an essential tool that is used by MDH BHA and Public Health Services to monitor overdose events, identify emerging risks and service needs and to inform system and program planning.

Behavioral Risk Factor Surveillance System. The Behavioral Risk Factor Surveillance System (BRFSS) is a critical population-based tool used in Maryland to monitor public health trends among adults. This survey provided valuable data on a wide range of health-related behaviors, including alcohol and drug use, mental health status, Adverse Childhood Experiences (ACEs), women's health, and social determinants of health such as life satisfaction, mental quality of life and physical health quality of life, transportation, and housing stability. In a needs assessment capacity, BRFSS indicators help identify emerging issues, guide resource allocation, and inform the development of targeted prevention and intervention strategies at both state and local levels. These data support evidence-based planning and policy-making to improve health outcomes across Maryland's communities. BHA uses this data regularly to assess mental and physical health quality of life in the State's adult population and examine the relationship between exposure to Adverse Childhood Experiences (ACEs) and mental health and substance use issues.
For example, 2020-2023 BRFSS data was used in a study conducted through the Building Healing Systems Initiative, to examine the relationship between exposure to ACEs and mental and somatic health indicators. The results indicate that nearly one-half (45.3%) of adults experienced at least one personal ACEs such as emotional, physical, and sexual abuse, 50.3% experienced at least one household ACE such as parental separation or divorce and Household Domestic Violence and nearly one-quarter (24.6%) reported experiencing 3 or more ACES. Individuals who reported 3 or more ACEs were 3.3 times more likely to report poor mental health (14+ days of poor mental health) and nearly twice as likely (1.8X) to report poor physical health (14+ days of poor physical health). In Maryland, it is estimated that nearly 15% (534,000) of Maryland adults have a significant ACEs score, making them at higher risk for potential mental health or substance use disorders. Based on survey results, approximately one-half of all Maryland adults experience problems with mental health for a significant period of time throughout the month.

Youth Risk Behavior Surveillance Survey (YRBSS). The YRBSS is a key surveillance tool for understanding the health behaviors and experiences of high school-aged youth in Maryland. It provides population-level data on critical indicators such as mental health status, suicidal ideation and behavior (including plans and attempts), alcohol and drug use, and increasingly, the prevalence and impact of Adverse Childhood Experiences (ACEs). When used in a needs assessment, YRBSS data help school systems, public health agencies, and community organizations design targeted prevention efforts, enhance mental health and substance use supports, and address the root causes of trauma in youth populations. While the Youth Risk Behavior Survey (YRBS) includes questions related to Adverse Childhood Experiences (ACEs), it does not generate an overall ACEs score. Instead, the responses to individual ACEs-related questions, such as exposure to violence, family substance use, and experiences of neglect or abuse are analyzed separately. These individual indicators provide valuable insight into the types and prevalence of trauma that youth may experience. This data is used to inform needs assessments, identify trends, and guide the development of trauma-informed interventions and policies aimed at improving the health and well-being of high school-aged youth. By highlighting risk and protective factors, the YRBSS informs strategies that aim to promote resilience, reduce harm, and support the well-being of adolescents across Maryland.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

The BHA reviews and assesses the unmet needs and critical gaps in Maryland's PBHS through ongoing data analysis. This ensures that resources, including federal Block Grant funding, are prioritized for populations and geographic areas with the greatest need.

Access Gaps: Maryland PBHS serves over 330,000 people for both MH and SUD treatment services annually with a combined expenditure exceeding $2.5 billion in FY2024. The PBHS services both Medicaid recipients and the uninsured population, with 89.3% of claims paid through Medicaid funds in FY2024. The overall use of PBHS services increased between FY2019 and FY2024, with children and adolescents (aged 0-17) accessing mental health services increased by 16.4% and adults (18 and older) experiencing a 32% increase in service use.
Although there has been an increase in usage, only a small percentage of estimated Marylanders eligible for Medicaid use the PBHS. For example, in FY2024, an estimated additional 325,000 Marylanders were eligible for Medicaid, which represents a massive potential unmet need for behavioral health treatment. However, only 14% - 17% of this newly eligible population used PBHS services in those fiscal years. These low usage rates suggest that there are significant challenges that prevent eligible people from using the services that may include, but not limited to awareness, stigma, logistics (e.g., lack of transportation, childcare, or time off from work), and provider shortages.

Treatment Gaps based on geographic locations: BHA developed a White Space Analysis through collaboration with local behavioral health system authorities and various data sources. This point in time analysis from April 2024 shows the services in each jurisdiction and the funding streams. The data is derived from the 2022 ASO data and 2024 local jurisdiction 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.

Behavioral health services are heavily concentrated in the state's population centers, such as the Baltimore Metropolitan region and the Capital area (Montgomery and Prince George's Counties). Services are far more limited in the rural areas of the state, particularly along the Eastern Shore and Western Maryland. Residents in the jurisdictions where there are no in-county PBHS providers must travel across jurisdictional boundaries to access services.
For example, according to the White Space Analysis, while 900 Crisis Hotlines are available in all jurisdictions, Crisis Intervention Teams are not present in Somerset County and Crisis Walk-ins/Bed/Stabilizations are not available in Prince George's, Somerset, and Wicomico Counties.

Growing Service Demand: Overall utilization of the PBHS has increased, but gaps remain, particularly for those with serious conditions and certain people. The total number of individuals receiving mental health services increased by 22.2% between FY 2019 (226,232 individuals) and FY 2024 (276, 358 individuals. Children and adolescents (aged 0-17) accessing mental health services increased by 16.4%. Adults (18 and older) experienced a 32% increase in mental health service use. The increase demonstrates a growing service demand.

Over the past several years, Maryland has experienced an increase in emergency department (ED) boarding and crowding in part due to an increase in behavioral health patients usage. A previous study from the Maryland Hospital Association found that 42% of behavioral health ED patients experienced a delay being discharged or transferred. These patients were delayed for an average of 20 hours per patient. The top reason for the Emergency Department Delay was waiting for bed space in the placement setting.

Specific Populations:
Individuals who are dually diagnosed: Furthermore, approximately 28% of individuals receiving mental health services in the PBHS in FY2024 were dually diagnosed. This population accounted for a disproportionate 39% of all mental claim expenditures, indicating high complexity and resource needs.

Uninsured Individuals: Access for the uninsured population, while still a gap, has improved significantly. The number of uninsured individuals using PBHS services jumped by 251% from FY2022 (n=2,839) to FY2024 (9,980 individuals)

Children: In FY 2024, 96% of individuals under age 18 served in the PBHS had a SED utilizing 95% of all service expenditures attributed to youth ages 0-17. In FY2024, an estimated 44,000 children in rural counties were diagnosed with a Serious Emotion Disturbance, but only 35% (15,400) were served in the PBHS.
In 2025, Maryland BHA in partnership with the Maryland Coalition of Families and Manatt Health developed a roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth, and Families. As part of this process, a needs assessment was conducted. Findings from the needs assessment included challenges in navigating the PBHS and getting connected with the services and supports their child or young person needs.

Adults, aged 18 to 64: It is estimated that there are 263,807 adults in Maryland with Serious Mental Illness. Sixty nine percent of all adults served in the PBHS had a SMI and utilized 81% of all service expenditures. It is estimated 92,000 adults with SMI were from rural counties, with only 31% (29,000) receiving PBHS services, demonstrating a major gap in penetration for serious conditions in rural areas.

Pregnant Women and Women with Children: The estimated prevalence of pregnant women with substance use disorder diagnosis who are Medicaid eligible are 24, 437. However, in FY 2024, only 475 pregnant women received SUD services within the PBHS. In FY 2024, the estimated prevalence is that 82,867 women with children needed SUD services in the Medicaid population in Maryland. However, only 12,083 (14.5%) were served.

Older Adults: Of adults with a SMI diagnosis, 3.2% (4,344) were aged 65 and over.
Veterans: Veteran suicide rates in CY 2022 were highest in Garrett (91.3 per 100,000) and Caroline (88.0 per 100,000) counties. In CY 2022, the Statewide suicide rate for Non-Veteran adults (18 and over) was 9.6 per 100,000 while the suicide rate for Veteran's in the same time period was 24.5 per 100,000. Analysis also shows that over the most recent four calendar years (2019-2022), 64-75% (CY 22 75%) of all Veteran suicides occurring in Maryland involve firearms compared to 41-45% of the general adult suicide population. In FY 2024, the number of Veterans served in the PBHS shows a decrease (-6%), however, this decrease can be attributed due to the issue of data reporting as discussed earlier under the parity issue; Maryland providers have been given the choice to "Opt Out" of reporting certain data elements. In FY 2024, of the total number of individuals receiving mental health services, 1.2% were Veterans, utilizing 1.9% of the total expenditures associated with mental health treatment services. 2.2% of individuals receiving substance use disorder treatment services were Veteran and accounted for 3.5% of all associated substance use expenditures in the PBHS during the same time period.

Individuals experiencing homelessness: In FY 2024, nearly 89,000 PBHS Mental Health service recipients were from a rural county, of which, 3.1% were currently or had experienced homelessness in the past 3 months. One out of 3 all homeless individuals receiving mental health services in the fiscal year were from a rural jurisdiction. Over 42,000 PBHS Substance Use Disorder service recipients were from a rural county, of which 5.5% were currently or had experienced homelessness in the past 3 months. Twenty-six percent of all homeless individuals receiving SUD treatment in the fiscal year were from a rural county.

Maryland's Behavioral Health Workforce

In October 2024, the Maryland Health Care Commission partnered with the Maryland Department of Health and Trailhead Strategies to conduct a needs assessment on the Behavioral Health Workforce. In summary, there are 34,600 behavioral health professionals in the current workforce. Thirty-two thousand eight hundred additional workers (32,800) are needed by 2028 to meet demand. Rural counties such as Queen Anne's Calvert, Charles, Worcester, and Carroll counties as well as Prince George's have the fewest professionals per resident. Other key findings included the need for competitive compensation for the behavioral health workforce as well as the need to use technology to help the current health care workers serve patients more efficiently and effectively to meet population needs long term

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

The BHA FY 2025-2027 State Strategic Plan outlines current services and behavioral health needs and the administration's goals and objectives to define the development of BHA programs. Maryland has identified and will address unmet service needs and gaps through several key cross-cutting strategies that appear across multiple indicators.

These intersecting and reinforcing implementation strategies are aligned with BHA's four strategic plan priorities and utilize Block Grant resources to expand evidence-based practices, reduce challenges, and improve access to care

Hospital Care Coordination. To resolve the ED boarding crisis and resolve the psychiatric hospital overstay, the BHA's Hospital Care Coordination 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 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 has also created a state-wide Bed Registry and Care Traffic Control System. The pilot efforts 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.

Assisted Outpatient Treatment Strategy: To address unmet service gaps for individuals with SMI
Maryland lawmakers passed HB576/SB 453 during the 2024 legislative session. This legislation requires the MDH to ensure that Assisted Outpatient Treatment (AOT) is operational statewide by July 1, 2026. The MDH is engaged in multiple early implementation efforts to meet this timeline, including drafting regulations, development of clinical and operational guidance, and stakeholder engagement. Per the statute, an individual over age 18 with a diagnosis of severe and persistent mental illness may be petitioned for court-ordered outpatient services based on a finding through the circuit court of clear and convincing evidence that the individual meets criteria for AOT. Eligibility for AOT as outlined by statute include several criteria capturing a history of nonadherence to outpatient services and utilization of inpatient services. Program evaluation and research findings from outside states suggest that AOT is associated with decreased inpatient utilization in individuals with severe and persistent mental illness. BHA anticipates that AOT will be an additional tool to address unmet service gaps for individuals with SMI.

Maryland's Early Intervention Program Strategy
Another path to increase access to services is to have specialized programs 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 RA1SE-IES Coordinated Specialty Care (CSC) model. The Set-aside funds will assist in developing new FEP programs that would support planning (e.g, conducting additional needs assessment, trainings) and sustainability for these new FEP sites. Planning to sustain existing FEP programs include conducting critical analysis to research and proposed updated rates that are comprehensive, evidence-based, and aligned with market rates.

Pregnant Women and Women with Children (PWWC)-One of the Performance Indicators for this SUBG Priority Populations includes the number of pregnant and parenting women who access recovery support services in Maryland through the Recovery Housing for Pregnant Women and Women with Children Program. In FY 2024 there were 12,083 women with children and 475 pregnant women received SUD services in the PBHS. In FY 2024, 36% of the individuals receiving substance use disorder treatment services were from rural jurisdictions. For this population, the BHA provides oversight of residential treatment and transitional services for pregnant women and women with children, Pregnant Women and Women with Children Medication Assisted Treatment Prescription Drug Opioid Addiction (PDOA) federal grant, Sobriety Treatment and Recovery Teams (START), childcare during withdrawal management initiative, recovery support specialist in pregnancy/postpartum project, recovery housing for women and women with children, and several legislatively mandated initiatives: SB 512 (1997) Substance Exposed Newborns, HB 7

(2000) Integration of Child Welfare and Substance Use Treatment Services Act, and HB 1160 (2000) the Welfare Innovation Act of 2000 (Temporary Cash Assistance). BHA approved Residential Treatment Programs for Pregnant Women and Women with Children (PWWC), are required to provide a service for pregnant women within 48 hours of presenting to the program.

Deaf and Hard of Hearing Population
Lack of funding and access to behavioral health services as well as the limited availability of local, 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 with the Governor's Office of the Deaf and Hard of Hearing (GODHH) worked closely with the MDH 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.

Maryland's Commitment to Veterans (MCV)
Maryland became a Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families (SMVF) participant in May of 2020. The State brought together a multidisciplinary team of professionals to develop a state plan to address the complex issue of suicide in this Maryland population. The team is focused on developing initiatives within three priority areas as part of our short-term action plan. These priority areas are: (1) Identify SMVF and screen for suicide risk, (2) Promote connectedness and improve care transitions, and (3) Increase lethal means safety and safety planning. Initiatives within these priority areas that will be utilizing MHBG funding to target SMVF with SMI include: (1) development of an "Ask the Question" training and marketing campaign to encourage the use of best practice, standardized language for identifying SMVF accessing state agency services to include libraries. This training will also be accessible for outside organizations and for incorporation into the other initiatives; (2) expansion of crisis intercept mapping opportunities to ten additional counties in order to share information about the community crisis care system and develop plans to address major gaps; (3) development of a caring contacts implementation toolkit and provide support to emergency department staff; (4) development and expansion of a virtual primary care provider safety planning training program with targeted marketing to primary care providers in the jurisdictions participating in crisis intercept mapping project.

Care for Older Adults in Maryland
Medicaid waiver programs for older adults and adults with a brain injury are monitored and promoted by the Office of Older Adults and Long-Term Services and Supports, including Medicaid waiver programs for Long-Term Care Services and Supports and Assisted Living Facilities. The office is operating and developing programs and resources for aging Marylanders with behavioral health conditions or living with brain injuries. The office is also overseeing the process (Pre-Admission Screening and Resident Review (PASRR)) for adults with SMI, developing resources for older adults with behavioral health conditions, as well as ensuring they receive needed services in the least restrictive setting. Programs are providing support to older adults with behavioral health conditions, including through outreach services to seniors for mental health (including telemental health in six jurisdictions), behavioral health assisted living facilities, Regional PASRR Coordinators, and specialized residential psychiatric programs for rehabilitation of individuals with medical complexities. Grant-funded services are supporting Behavioral Health Assisted Living programs for those adults or older adults with behavioral health conditions who are discharging from, or at risk of institutionalization in a state psychiatric hospital or nursing facility, and/or who need assistance with daily living in seven jurisdictions in the State. This office is collaborating across many state agencies to ensure it is meeting the behavioral health and support needs of older adults and those living with brain injury.

To Support Individuals Experiencing Homelessness: In addition to the MHBG, Projects for Assistance in Transition from Homelessness (PATH) supports serving individuals with SMI or co-occurring SUD experiencing homelessness. Maryland's allocation for FFY 2024 was $1,305,852. Funding is used to provide outreach, case management, screening and diagnostic services, housing assistance and referrals to job training and other supportive services to individuals with SMI or co-occurring SUD who are experiencing homelessness, with the core goal of achieving treatment engagement and long-term recovery. s in Maryland's 21 jurisdictions. In SFY 2026, it is estimated 1,217 individuals will be enrolled into the PATH program.

Implement data and continuous performance improvement through the Consumer Quality Team (CQT) Strategy:
The Consumer Quality Team of Maryland is a consumer run initiative which is housed within the Mental Health Association of Maryland. Key elements of the model are the following:
- CQT is staffed by trained consumers and family members, and independent of provider organizations and the government entities that fund service delivery. This structure maximizes trust among service recipients and increases their comfort level in sharing information about care they receive.
- While most auditors and regulators focus on the clinical programs, CQT focuses on the experiences of individuals. The consumer -centric model allows for the ability to collect important information about individuals' unique experience for the primary purpose of immediate quality improvement.
- CQT utilizes a structured and confidential qualitative interviewing process, rather than a formal survey, and through this process is able to elicit useful information, both positive and negative, which would not be shared through a survey.
- CQT site visits involve multiple behavioral health program areas, including Adult Inpatient Mental Health units, Adult and youth Psychiatric Rehabilitation Programs (PRP), Adult Intensive Outpatient Programs (IOP), Adult Partial Hospitalization Programs (PHP), Youth Residential Treatment Centers, Wellness & Recovery Centers, andMental Health Intensive Outpatient programs and Partial Hospitalization programs. More recently, CQT undertook efforts to address quality issues at SUD treatment programs, including

Level 3 Residential Treatment Programs, SUD IOP and SUD PHP.
- The CQT feedback loop is central to the success of the program, which ensures that consumer feedback, both positive and negative, is shared at the program, local jurisdiction and state levels. Exit interviews conducted with program or hospital management at the conclusion of each site visit
- Written site visit reports shared with program and facility management, local core service agencies and the Behavioral Health Administration
- Quarterly review of CQT reports with local behavioral health authorities
- Quarterly Quality Improvement meetings with MDH Behavioral Health Administration management to review emerging trends, identify significant concerns, and opportunities for program improvements for the reporting period

Recent CQT data obtained from site visits in May 2025 with Adult PRP, SUD IOP, and SUD PHP providers, demonstrated that consumers generally reported positive experiences with program staff across all program areas, their level of involvement and participation in the development of treatment/recovery goals, provider use of meeting and event calendars, flexibility to participate in services as needed, and the clarity of program rules and expectations. Consumers also identified a number of challenges and areas in need of improvement, including: inconsistent communication regarding provider services and resources, limited transportation options provided, lack of evening and weekend programming and group options, and high staff turnover. Enhance the accessibility and use of Data: BHRI and Data Tools-The BHA Office of Research and Innovation (BHRI) and Data Offices have used 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 key Behavioral Health quality metrics and the development of dashboard visualization tools to be used to evaluate and track performance across the PBHS. These behavioral health quality measures 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 mentioned previously) to inform and guide system planning and resource allocation decisions. To facilitate the effective use of results based data, BHA BHRI has developed a Performance Management and Accountability Toolkit, that includes 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.

Use of Epidemiological Data to Inform Prevention-The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements. Maryland has taken many steps to attempt to track and prevent both suicides and deaths from unintentional overdoses (OD). Suicide and overdose death records have been matched to PBHS service utilization, and the characteristics of those who have died have been examined and shared with many groups, including the majority of BHA staff as well as the staff members of the LBHAs. Demographically, those who were active in the PBHS were very similar to the population of all overdose deaths. Those descendants who were active in the PBHS, however, were most likely to have had a history of receiving both specialty mental health and substance use disorder services. Maryland has also used its real time reporting system that was established to provide early identification of community-based epidemics, reports from which are available to LBHAs, to identify overdose admissions as well as suicide attempts. Peers have been hired both by hospitals and by the local behavioral health systems authorities to work with those individuals who have gone to the emergency department as a result of an overdose and have them work with the individual to engage in treatment. Maryland has used data to identify any spikes of overdose events in local jurisdictions and sends alerts as soon as a spike has been detected.

Addressing the Behavioral Health Workforce using Training: Maryland Addiction Consultation Service (MACS)
In collaboration with University of Maryland School of Medicine, Department of Psychiatry, BHA expanded the existing Maryland Addiction Consultation Service (MACS), which offers telephone consultation, training, education, and assistance with referral identification to prescribers across Maryland in the treatment of their patients' substance use disorders and chronic pain management needs. Efforts are underway to plan for an expansion that would offer statewide technology transfer and technical assistance (TT), leverage telemedicine technology to increase access to rural areas and provide strategies for educating an emerging workforce. MACS Technology Transfer (MACS TT) will work with BHA to study, inform, and disseminate key best practices and policies to optimize the capacity and quality of workforce development related to addiction treatment, and more specifically the use of medications for OUD. One of the goals is to improve the quality of primary care and specialty prescribers across Maryland in the identification and treatment of substance use disorders. Evaluation goals include: (1) document and track activities and determine the effectiveness of the expanded MACS TT efforts, (2) improve the implementation and utilization of MACS TT, and (3) support data-driven decision-making with the goal of continuous quality improvement.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Care Navigation

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase the abilities of participants with behavioral health disorders to live successfully in the community.

Strategies to attain the goal:

Implement Assisted Outpatient Treatment (AOT) Prevent inpatient hospitalizations by engaging individuals with serious and persistent mental illness in community-based services through court-ordered and stipulated voluntary AOT treatment plans.

Targeted Case Management (TCM) and 1915(i) Services. Expand the reach and access to TCM and 1915(i) services through: 1) the distribution of available and easily accessible information/resources regarding how to access and the eligibility requirements of the services; 2) Review the distribution of current TCM and 1915(i) service providers and service users and target resources to those areas with the greatest needs; 3) Work with jurisdictional partners and providers to ensure a consistent approach to service delivery based on best practices; 4) make necessary changes to the COMAR Regulations in order to implement changes made to the SPA that decreases barriers enrollment in the services.

Housing Increase the number of individuals referred to permanent supportive housing programs and independent housing. Residential Rehabilitation Programs to increase the number of individuals who are transitioning from RRP to live independently in the community by working on interventions that assist individuals to live in the community independently.

Peer / Wellness Recovery Center Strategy – Peer Recovery Specialists stationed at Wellness Recovery Centers will connect with individuals immediately after discharge from inpatient hospitalization and offer direct linkage to peer-led recovery support services in the community. Peers will provide individualized follow-up through in-person check-ins, phone calls, or text messages during the first 30 days post-discharge, facilitate participation in Wellness Recovery Center groups and activities, and assist individuals in navigating outpatient mental health services and community resources. This ongoing peer engagement and access to recovery-focused programming will help stabilize individuals in the community and prevent avoidable readmissions.

Mental Health Programs: Emergency Department Care Coordination will engage individuals in the ER to link them with mental community treatment services or/and recovery support. In addition, individuals will be linked with Rural Psychiatric and Mental, Outpatient Civil Commitment, Health Homes and Pro Bono Mental Health Counseling Services.

Efforts underway to increase enrollment in intensive care coordination and In-home services for children with complex needs by Implementing changes made to the 1915(i) State Plan Amendment that lowers the actuity level for eligibility, streamlines the enrollment process, and increases referrals through outreach efforts that are directed at parents/caregivers and behavioral health providers.

The state will require each First Episode Psychosis (FEP) provider to conduct a minimum of 13 outreach events per year to provide awareness and build relationships with programs for potential clients who experience first episode psychosis. Outreach is done with community behavioral professionals, community mental health partners, state stakeholders and advocacy groups, public schools, state universities to include HBCUs, hospitals, and treatment centers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	PBHS service recipients with a primary MH diagnosis readmitted to the same or different inpatient hospital.
Baseline measurement (Initial data collected prior to and during 2026):	The % of PBHS service recipients who are discharged and readmitted for inpatient hospitalization will not exceed 18%.
First-year target/outcome measurement (Progress to the end of 2026):	PBHS service recipients who are discharged will not exceed 17%.
Second-year target/outcome measurement (Final to	PBHS service recipients who are discharged will not exceed 17%.

the end of 2027):

Data Source:

ASO claims based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #:	2
Indicator:	Children with SED receiving mental health services in the Maryland PBHS
Baseline measurement (Initial data collected prior to and during 2026):	The # of children with SED receiving mental health services in the Maryland PBHS is 79,052
First-year target/outcome measurement (Progress to the end of 2026):	Children with SED receiving mental health services in the Maryland PBHS will increase 3%: 81,425
Second-year target/outcome measurement (Final to the end of 2027):	Children with SED receiving mental health services in the Maryland PBHS will increase 3%: 83,868

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #:	3
Indicator:	Adults with SMI receiving mental health services in the Maryland PBHS
Baseline measurement (Initial data collected prior to and during 2026):	The # of adults with SMI receiving mental health services in the Maryland PBHS: 134,105
First-year target/outcome measurement (Progress to the end of 2026):	Adults with SMI receiving mental health services in the Maryland PBHS will increase by 6%: 142,151
Second-year target/outcome measurement (Final to the end of 2027):	Adults with SMI receiving mental health services in the Maryland PBHS will increase by 6%: 150,680

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #: 4

Indicator: Individuals with First Episode Psychosis receiving Coordinated Specialty Care

Baseline measurement (Initial data collected prior to and during 2026): The # of individuals with FEP receiving will CSC will increase by 2%: 57

First-year target/outcome measurement (Progress to the end of 2026): Individuals with FEP receiving will increase by 2%: 59

Second-year target/outcome measurement (Final to the end of 2027): Individuals with FEP receiving will increase by 2%: 61

Data Source:

FEP CSC programs quarterly reports collected by MDH-BHA Office of Primary Behavioral Health/Early Intervention.

Description of Data:

Number of individuals with FEP that receive CSC.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 2

Priority Area: Increase access to Maryland's Public Behavioral Health System

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Access

Strategies to attain the goal:

Implement Assisted Outpatient Treatment (AOT) Engage individuals with serious and persistent mental illness in Maryland PBHS services through court-ordered and stipulated voluntary AOT treatment plans.

Peer Recovery Strategy – Deploy Peer Recovery Specialists in high-need community settings such as emergency departments, homeless shelters, and recovery community centers to identify individuals with behavioral health needs. Peers will provide motivational engagement, assist with treatment enrollment, and support ongoing participation, helping drive a four-percent annual increase in the number of individuals receiving PBHS services.

Increase the number of individuals that engage with Benefit Case Managers prior to discharge from the State Hospital to ensure their entitlement benefits are turned on. Individuals transitioned into a community program will work with the community case manager for mental health services and support.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The # of individuals who receive behavioral health services in the PBHS

Baseline measurement (Initial data collected prior to and during 2026): The # of individuals who received BH services in FY24: 331,868.

First-year target/outcome measurement (Progress to the end of 2026): The # of individuals who receive BH services will increase by 4%, 345,143

Second-year target/outcome measurement (Final to the end of 2027): The # of individuals who received BH services will increase by 4%, 358,949.

Data Source:

ASO Claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #: 2

Indicator: Mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge

Baseline measurement (Initial data collected prior to and during 2026): The % of mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge which is 52.10%

First-year target/outcome measurement (Progress to the end of 2026): The % of mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge will meet or exceed 45 percent: 54%

Second-year target/outcome measurement (Final to the end of 2027): The % of mental hospital inpatient treatment recipients who receive follow-up mental health care within seven days of discharge will meet or exceed 45 percent: 55%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Priority #: 3

Priority Area: Quality and Access

Priority Type: MHS

Population(s): Other

Goal of the priority area:

Implement utilization of the latest technology to expand access to behavioral health services in the least restrictive settings.

Strategies to attain the goal:

The Administration will facilitate the access and expansion to telehealth technology through the promotion and education of available telehealth resources and information on overarching policies to statewide providers and service recipients strategically targeting rural jurisdictions and areas with limited service access and availability.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rural BH outpatient service recipients receive services via telehealth

Baseline measurement (Initial data collected prior to and during 2026): The % of rural BH outpatient service recipients receive services via telehealth is 55.60%

First-year target/outcome measurement Rural BH outpatient service recipients receive services via telehealth, 45% or more: 56%

(Progress to the end of 2026):

Second-year target/outcome measurement (Final to the end of 2027): Rural BH outpatient service recipients receive services via telehealth, 45% or more: 57%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #: 2

Indicator: Statewide BH outpatient service recipients receive services via telehealth

Baseline measurement (Initial data collected prior to and during 2026): The % of statewide BH outpatient service recipients receive services via telehealth is 57%

First-year target/outcome measurement (Progress to the end of 2026): Statewide BH outpatient service recipients receive services via telehealth, 45% or more: 57.50%

Second-year target/outcome measurement (Final to the end of 2027): Statewide BH outpatient service recipients receive services via telehealth, 45% or more: 58%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #: 3

Indicator: Rural mental health outpatient service recipients receive services via telehealth.

Baseline measurement (Initial data collected prior to and during 2026): The % of rural MH outpatient service recipients receive services via telehealth is 50.40%

First-year target/outcome measurement (Progress to the end of 2026): Rural MH outpatient service recipients receive services via telehealth, 45% or more: 52%

Second-year target/outcome measurement (Final to the end of 2027): Rural MH outpatient service recipients receive services via telehealth, 45% or more: 53%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #: 4

Indicator: Statewide mental health outpatient service recipients will receive services via telehealth.

Baseline measurement (Initial data collected prior to and during 2026): The % of statewide mental health outpatient service recipients will receive services via telehealth is 57.50%

First-year target/outcome measurement (Progress to the end of 2026): Statewide mental health outpatient service recipients will receive services via telehealth, 45% or more: 58%

Second-year target/outcome measurement (Final to the end of 2027): Statewide mental health outpatient service recipients will receive services via telehealth, 45% or more: 59%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Priority #: 4

Priority Area: Expansion of behavioral services

Priority Type: MHS, BHCS

Population(s): BHCS, Other

Goal of the priority area:

To increase availability and access to behavioral health services

Strategies to attain the goal:

Expand the availability of crisis receiving and stabilization facility services as an alternative to visiting an emergency department for urgent behavioral health needs. The administration will do this by:
(1) Partnering with local behavioral health authorities and providers to enhance existing behavioral health urgent care services and to license additional Behavioral Health Crisis Stabilization providers.
(2) Providing grant funding, fee-for-service reimbursements, training and technical assistance to jurisdictions and providers to improve and expand these services across the state.

Increase the number of EBP SE teams by promoting and training non EBP-SE teams to become EBP SE teams in order to increase the number of available EBP SE team in the state. Increase awareness of EBP teams to increase referrals to employment services.

Increase the number of EBP ACT teams by promoting and training MTS team to become EBP ACT in order to increase number of available EBP ACT teams available in the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: PBHS MH service recipients with three or more BH related Emergency Department (ED) visits

Baseline measurement (Initial data collected prior to and during 2026): The % of PBHS MH service recipients with three or more BH related Emergency Department (ED) visits will not exceed five percent is 0.80%

First-year target/outcome measurement (Progress to the end of 2026):	PBHS MH service recipients with three or more BH related Emergency Department (ED) visits will not exceed five percent: 0.90%
Second-year target/outcome measurement (Final to the end of 2027):	PBHS MH service recipients with three or more BH related Emergency Department (ED) visits will not exceed five percent: 1.00%

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #:	2
Indicator:	Individuals who received Evidence Based Practice-Supported Employment services in the Maryland PBHS
Baseline measurement (Initial data collected prior to and during 2026):	The # of individuals who received EBP-SE services in the Maryland PBHS will increase 1 percent: 2,910
First-year target/outcome measurement (Progress to the end of 2026):	The # of individuals who received EBP-SE services in the Maryland PBHS will increase 1 percent: 2,940
Second-year target/outcome measurement (Final to the end of 2027):	The # of individuals who received EBP-SE services in the Maryland PBHS will increase 1 percent: 2,950

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

Indicator #:	3
Indicator:	Individuals who received Evidence Based Practice-Assertive Community Treatment services in the Maryland PBHS
Baseline measurement (Initial data collected prior to and during 2026):	The # of individuals who received EBP-ACT services in the Maryland PBHS will increase 1%: 2,766
First-year target/outcome measurement (Progress to the end of 2026):	Individuals who received EBP-ACT services in the Maryland PBHS will increase 1%: 2,793
Second-year target/outcome measurement (Final to the end of 2027):	Individuals who received EBP-ACT services in the Maryland PBHS will increase 1%: 2,800

Data Source:

ASO claims data based on claims paid through 12/31/2024.

Description of Data:

The ASO claims data is based on all individuals receiving MH or SUD services in the Maryland Public Behavioral Health System (PBHS) reimbursed by Medicaid or State of Maryland General Funds for those who qualify based on medical necessity and Medicaid eligibility standards.

Data issues/caveats that affect outcome measures:

FY 24 data are not final as a provider has 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 claims have been submitted for reimbursement.

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Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application *Funding Agreement/Certifications and Assurances.*

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis Services								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$3,574,034.00	$0.00	$0.00	$3,689,980.00	$0.00	$0.00	$261,660.00
7. State Hospital			$0.00	$0.00	$3,783,010.00	$0.00	$0.00	
8. Other Psychiatric Inpatient Care			$0.00	$0.00	$0.00	$0.00	$10,000,000.00	
9. Other 24-Hour Care (Residential Care)		$1,436,930.00	$0.00	$0.00	$105,691,304.00	$0.00	$0.00	$0.00
10. Ambulatory/Community Non-24 Hour Care		$17,398,298.00	$0.00	$31,013,250.00	$185,873,447.00	$0.00	$13,029,157.00	$0.00
11. Crisis Services (5 percent Set-Aside)[c]		$11,544,063.00	$0.00	$6,399,674.00	$45,554,328.00	$0.00	$52,200,000.00	$2,354,940.00
12. Other Capacity Building/Systems Development								
13. Administration[d]		$1,787,017.00	$0.00	$4,480,201.00	$23,020,891.00	$0.00	$223,346.00	$0.00
14. Total		**$35,740,342.00**	**$0.00**	**$41,893,125.00**	**$367,612,960.00**	**$0.00**	**$75,452,503.00**	**$2,616,600.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	0.00
1b. Crisis Services for Adults	9498524.00
1c. CSC/ESMI program for Adults	2586554.00
1d. Other outpatient/ambulatory services for Adults	1436930.00
1e. *Other Direct Services for Adults	5086559.00
2. Subtotal of Services for Adults	18608567.00
3. Services for Children	
3a. EBPs for Children	1340000.00
3b. Crisis Services for Children	2045540.00
3c. CSC/ESMI program for Children	987480.00
3d. Other outpatient/ambulatory services for Children	0.00
3e. *Other Direct Services for Children	1738712.00
4. Subtotal of Services for Children	6111732.00
5. Other Capacity Building/Systems Development[a]	9233026.00
6. Administrative Costs[b]	1787017.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**35740342.00**

Please provide brief explanation for services with an asterisk* below:

*Other direct services to children includes funds to jurisdictions to cover the costs of school-based mental or behavioral health programs, assessment services for children and adolescents, in-home intervention services, youth outreach projects, therapeutic after school programs, and early childhood services. *Other direct services for adults include funds to jurisdictions to cover state care coordination to promote the continuum of care by helping adults and older adults across Maryland who are in varying stages of recovery from a Substance Use Disorder (SUD) or co-occurring Substance Use and Mental Health Disorder (SUD/MH). In addition, provide access to behavioral health treatment, psychiatric medications, and transportation for individuals with limited resources. Other direct services include family peer support and navigation, advocacy program/peer-led education, outreach and training, suicide prevention, Community Reentry/Diversion Services, and behavioral health care services for individuals experiencing homelessness.

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 12/31/1969 MHBG Planning Period End Date: 12/31/1969

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems	$402,868.00	$0.00	
2. Infrastructure Support	$0.00	$0.00	
3. Partnerships, Community Outreach, and Needs Assessment	$4,000.00	$0.00	
4. Planning Council Activities	$0.00	$0.00	
5. Quality Assurance and Improvement	$2,089,236.00	$0.00	
6. Research and Evaluation	$3,310,390.00	$0.00	
7. Training and Education	$3,426,532.00	$0.00	
8. Total	**$9,233,026.00**	**$0.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

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Footnotes:

No updates for Table 6.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

a}) Adults with serious mental illness (SMI)
Maryland is continually improving access to care for adults with SMI. The State revised its methodology to calculate prevalence of SMI aligned with federal regulations, and the current estimate of those adults aged 18+ for each county is multiplied by the rate as included in federal definitions (5.4%). A somewhat stricter definition of SMI necessitated new estimates of treatment prevalence. Specific diagnostic codes were selected for Axis I and II to identify the rate of adults with SMI treated in PBHS, and very small modifications to diagnostic categories were made this year. All data has been updated to reflect these changes. There is no available mechanism to define levels of functioning in the data system, therefore, estimates rely on diagnoses. As Maryland implements the PBHS, the state gives careful consideration to maintaining services to the priority populations (as previously defined elsewhere in this document) in both FFS and contract based systems. Services to these priority populations are through Assertive Community Treatment (ACT) Teams, Targeted Case Management, Psychiatric Rehabilitation Programs, Crisis Services and Supported Employment, supported housing initiatives, and health home programs that integrate behavioral health and somatic care. Coordinated public awareness campaigns further expand access to services by sharing information on calling the National 988 hotline, opioid use, problem gambling, suicide prevention, and reducing stigma.

b) Adults with SMI and co-occurring intellectual and developmental disabilities (I/DD)
Several grant-funded initiatives focusing on screening, intervention, and provider support/education for individuals diagnosed with SUD are available to adults with SMI in Maryland, including the Maryland Addiction Consultation Service (MACS); Hub and Spoke Initiatives; and SBIRT, among others. Previously referenced services for adults with SMI (ACT, Psychiatric Rehabilitation, Supported Employment, etc.) target adults with a SMI primary diagnosis, but do not exclude individuals with a co-occurring secondary SUD. SUD services are also available to adults with SMI in wraparound, holistic care models. For example, ACT teams are expected to provide SUD services, and ACT fidelity assessments consider the presence and role of specialist in co-occurring disorder(s).

c) Pregnant women with substance use disorders
The State provides access to various levels of care for SUD treatment and recovery support for pregnant women. Every level of care must admit pregnant women in need of treatment services within 48 hours of request or provide interim services while they wait for a particular service or program. There are five approved Residential Treatment Programs for Pregnant Women at the 3.1, 3.3, and 3.5 levels of care in the State, which are expanding specifically for pregnant and parenting women (PPW), as residential programs that provide clinical services and life skills development for families. Recovery houses for PPW with live-in children from ages of 0-17 are offered for up to a year as the mother grows in her recovery skills and builds recovery capital for the future. Programs' Recovery Support Coordinators (RSC) work to develop recovery plans for families and provide mothers with employment and education opportunities to gain healthy recovery skills and tools critical in early recovery. Other recovery wrap-around services for PPW are offered as well, such as care coordination, referral services, and learning healthy habits that support recovery from SUD.

d) Women with substance use disorders who have dependent children
Maryland provides needed SUD treatment services for women with dependent children. Five approved residential treatment programs are expanding specifically for PPW to provide clinical services, family life skills development, and recovery services for women with dependent children. Wrap-around recovery supports are provided by the Recovery Support for Pregnant and Postpartum Women's (RSPPW) Program, including community outreach services to heighten public awareness, and allow women to attend community health fairs, wellness centers, religious events, and recovery events. Additional needed services are provided by the RSPPW program to support women who need more support for their recovery. RSCs provide necessary referrals to outpatient SUD treatment, assist with educational and job development program applications, resume writing, and locating housing programs. Recovery houses for women with live-in children from ages of 0-17 are offered for up to a year and provide a safe and stable place for women and their children to grow, practice healthy habits for recovery, and work towards independence. Any women with dependent children in recovery can apply for this program and services.

e) Persons who inject drugs
Maryland Health-General §3101-109 authorizes government and community-based organizations as ORPs, which is authorized to provide Life-Saving Overdose Prevention and Response Services and Opioid Overdose Reversal Medications (OORMs), coupled with Overdose reversal education and training services, furthering support for overdose reversal and linkages to SUD treatment and recovery. OHR centrally purchases naloxone Populations at elevated risk of overdose, are identified through Maryland's overdose data. Populations are also targeted who are at highest risk of witnessing an overdose in their service area. ORPs build relationships, provide information about local resources, and facilitate linkages to care. MDH freely distributes naloxone to IOPs, OTPs, and other organizations as required by the Maryland STOP Act of 2022, furthering support for Life-Saving overdose prevention and linkages to care. Furthermore, MDH maintains a statewide standing naloxone order, which allows naloxone to be obtained without a prescription at Maryland pharmacies.

f) Persons with substance use disorders who have, or are at risk for, HIV or TB
Not Applicable.

g) Persons with substance use disorders in the justice system
The State is improving access to care for individuals with SUD and/or co-occurring conditions following enactment of 2020 legislation to increase screening, evaluation, and treatment for OUD, and specifically to increase utilization of MOUD. All of Maryland's 24 local correctional facilities were operating MOUD programs that provide at least one form of MOUD as of February 2025, ensuring baseline access to MOUD statewide. In FY 2024, there were over 25,000 assessments for substance use among over 11,000 incarcerated individuals. Over half, or 56.4% of incarcerated individuals received an OUD diagnosis, and 4,075 received MOUD treatment while incarcerated.. Maryland continues to expand clinical capacity and align with best practices to bring comprehensive care to incarcerated individuals with SUD.

h) Persons using substances who are at risk for overdose or suicide
Maryland recognizes that higher risk of suicide accompanies experiences of substance use and mental health challenges. These are interconnected public health concerns influenced deeply by exposure to trauma, the social determinants of health, and co-occurring health conditions. The MDH BHA's Office of Integrated Wellness and Prevention (IWP) coordinates strategies for prevention, including for risk of suicide, substance use, and problem gambling to ensure individuals receive comprehensive and compassionate care. Through the Office of IWP, Maryland prioritizes integrated, trauma-informed suicide and overdose models that bridge prevention efforts related to risk of suicide and substance use, rather than siloing them.

The IWP supports access to care through:
Committees for Suicide and Overdose Fatality Review (SFR and OFR):
These multidisciplinary teams review deaths by suicide and overdose to identify missed intervention points, system gaps, and social risk factors. Maryland has 23 Local Overdose Fatality Review Teams (LOFRTs) and a Statewide Suicide Fatality Review Team that produce recommendations to guide service improvements, increase care coordination, and reduce preventable deaths.

988 Suicide & Crisis Lifeline Implementation:
Maryland continues to strengthen its 988 infrastructure, improving data collection, expanding marketing campaigns, and conducting community outreach to ensure that individuals experiencing suicidal crises or substance-related emergencies receive timely.

Governor's Commission on Suicide Prevention and Regional & Statewide Coalitions:
These entities are coordinating cross-sector efforts to expand access to behavioral health services, identifying priority populations , and guiding statewide planning.

Addressing Substance Use and Suicide Risk Through Community-Based Prevention:
Prevention programs funded through federal block grants are enhancing local capacity in Maryland to support individuals who are at risk of suicide or overdose by, expanding workforce training, and reducing stigma.

Substance Use Primary Prevention (20% SUPTRS Set-Aside):
SUPTRS funds are distributed to all 24 jurisdictions and 4 University Alcohol, Tobacco, and Other Drug (ATOD) Prevention Centers in Maryland.
Local programs use SAMHSA's Strategic Prevention Framework (SPF) and focus on education, environmental change, and outreach, including media campaigns, prevention curricula (e.g., Strengthening Families, Kids Like Us), and compliance initiatives. These efforts emphasize preventing first substance use and promoting safe storage and disposal of controlled medications.

Addressing Risks of Co-Occurrence Through Training and Community Education:
Maryland is investing in training for providers and community members to recognize and respond to both risks of suicide and substance use. Over half of Maryland jurisdictions are participating in BHA grant-supported programs that provide:
Training in evidence-based practices, including CAMS-care, DBT, QPR, ASIST, CALM, and CBT
Anti-stigma campaigns at the community-level promoting acceptance of help-seeking and illuminate available peer support
Special initiatives the State is tailoring to vulnerable populations

Maryland is ensuring that individuals using substances who are at higher risk of overdose or suicide are receiving trauma-informed, and coordinated care. Federal support is sustaining these critical initiatives, e and modernizing surveillance and intervention systems. Maryland's integrated model is demonstrating the importance of bridging prevention efforts and addressing the full complexity of risk of suicide and substance use in our communities.

i) Other adults with substance use disorders

BHA's Division of Treatment and Recovery is developing and implementing an integrated system of care for this population. The Division is developing policies and regulations related to clinical services for adults and older adults; identifying gaps in services and best practices to enhance access and quality of care; and directing, administering, and overseeing the statewide continuum of community-based outpatient behavioral health treatment services, including outpatient mental health centers, outpatient substance use treatment, withdrawal management, substance use intensive outpatient treatment, mental health and substance use partial hospitalization programs (PHP), group practices, private licensed practitioners, and residential substance use treatment programs.

Within the Division of Treatment & Recovery, oversight of behavioral health treatment for adults and older adults, including services for MH/SUD (including co-occurring MH) treatment, state care coordination, targeted case management, behavioral health homes and related services to individuals who are deaf, deaf-blind, hard of hearing, late-deafened (DDBHH/LD), or have other communication needs, as well as services under the federal State Opioid Response (SOR) grant, is provided.

Medicaid waiver programs for older adults and adults with a brain injury are monitored and promoted by the Office of Older Adults and Long-Term Services and Supports, including Medicaid waiver programs for Long-Term Care Services and Supports and Assisted Living Facilities. The office is operating and developing programs and resources for aging Marylanders with behavioral health conditions or living with brain injuries. The office is also overseeing the process (Pre-Admission Screening and Resident Review (PASRR) for adults with SMI, developing resources for older adults with behavioral health conditions, as well as ensuring they receive needed services in the least restrictive setting. Programs are providing support to older adults with behavioral health conditions, including through outreach services to seniors for mental health (including telemental health in six jurisdictions), behavioral health assisted living facilities, Regional PASRR Coordinators, and specialized residential psychiatric programs for rehabilitation of individuals with medical complexities. Grant-funded services are supporting Behavioral Health Assisted Living programs for those adults or older adults with behavioral health conditions who are discharging from, or at risk of institutionalization in a state psychiatric hospital or nursing facility, and/or who need assistance with daily living in seven jurisdictions across the state. This office is collaborating across many state agencies to ensure it is meeting the behavioral health and support needs of older adults and those living with brain injury.

j) Children and youth with serious emotional disturbances or substance use disorders
The MDH-BHA Division for Primary Behavioral Health, Early Intervention (PBHEI) oversees and guides all behavioral health services provided to children, adolescents and young adults and their families. PBHEI is rendering services to children and youth with SED or SUD, and is developing a system of care for children, adolescents, young adults, and their families (covering those from early childhood up to age 25) that is meeting their needs for MH/SUD and/or co-occurring conditions. PBHEI is assuring the highest quality of care and service delivery through providing evaluation of BHA-funded networks of services for this age group, and statewide planning, development, administration, and monitoring of provider performance. PBHEI is managing several special projects with all other child serving State and local agencies and developing highly coordinated and individualized approaches to care, including:
- Helping local behavioral health authorities resolve problems in cases related to early childhood up to age 25;
- Improving service delivery approaches to population and special needs groups within the child and adolescent population by leading for Medicaid waiver demonstration projects;
- Continually improving targeted case management (or TCM/1915(i)) services expanding utilization by decreasing eligibility and accessibility service challenges;
- Expanding and implementing use of evidence-based practices for MH/SUD and shaping and improving outcomes in programs for the targeted population;
- Overseeing and supporting funding for fourteen Adolescent Clubhouses, which are statewide recovery oriented support programs for at-risk youth (ages 12 – 17, (18, if still in high school)) for SUD, or recently received or were discharged from SUD treatment.
- Clubhouses are unique, using evidence-based and promising practices to provide adolescents with screening, intervention, and recovery support services.

The recovery oriented model at clubhouses uses various SUD interventions to support recovery, including providing psychoeducation for identifying and mitigating triggers and cues linked to past substance use or misuse, and using youth driven or peer-led recovery oriented social activities to engage adolescents in healthy lifestyle choices.

Developing a portfolio of SUD screening and early intervention tools to expand the providers' behavioral health skills statewide and ensure parents and caregivers have access to resources necessary for building skills.
Identifying utilization rates, gaps in adequately-trained providers, and available resources for higher levels of SUD severity and dual-diagnosis through data exploration and stakeholder outreach.

k) Children and youth with SED and a co-occurring I/DD
By collaborating closely with the Maryland Department of Disabilities, including actively participating in interagency meetings with partners from the Developmental Disabilities Administration (DDA), MDH BHA is consistently focused on addressing the needs of youth with SED who also have a DDA-eligible diagnosis. This collaborative process includes meeting regularly and identifying and addressing the needs of youth with SED and a DDA-eligible diagnosis currently seeking or receiving services in community settings, hospitals, or emergency departments.

Through this collaboration with the DDA, the BHA is supporting efforts that are developing coordinated plans of care aimed at bridging service gaps and promoting integrated supports across historically siloed systems. Additionally, the BHA is providing expertise in response to case-specific inquiries, including equipping the public with information about services that are available through the DDA, such as through waiver programs, as well as liaising with families and care teams, connecting them with appropriate DDA contacts, all of which helps to guide families through the sometimes onerous eligibility and enrollment processes.

l) Individuals with co-occurring mental and substance use disorders
In Maryland's PBHS, services to provide treatment and care across the continuum for SUD are aligned with the 3rd Edition of the American Society for Addiction Medicine (ASAM) Criteria. For both youth and adults, the Behavioral Health Administration licenses The ASAM Criteria, 3rd Edition, levels of care. The 3rd Edition includes a dimensional assessment that incorporates addressing need for co-occurring mental health conditions, and as such, for individuals with a primary diagnosis of SUD. BHA has adopted SAMHSA's integrated care model by treating both mental health and co-occurring conditions simultaneously to ensure the whole person is being treated. One example of this is providing co-occurring treatment for individuals who are deaf, deaf-blind, or hard of hearing who are in SUD treatment center, in which services must be routed in evidence-based practice, and interpretation services that focus on life skills and vocational support. Moreover, we partner with other agencies and community organizations to reduce service fragmentation for older adults in need of co-occurring SUD and MH services, especially those living at home. Lastly, BHA is working to adopt the collaborative care approach ,aimed at improving patient outcomes, infusing team collaboration across primary care and outpatient care facilities.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

State Medicaid agencies have been required to respond to the Centers for Medicare & Medicaid Services (CMS) final rule on compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act (ACA) since 2017.

MDH has been providing analysis of compliance between the State's Medicaid and Children's Health Insurance Program's (CHIP) and the MHPAEA and Affordable Care Act annually, which has been submitted since 2018. MHPAEA requires parity in how treatment limitations and financial requirements are applied to MH/SUD benefits and medical/surgical (M/S) benefits that are provided to enrollees of Medicaid managed care organizations (MCOs), enrollees with coverage from Medicaid alternative benefit plans (ABPs), and enrollees in the CHIP. MDH's most recent analysis, submitted in October 2024, found the manner of delivery and management of MH/SUD benefits is comparable and no more stringent than the delivery and management of M/S benefits.

Please see MDH's website for the latest report: https://health.maryland.gov/mmcp/pages/mental-health-parity.aspx

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

In Maryland's PBHS, services to provide treatment and care across the continuum for SUD are aligned with the 3rd Edition of the American Society for Addiction Medicine (ASAM) Criteria.
The ASAM Criteria are the evidence-based standard of practice, in general, nationwide. In short, The Criteria provide guidance for comprehensive or multidimensional assessments of individuals for placement decisions for SUD treatment within the appropriate level of care on the continuum of care, as well as provide instruction and navigation for other services and supports to effectively care for individuals with SUD.

a. Please describe how this system differs for youth and adults.

For both youth and adults, the BHA licenses The ASAM Criteria, 3rd Edition, levels of care. The 3rd Edition includes a dimensional assessment that incorporates addressing need for co-occurring mental health conditions, and as such, for individuals with a primary diagnosis of SUD.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

N/A

c. How many IT-COD teams do you have? Please explain.

N/A

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

a) Access to behavioral health care facilitated through primary care providers
Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP):
Since 2013, BHIPP has enrolled nearly 1,900 pediatric providers who have provided 12,500 warm line consultations to pediatricians (or other primary care clinicians) in practices and emergency departments. BHIPP has had over 8,000 interventions provided by co-located social work interns, who were placed through a partnership between BHIPP and a rural university graduate school of social work, and has trained them in the principles of screening and brief interventions, as well as common behavioral health issues in children and adolescents.

BHIPP also provides specific specialized telepsychiatry consultation resources when routine consultation has been insufficient. This resource has been offered in person, in webinar-based training, and in ongoing TeleECHO model learning collaboratives, educating and informing primary care clinicians on the most common presenting behavioral health issues. The program, the Extension for Community Healthcare Outcomes (ECHO), is a "hub and spokes'' model. TeleECHO Clinics connect BHIPP consultants with community PCPs to provide didactic presentations and case-based learning through real-time online learning sessions. Participants join TeleECHO clinics from their own desktop or mobile devices using free video conferencing software. BHIPP TeleECHO Clinics improve providers' knowledge of mental health screening, evaluation, and in-office interventions, emphasizing both behavioral and pharmacological treatments. MDH/BHA funding also supports the Kennedy Krieger Institute, which also provides a TeleECHO program, focusing on supporting an array of health professionals in diagnosis, treatment, and management of developmental, emotional, and behavioral health conditions in children ages 0-8. Topics include the assessment of disorders related to anxiety, attention deficit/hyperactivity, the autism spectrum, communication, developmental delay, disruptive behavior, sleep, and trauma in children. These TeleECHOs are conducted in regions of the State with limited access to behavioral health professionals. BHIPP develops a standardized curriculum each year, designed to provide education and training for all providers serving this age group.

The Maryland Addiction Consultation Service (MACS) offers support to primary care and specialty prescribers across Maryland in the identification and treatment of SUD and chronic pain management. In the MACS program, prescribers have access to support through 1) free phone consultation, 2) training and education, and 3) assistance with resource identification for their patients. MDH BHA is continuing these services to better meet prescribers' needs to develop their practice and competency in providing office-based MOUD. MACS provides phone consultation for clinical questions, resources, and referral information. Types of questions appropriate for MACS includes initiation, maintenance, or termination of buprenorphine, diagnostic questions, alternative medication treatment, pain management clinical concerns, co-occurring disorders, and discuss technical assistance needs. MACS also offers increased training opportunities to expand the SUD workforce, as well as personalized technology transfer and technical assistance on evidence-based, comprehensive care for treatment of SUD to prescribers and clinics across the State.

Additional components in MAC include: 1) statewide outreach; 2) statewide in-office and remote technology transfer and technical assistance; 3) Project ECHO; and 4) workforce development. MACS ECHO sessions follow a collaborative model of medical education that improves access to specialty care by linking expert specialist teams with healthcare providers and their practices through real-time, online learning sessions. Knowledge-sharing networks create a learning loop where community providers learn from specialists and each other. This allows best practices to emerge and increases access to high quality specialty care serving local communities.

b) Efforts to improve behavioral health care provided by primary care providers
In July 2020, MDH BHA began implementing a pilot program providing services through a collaborative care model (CoCM). CoCM is an established evidence-based, patient-centered care model that improves behavioral health care in primary care settings. The CoCM approach is team-based, integrating and increasing the effectiveness of MH/SUD treatment and reducing stigma around these conditions as well. Primary care provider (PCP)-led teams of qualified professionals are eligible to provide and receive reimbursement for CoCM services. The CoCM pilot program expanded statewide on October 1, 2023 as a result of the 2023 legislative session (HB48/SB101, Ch. 284 of the Acts of 2023). MDH continues to monitor CoCM utilization.

Maryland Addiction Consultation Service (MACS) offers free individualized technical assistance (TA) to healthcare providers and their practices across Maryland. They have a team of expert SUD consultants who are supporting organizations to grow their office-based services for SUD. Based on the practice's goals and priorities, they set up follow-up phone, video or in-person consultations. Depending on the needs and the status of the program, these can occur once or can foster an ongoing support system. In addition to these consultations, MACS have educational resources available to support the growing practice.

Maryland Primary Care Program (MDPCP) is a voluntary program open to all qualifying Maryland primary care providers providing funding and support for the delivery of advanced primary care throughout the state. MDPCP is integrating behavioral health care within primary care offices through three potential models of care: Primary Care Behaviorist Model (PCBM), Collaborative Care

Model (CoCM), and Targeted Tactics for Behavioral Health conditions. As of August 2024, there were 511 primary care practices and 13 Federally Quality Health Centers (FQHC) participating in MDPCP statewide in 2024. All MDPCP practices report implementing strategies to integrate behavioral health care into their workflows. Eighteen percent (18%) implemented PCBM, thirty-six percent (36%) implemented CoCM, and forty percent (40%) implemented referral to a behavioral health specialist. More than 300 MDPCP Practices implemented the SBIRT protocol. MDPCP practices conducted 1,301,805 SBIRT screenings between August 2021 and March 2024.

In Maryland, the Healthy Kids Program (https://health.maryland.gov/mmcp/epsdt/pages/home.aspx) provides preventive health care services to meet the federal requirement through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Coverage is provided through Medicaid for children from birth up to age 21. To prevent health problems from becoming more medically complex and costly to treat, preventative care services identify and treat health problems early.

c) Efforts to integrate primary care into behavioral health settings
BHA's Treatment & Recovery Services Division encourages eligible providers to become Health Homes and works with Medicaid to review applications submitted by behavioral health providers for licensure as Health Homes. Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. For example, Health Homes targets populations with behavioral health care needs meeting the criteria listed above. Health Homes offer participants enhanced care coordination services from their known providers, in a community-based approach, rather than a residential program. Health Homes are designed to enhance person-centered care, empower participants to prevent or manage chronic conditions, and to improve health outcomes while reducing avoidable hospital encounters. Health Homes provide six core services, as follows: Comprehensive Care Management; Comprehensive Transitional Care; Care Coordination; Individual and Family Support; Health Promotion; and Referral to Community & Social Support.

Health Homes Programs
This program augments Maryland’s broader efforts to integrate somatic and behavioral health services by assisting participants of all ages improve overall wellness through a whole-person approach to addressing behavioral, somatic, and social needs. The Health Homes program targets adults with a diagnosis of SPMI, children with SED, or adults with SUD at higher risk for other chronic health conditions due to current or past use of alcohol, tobacco, or other non-opioid substances. Health Homes are only available to individuals enrolled in Maryland Medicaid. Participants must be enrolled with a psychiatric rehabilitation program (PRP), mobile treatment services program (MTS), or opioid treatment program (OTP) that is a MDH approved Health Home provider in order to receive Health Home services. Health Home providers connect participants and caregivers to targeted supports and services, offer health promotion and educational activities, monitor somatic and behavioral health needs, and assist with transitional care.

MDH Maryland Medicaid
MDH’s Maryland Medicaid program, in whole or in part, funds the cost of health care services for nearly 1.8 million Marylanders in FY 2023. In FY2020 nearly 225,000 Marylanders received specialty mental health services annually through the PBHS and 96% were participants in the Medicaid system. In addition, 100,000 Marylanders received publicly funded substance use disorder services and 96% were Medicaid participants. Of those receiving services under the PBHS, approximately 28% had a dual diagnosis of primary mental health and secondary substance use and 59% of PBHS recipients had a primary substance use disorder and secondary mental health diagnosis. Most of Maryland’s crisis services, which are largely grant funded at this time, have integrated mental health, substance use disorder, and co-occurring capacity. MDH began reimbursing for services rendered by certified peer recovery support specialists on June 1, 2023 for SUD. MDH is in the process of promulgating regulations to reimburse for mobile crisis services and crisis stabilization units. MDH is required by legislation to seek funding for CCBHC’s planning grant. The services available under the PBHS are those presently covered by Medicaid as well as others offered by Federal, State, and other grants that support the continuum of care.

BHA shares responsibility for the monitoring performance of all contract deliverables as the ASO administers and manages services for individuals that are Medicaid eligible as well as the eligible uninsured population, and manages services that impact both referenced populations with services that are state only or grant funded. This braided management of resources among Medicaid and non-Medicaid individuals and services creates a seamless system of care that assists individuals receiving services as they move on and off Medicaid, and across various funding streams. BHA provides key direction and management in the ASO design and building of the system to manage PBHS services and is also responsible for managing the array of behavioral health services provided across the State and at the local level.
Currently, about 85% of all Maryland Medicaid participants receive somatic health services through a Managed Care Organization (MCO), which is responsible for providing somatic care and primary behavioral health care through a risk-based, capitated payment system. Currently nine MCOs participate in the HealthChoice program. Providing managed care in Maryland requires ensuring access to services, meeting certain quality measures, collecting and analyzing encounter data, and participating in performance improvement projects as defined by MDH. Any MCO that meets the standards set by MDH can participate in HealthChoice.

The remaining 15% of participants receive their somatic care through a Fee for Service (FFS) system. Populations whose services are paid FFS include individuals who are:
-Newly eligible for Medicaid and waiting to select an MCO,
-In a spend down category,

-Over the age of 65,
-Dually eligible for Medicare and Medicaid,
-Living in institutions,
-Participating in the Employed Individuals with Disabilities program,
-Participating in the Rare and Expensive Case Management (REM) program, or
-Participating in the Model Waiver.

The PBHS provides a wide array of behavioral health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Mental health services provided by the PBHS and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. The ASO also pays for residential crisis services. SUD services include comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and American Society of Addiction Medicine (ASAM) residential SUD treatment services at the 3.7WM, 3.7, 3.5, 3.3 and 3.1 levels. The ASO also pays for information and referral, prevention, and recovery support services. BHA has provided additional funding for projects that integrate with primary care, but due to the availability of State Opioid Response (SOR)funds, block grant funds were not accessed and used elsewhere.

Screening Brief Intervention and Referral to Treatment (SBIRT), Overdose Survivors Outreach Program (OSOP) and Medications for OUD (MOUD) in Hospital Emergency Departments:

Since 2014, the State of Maryland has implemented Screening, Brief Intervention, and Referral to Treatment (an evidenced-based program) in hospital emergency departments (33) & mother-baby units (10), primary care practices (almost 500), OBGYN ambulatory practices (37) and several other settings. As this work progressed, two other programs were added to the SBIRT model. This includes both the Opioid Survivors Outreach Program and the Hospital Based Buprenorphine Program. Together, these three programs (SBIRT, OSOP, and HBBI) have been known as the 'Reverse the Cycle Program' and represent a comprehensive approach in Maryland's efforts to address the current opioid crisis.
RTC is a comprehensive hospital substance use response program with three vital components:
1) Universal screening + peer intervention
2) Outreach for patients with high risk of overdose and/or readmission
3) Initiation of medications for opioid use disorder
One of the current providers has served hospital emergency departments with consultation, training, policy and medical protocol development, workflow, and electronic health record modification(s) to implement SBIRT, OSOP, and changes regarding the manner in which MOUD is started with patients who present with OUD in their emergency department. This includes development of protocols to support a new medical order set for prescriptions and home induction.

Maryland Addiction Consultation Service (MACS):
Maryland continues to support the availability and utilization of effective treatment options for OUD, such as buprenorphine. MDH funds the Maryland Addiction Consultation Service (MACS) to increase treatment rates with buprenorphine by providing training and consultation to medical providers. Through a substance use warmline, MACS offers real-time guidance to prescribers treating complex cases of OUD, in alignment with the enactment of The MAT and MATE Acts in 2022. Over 3,000 providers have enrolled in the program, which includes outreach, training, newsletters, and partnership-building with pharmacies. The project helps fill gaps in care by supporting providers to treat higher risk patients, for example, from closed pain management practices, and by offering training on issues like drug-related wound care. MACS also works to increase access to treatment through telemedicine, and to reduce stigma. MACS is a scalable strategy to increase access to high-quality OUD treatment across Maryland.

Hub and Spoke:
The HUB and SPOKE program aims to maintain continuous patient care for individuals with Opioid Use Disorder (OUD). This is achieved by enabling transfers between community-based prescribers (Spokes) or institutional facilities initiating MOUD treatment, and higher-level SUD treatment programs (Hubs). The Hub and Spoke program currently includes six participating jurisdictions: Anne Arundel, Baltimore County, Calvert County, Howard County, and St. Mary's County.

OUD MEETS (Opioid Use Disorder Medical Patient Engagement, Enrollment in treatment and Transitional Support Program) People with a history of OUD often require acute medical hospitalization stays for serious medical complications related to their opioid use disorder. Those who inject substances or have a history of intravenous drug use (IVDU) have higher risk of medical complications, including osteomyelitis, endocarditis, soft tissue infections, and abscesses. Hospitalization stays are an opportunity to engage patients in effective treatment for OUD. The OUD MEETS program aims to overcome the administrative and logistical challenges to initiating, titrating, and continuing effective OUD treatment and patient engagement in the hospital setting, and in the transition from acute to subacute settings. Skilled nursing facilities can also participate and their teams can access additional training on the treatment of OUD. OUD MEETS was implemented in collaboration with Behavioral Health Systems Baltimore, two different academic hospitals, three partnering OTPs, and six SNFs, which paved the way for the program's expansion into Anne Arundel County.

d) How the state provides integrated treatment for individuals with co-occurring disorders
The State addresses integrated treatment for individuals with co-occurring disorders (mental health and substance use disorders)

through comprehensive assessments, integrated treatment planning, utilizing evidence-based and best practice interventions, and relapse prevention, peer and family involvement, continuity of care and monitoring, and community based supports. The Treatment and Recovery Services Division, Office of Treatment services aims to support these efforts utilizing block grant funding for behavioral health initiatives such as, behavioral health system access and coordination, where local health departments serve as a central access point in the provision of case management and referral services; street outreach services to be a bridge to engage and connect people who use drugs and/or may be experiencing a mental health crisis to services in the community; embedding individuals in the courts to provide behavioral health assessments to individuals forensically involved; provide community case management to individuals who have been referred in the jurisdiction to individuals in need of referrals to ancillary linkages, i.e., entitlements, medication management, and/or other recovery services that aim to support improved physical, emotional, and cognitive functioning to reach and maintain abstinence; providing intensive case management and care coordination services to individuals utilizing hospital emergency departments (EDs) for mental health and substance related emergencies; and providing services to special populations, such as the deaf, deaf-blind, hard of hearing, late-deafened, and limited English proficient to facilitate or make provisions for language interpretation (deaf and Non-English) speaking.

Evidence Based Practice (EBP) - Assertive Community Treatment teams provided integrated services for individuals who have co-occurring disorders by staffing teams with substance abuse specialist, peer support specialist, vocational specialist, nurses, social workers and psychiatrists. Two residential rehabilitation providers use EBP Integrated dual disorder Treatment (IDDT) principles while serving individuals in a residential setting.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

a) Adults with serious mental illness
The Adult Targeted Case Management Program (TCM) improves the overall quality of life and promotes long-term recovery among eligible adults and older adults with SMI and that meet medical necessity criteria (MNC) outlined by the Administrative Service Organization (ASO). Adult TCM is a FFS rather than block grant funded program assisting participants to access a full range of available mental health services, and any needed counseling, educational, financial, housing, social, somatic, and other supportive services to maintain well-being in the community.

Adult TCM enhances participants' mental wellness and integration into the community with access to needed resources for moving forward in their recovery and that help them achieve their individual goals. The primary aim of Adult TCM services is prevention of homelessness and incarceration, care of individuals from unnecessary inpatient emergency department (ED) use and institutional levels of care, and enhancing community well-being and stability. Adult TCM has two levels of intensity that depend on participants' needs; both levels are based on severity of participants' mental illness.

For uninsured eligible adults, individuals are provided with assistance to apply for Medicaid benefits and entitlements for which they may be eligible, including but not limited to Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Outreach, Access, and Recovery (SOAR), Supplemental Nutrition Assistance Program (SNAP), and Temporary Cash Assistance (TCA).

BHA is also funding programs for Rural Psychiatric Mental Health Services and Emergency Department Care Coordination.

The Rural Psychiatric Mental Health Services program supports access in the State's rural areas for individuals to Outpatient Mental Health Centers (OMHC), coordinating linkages to care for adults diagnosed with SMI or co-occurring mental illness and SUD. OMHC provides Care Coordination between community providers, stakeholders, individuals, family members, and behavioral health care advocates. OMHC's key services include coordinating legal engagement with authorized court officials, assistance with navigating entitlement services, travel for delivering services offsite - when individuals are unable to access onsite crisis services, providing travel to participate in training, and referrals to behavioral health care community supports and services. These are essential services that are not reimbursable by health care insurers, and are vital for effective treatment.

Emergency Department Care Coordination provides intensive case management and care coordination services to hospital Emergency Departments (ED) to integrate community and home-based behavioral health care coordination services into the Hospital Health System. This program facilitates patients' self-care, encourages appropriate use of behavioral health care services, and reduces high-utilizers' visits to the ED in the context of the health care and substance use crises.

A Case Manager that provides patient engagement is embedded at the local hospital ED and at the Health Department. After a patient is enrolled and subsequently discharged from the ED, program staff conduct follow-up visits to the participants' homes, in the community, or at the Health Department for 60-90 days after the ED visit of individuals with a behavioral health crisis. Providing services in a community setting reduces challenges to accessing care, connects individuals to appropriate community behavioral health care, coordinates care, and provides recovery support resources. In FY 2024, the recidivism rate for the program was 11% for individuals referred to EDCC for behavioral health care needs, and were referred again within six months for behavioral health care needs.

b) Adults with substance use disorders
The BHA supports the provision of State Care coordination (SCC) to Local Behavioral Health Authorities (LBHAs) and Local Addiction Authorities (LAAs) in Maryland's 23 jurisdictions and Baltimore City. SCC is a care coordination/case management program that aims to expand access to a comprehensive array of community-based behavioral health services and faith-based community services for Maryland residents who are in early stages of recovery from a SUD or a co-occurring MH/SUD. This program coordinates care for adults and older adults transitioning to or stepping down treatment levels or recovery support services within the community. Transitions occur from various settings, including American Society of Addiction Medicine (ASAM) outpatient or residential levels of care (1, 2.1, 2.5-partial hospitalization program (PHP), 3.1, 3.3, 3.5, 3.7, 3.7wm - withdrawal management), incarceration, and homelessness.

The BHA supports a referral and care coordination program, or the Behavioral Health System Access and Coordination (BHSAC), for individuals with SUD, a MH disorder, or co-occurring MH/SUD. BHSAC provides case management and referral services through a referral hotline. Adults and older adults who call the behavioral health treatment and referral line receive screenings and/or assessments, referrals, and short-term (7 days or less) of case management. BHSAC ensures individuals making their first treatment appointment are referred to appropriate behavioral health care services and supports.

c) Children and youth with serious emotional disturbances or substance use disorders
Through various funding sources including State General Funds, SOR grants, or the SUPTRS Block Grant, several programs to address children and youth with SUD:

-Adolescent Clubhouses (ACHs) are located in the DC Metro Area, Central, and Southern Maryland. The BHA provides funding for and oversees for fourteen (14) ACHs. The ACH is a recovery-oriented, nonclinical, prevention-based program that provides sobriety and recovery support, and continuing care for youth ages 12-17 (or up to 18 if still in high school). The ACH's criteria for admission are focused on youth currently at risk of SUD, or who have recently received treatment for, or were discharged from, treatment for SUD, including for stimulant and opioid use. The clubhouses are vehicles for referring youth who may need but are not presently in SUD treatment. Each clubhouse uses an evidence-based assessment of youth for appropriateness at the time of intake/admission. ACHs integrate other evidence-based practices into daily programming and curriculum and utilize both family peers and young adult peer recovery support specialists (YAPRSS).Teen Intervene is located on the Eastern Shore and the initiative is a recovery-oriented, evidence-based, prevention program that focuses on the early detection and intervention of SUD, using EBP interventions for adolescents aged 12-19 diagnosed with mild to moderate SUD.

-Teen Intervene is a brief intervention administered in four one-hour, one-on-one sessions, using a combination of screening, Cognitive-Behavioral Therapy (CBT), and Motivational Interviewing (MI) to further adolescents along in the Stages of Change model (precontemplation; contemplation; preparation; action; and maintenance). These individualized sessions address the specific needs of the adolescents, focusing on positive behavior change, and ultimately, promote abstinence from substance use. The program helps adolescents understand their motivations for substance use, to evaluate the pros and cons of substance use behaviors, to learn skills to develop healthier habits, and to take responsibility for individual behavior change. Program outcomes reduce or eliminate substance use, improve academic performance, decrease inpatient hospitalizations for behavioral health issues, and decrease engagement with the legal system.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The state supports the provision of integrated services for individuals with co-occurring mental health and substance use disorders through Behavioral Health Integration Activities that include but are not limited to:

-Improving services for individuals with co-occurring conditions;
-Creating a system of care ensuring a "no wrong door" experience;
-Expanding access to appropriate and quality behavioral health services;
-Enhancing cooperation and engagement;
-Capturing and analyzing outcomes and other relevant measures for determining behavioral health provider and program effectiveness;
-Expanding public health initiatives, and
-Reduce costs of care through prevention, utilization of evidence-based practices, and preventing use of unnecessary or duplicative services.

University of Maryland Evidence Based Practice Center (EBPC)

BHA partners with the University of Maryland Evidence-Based Practice Center (EBPC) to encourage providers to integrate care through various activities, including providing training and consultation on evidence-based and promising practices and ensuring fidelity in adherence for obtaining expected outcomes. This partnership provides on-site EBPC training and consultation, training and consultation for SUD Specialists Team Leaders, and Assertive Community Treatment (ACT) teams to enhance teams' Dual-Diagnosis Capability (DDC) in collaboration with the ACT Consultant/Trainer. Additionally, intensive training and consultation is provided for agencies requesting assistance in implementing practice change, which promotes agency-wide Dual Diagnosis Capability (DDC). This includes providing training on empirically supported tools that help agencies self-assess DDC and plan for identified DDC gaps, and monitor and implement fidelity using empirically supported tools. Behavioral health care providers can also access training for using scientifically validated screening and assessment instruments supported by state regulations that require screening and assessment for co-occurring disorders. Alongside, the delivery of a series of cross-training sessions with MH/SUD professionals addresses integrated treatment principles and practices.

The Maryland Community Criminal Justice Treatment Program (MCCJTP) is active in 22 out of 24 jurisdictions. MCCJTPhas a critical role supporting local correctional facilities to meet behavioral health care needs of justice-involved individuals. The BHA collaborates with LBHAs and CSAs, overseeing delivery of evidence-based clinical treatment and case management services. This ensures continuity of care while an individual is incarcerated, and after they are released and are at high-risk. MCCJTP is a collaborative, multidisciplinary program including behavioral health care providers, legal service agencies, and local correctional facility staff. This program also facilitates stakeholder input from the judiciary, parole and probation, law enforcement, social services, consumer advocate, and community to ensure care is responsive to local needs, person-centered, and trauma-informed.

Integrated Regulations for Licensing and Accreditation. The BHA Office of Licensing and Compliance licenses community-based providers who treat MH/SUD and co-occurring diagnoses. MDH moved to accreditation-based licensure for behavioral health providers in accordance with authorizing legislation in 2016 that required all community-based behavioral health care providers to obtain accreditation (by an MDH-approved accreditation organization (AOs)) and to be licensed under COMAR 10.63. The Office of Licensing is working closely with the Office of Compliance and MDH-approved AOs accrediting community-based agencies as a prerequisite to applications for licensure. The Office gathers and maintains on data accreditation-based licensing, and provides licensing process technical assistance to providers and other stakeholders.

Behavioral Health Integration Project - Local Systems Management Integration Plan. MDH is strategically integrating behavioral health care, including administrative functions, funding streams, and local systems management. BHA developed the Local Systems Management Integration Plan that builds on an experiential analysis from all 24 state jurisdictions, in addition to financial data indicating systems management was an opportunity to increase value. While most local jurisdictions have established a LBHA, all jurisdictions continue on their integration journey. Integration must address differences leadership, budgeting, operations, workforce development, relationships, and communication approaches. The BHI Learning Community addresses various topics established by the BHI Steering Committee, and one outcome from this Learning Community is a Systems Manager Procedural Manual distributed throughout the BHA.

Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). Maryland continues efforts to address the gap between the need for and availability of child behavioral health services. Factors contributing to this gap include a lack of trained specialists, workforce shortages, particularly in rural settings, and/or provider capacity issues.

BHA's PBHEI team has collaborated with University of Maryland School of Medicine, the Johns Hopkins School of Public Health, and Salisbury University implementing the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). This is a free service available to all pediatric primary care providers that aims to expand their capacity to identify, refer, and/or treat child and adolescent MH problems, which offers services such as:

-Telephone consultation with PCPs for advice from child and adolescent MH specialists, including psychiatrists, psychologists, and clinical social workers at the University of Maryland and Johns Hopkins. Topics include MH screening, resource, and referral, and diagnosis and treatment, and psychologists and clinical social workers at the University of Maryland and Johns Hopkins.
-Opportunities for continuing education for PCPs and their staff for developing and enhancing knowledge of MH and skills to

address MH.
-Assistance with local referral and resources to link families to MH services in their community.
-In partnership with Salisbury University Department of Social Work, co-location of graduate-level social work students in PCP's practices for providing on-site MH consultation.

Maryland's Health Home model coordinates care for individuals with SMI and children with SED who also meet medical necessity criteria for services from Psychiatric Rehabilitation Programs (PRP) or Mobile Treatment (MT); it also provides individuals with OUD in methadone treatment at risk for other chronic conditions due to current alcohol, tobacco, or other substance use. Health Home services also incorporate comprehensive care management, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support. Ongoing activities support provider training, stakeholder education, and several forms of health information technology aid Health Homes to better serve participants at no or minimal cost to providers, including real-time hospital encounter alerts and pharmacy use data from the state prescription drug monitoring program, or the Chesapeake Regional Information System for our Patients (CRISP). In addition, an eMedicaid online portal is a mechanism for enrollment, reporting, and tracking. Currently, Maryland has 144 Health Home sites, with approximately 13,000 active participants.

MDH is fostering regular collaboration with the ASO and MCOs, and makes available behavioral health care educational materials for somatic care providers, which include information on appropriate screening tools for identifying individuals in need of behavioral health care services above what a PCP can provide or who need to be linked with behavioral health care services, such at SBIRT.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

N/A

8. Please indicate areas of **technical assistance needs** related to this section.

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Supported Employment	3.00
Family Psychoeducation	3.00
Coordinated Specialty Care	3.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,771,077.00	1,771,077.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Medicaid is the primary funding source for Supported Employment, Family Psychoeducation, Individual Therapeutic Services, Pharmacotherapy, and Case Management. Other insurances are used on a case-by-case basis (based on individuals having both Medicaid and private insurance). Positions staffed for this model are currently funded by Mental Health Block Grant Funding.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Maryland Early Intervention Program (MEIP) is designed to provide community-based, recovery-oriented, individualized services to young people who are within the first one to two years of developing psychosis and schizophrenia. The program is an evidence-based team intervention that can promote engagement and adherence to treatment, foster recovery, and reduce or prevent disability among individuals experiencing a first episode of psychosis. The award amount per year: $1,844,990.00.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Maryland developed an integrated outcome system for state-funded First Episode Psychosis (FEP) efforts. This information system was designed to compare domains and areas of interest across Maryland's FEP outcome reporting systems. The domains and areas of interest were identified by evaluating reporting items across several sources, FEP Outcome System, the MEIP Clinical System, and the MEIP Research System. A brief description of each data source can be found below:

BHA/University of Maryland Systems Evaluation Center (SEC) FEP Outcomes System: Maryland has implemented an outcomes system for its state-funded First Episode Psychosis (FEP) efforts. The system was developed through collaboration with SEC and the teams funded by the set-aside. The system design drew from a variety of sources, including outcome efforts within and outside of Maryland. It also includes information related to the Conditions of Award for the funded teams. Each team submits data every quarter. Data elements include employment, education, substance use, somatic issues, homelessness, legal issues, services provided, client demographics, and other areas. The data is then aggregated and analyzed by the SEC by team and for all sites combined. The FEP Leadership Team meets to review the results and discuss implications at the state and team level. As needed, BHA follows up with each team to clarify data, celebrate successes, or address potential challenges reflected in the data. The data is also used to inform BHA-generated reports to SAMHSA. Thus far, the EPINET grant has benefited Maryland by allowing the state and sites to expand the data available to them, thereby promoting the implementation of high-quality FEP services. BHA and SEC continue to coordinate with the EPINET research team to coordinate data submissions for these teams to continue to streamline data collection and reduce the reporting burden.

MEIP Clinical System: Created by the Maryland Early Intervention Program (MEIP) for Set Aside clinics to collect outcomes data for all individuals receiving FEP clinical services funded by the Set Aside. These data include identifiers and are entered into a HIPAA compliant system.

MEIP Research System: Created by the Maryland Early Intervention Program (MEIP) to collect research data for individuals who have completed informed consent and enrolled in the study. It includes additional assessments, as well as elements collected via chart review. Chart review includes review of clinics' Electronic Health Records (EHRs) and paper medical records, as well as extracting information from the MEIP Clinical System for individuals enrolled in the study. Maryland continues its partnership with Early Psychosis Intervention Network (EPINET). EPINET is an initiative that aims to create a national network among treatment centers that offer evidence-based specialty care to persons experiencing subthreshold psychotic symptoms or a first episode of psychosis. EPINET will link clinical sites through common data elements, data sharing agreements, and a unified informatics approach for aggregating and analyzing pooled data. EPINET provides for systematic analyses of participant-level data among treatment centers that offer evidence-based specialty care to persons experiencing subthreshold psychotic symptoms or a first episode of psychosis. Systematic analyses of participant-level data collected in EPINET will help inform methods for achieving quality, safety, and value in early psychosis care and will accelerate research into psychosis risk factors, biomarkers of psychosis risk and onset, and pre-emptive interventions.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

In FY2025, the state increased fidelity training/consultation services to support the CSC programs by attending treatment team meetings and providing support. A fidelity tool was successfully piloted for the state to use across CSC programs in the state.

Family Psychoeducation training and consultation were provided by the University of Maryland by their Evidence-Based Practice Trainers to all CSC teams to support the increase of CSC's clients and family members. Lastly, our FEP Coordinators conducted fidelity for Supported Employment and Education Services to our CSC teams and continued to conduct and structure data workbooks that our CSC teams submit for quarterly reporting.

In FY2026 and FY2027, based on the findings/outcomes from the FY2024 CSC Fidelity Pilot and ongoing modifications to the tool in FY2025, BHA is using the fidelity tool to review and monitor CSC programs every two years. The CSC teams will work with the CSC Trainer and Consultant, the Family Psychoeducation Trainer and Consultant, along with the Supported Employment Trainer and Consultant, to complete any recommendations from their fidelity action plans, which prepare them to effectively provide services to the population being served, including their families.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

-Schizophrenia: 295.9 (F20.9)
-Schizoaffective D/O Bipolar Type: 295.7 (F25.0)
-Schizoaffective D/O Depressive Type: 295.7 (F25.1)
-Schizoaffective Disorder - Unspecified: 295.70 (F25.9)
-Schizophreniform D/O: 295.4 (F20.81)
-Delusional D/O: 297.1 (F22)
-Brief, Brief Psychotic Disorder: 298.8 (F23)
-Other specified schizophrenia spectrum and other psychotic disorder: 298.8 (F28)
-Unspecified schizophrenia spectrum and other psychotic disorder: 298.9 (F29)
-Major Depressive Disorder with Psychotic Features (single episode or recurrent): 296.34, 296.24 (F32.3, F33.3)
-BPD, Bipolar Disorder with Psychotic Features: 296.54, 296.44 (F31.5, F31.2)
-Substance-induced psychotic disorder
-Other non-affective psychoses

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

There is an incidence of approximately 260 new cases of first episode psychosis per year (FY24 and 25) in Maryland.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

The state requires each FEP provider to conduct a minimum of 13 outreach events per year to provide awareness and build relationships with programs for potential clients who experience first episode psychosis. Outreach is done with community behavioral professionals, community mental health partners, state stakeholders and advocacy groups, public schools, state universities to include HBCUs, hospitals, and treatment centers.

Maryland Early Intervention Program (MEIP) has a Centralized Line designated to assist the public with guidance on FEP treatment. When a client is enrolled in one of the FEP programs, they are referred to each discipline in order to help the client obtain structure and understanding of their diagnosis and treatment. We have also provided our 988 Team with an overview of ESMI and the current resources in the state. We hope to continue this collaboration and provide relevant training.
Below are as follows:

1) Supported Employment and Education Specialists are advocates for their clients in the work field. They help clients in identifying what kind of job interests, conduct mock interviews, and provide support on the job training.

2) Family Psychoeducation is a therapeutic approach where practitioners partner with consumers and their family members to treat serious mental illness. Family Psychoeducation includes a lot of working elements and focuses on the illness as the purpose of treatment, as opposed to family therapy.

3) Certified Peer Recovery Specialists, with unique lived experience, offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people.

12. Please indicate area of technical assistance needs related to this section.

It would be helpful to receive technical assistance that increases FEP clinicians' understanding of the differential diagnosis for autism and psychosis. In addition, it would be helpful to receive training on available resources on autism in schools, for effective client advocacy.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

Not applicable.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

To improve engagement of people with SMI and their caregivers in health care decisions, the University of Maryland Evidence-Based Practice Center (EBPC) trains and consults with providers on person-centered planning (PCP). PCP is an approach to treatment planning that increases consumer and caregiver engagement in health care decisions by explicitly connecting planned service interventions to consumer goals. First, EBPC Consultant/Trainers incorporated PCP practices and guiding principles into all EBPs for which they provided support (i.e., Assertive Community Treatment, Co-Occurring Disorders Treatment, Evidence-Based Supported Employment, Transition Age Youth Services). In and after FY19, the EBPC has added a new State-funded Consultant/Trainer position that included a focus on PCP for providers in Mobile Treatment Programs, Psychiatric Rehabilitation Programs (PRPs), and Residential Rehabilitation Programs (RRPs). Some products of the EBPC efforts to support PCP implementation throughout Maryland include:

The development of a plan for PCP implementation and maintenance throughout the state that sets annual goals and priorities per BHA guidance.

In addition to the provider and/or program type specific training, all providers are able to attend training in the core concepts of PCP - spirit and engagement, assessments, components of treatment planning, and using plans to foster more active work on goals. Providers are also offered applied learning activities including a series of case studies where participants use assessments to practice writing interpretive summaries and treatment plans for individuals with commonly seen diagnoses, presentations, co-occurring concerns, and environmental stressors. Monthly Technical Assistance sessions are also available for providers to ask questions and problem-solve challenging situations including engaging people in PCP. The development and delivery of trainings on using functional assessment data in conjunction with person-centered assessment practices to drive treatment planning and interventions for:

PRP outpatient (Supported Living) programs - developed and delivered training for use with agencies identified for technical assistance and for larger audiences that include training participants from multiple agencies and/or specializations.

RRP - developed training for use with agencies identified for technical assistance and for larger audiences with multiple agencies; and delivered training at agencies identified by BHA and by data reviews as needing technical assistance with assessing needs and delivering more effective progress-oriented interventions.

Assertive Community Treatment (ACT) - developed training in collaboration with the state's ACT trainer to improve implementation of PCP on ACT teams focusing on the incorporation of empirically supported interventions by interdisciplinary providers.

Provider Leadership - developed and delivered training for supervisors and leadership at agencies to increase PCP implementation by supporting leadership's delivery of feedback on PCP documentation and using person-centered practices to guide clinical or practice-oriented supervision of interventions.

System-wide needs - Each year, feedback from BHA and the Fidelity Monitoring Team (FMT) and colleagues at the EBPC is incorporated into training plans for enhancing person-centered assessment skills at a variety of provider types. The training developed has continued to be refined and rolled out statewide. Examples for this year include the development and piloting of training on Person Centered Approaches to Crisis Planning developed for RRP and ACT audiences and rolling out to providers statewide by the end of 2023.

The drafting of a Needs Assessment Survey for programs that have completed initial PCP training offered in years prior to the creation of the PCP Trainer-Consultant position. The Trainer-Consultant has submitted this plan for feedback to collaborators at the Systems Evaluation Center (SEC) at the University of Maryland, School of Medicine (UMSOM). Then with BHA approval, the Trainer-Consultant plans to roll out the plan and collect data. Initial data-gathering from training evaluation response data was analyzed this year and will inform the larger roll out of Needs Assessment Survey. PRP providers are required to complete an individualized rehabilitation plan (IRP) according to the requirements of COMAR 10.63.03.09 and COMAR 10.63.03.10. Documented active planning for the transition of the participant to a less intensive level of care is required. Once the participant has met all identified IRP goals and can no longer benefit from PRP services, the participant should be stepped down with the appropriate linkage to community-based resources, such as ongoing outpatient treatment, to maintain independence and support continued stay in the community.

The current ASO, Carelon, ensures all case management staff are trained on PCP and it has been integrated into the onboarding for new case management employees. Carelon’s clinical staff in collaboration with Provider Relations offer Technical Assistance support to providers with multiple denials for failure to meet MNC.

BHA contracts with the Mental Health Association of Maryland to implement the Consumer Quality Teams (CQT). CQT, which is staffed entirely by behavioral health consumers and family members, empowers individuals who receive services to become partners with providers, policy makers, and family members to improve the quality of care in the public behavioral health system. These teams conduct site visits with Maryland's public behavioral health service providers to interview consumers about their experiences with the service they receive. Feedback from the interviews is summarized and shared with the provider, local behavioral health authorities, and BHA. The provider reports that are produced, summarize both positive provider and service experiences as well as, concerns, and recommendations for improvements. The CQT Team also produces aggregate reports by provider type. Summarized findings are presented to a review team at BHA on a monthly basis where the findings are reviewed and recommendations for potential program improvements are developed.

4. Describe the person-centered planning process in your state.

Person-Centered Care Planning (PCCP) is a holistic approach to planning and providing behavioral health services. Person-centered approaches guide and organize services to increase consumer engagement in service interventions based on the connections between provider interventions and the consumer’s goals and visions. Consumers and the people important to them (often their caregivers) are the central members of the team responsible for planning and developing a person-centered plan (PCP). They are provided options for directing and managing the planning process. The family, friends, neighbors, professionals, and others important to the person can be invited to coordinate on treatment planning based on the person's preferences. Planning can take place at individuals' homes, jobs, community sites, day programs, or wherever he/she feels most comfortable reviewing and discussing his/her plan.

To ensure effective planning, providers share information about the options for services and supports available and provide progress updates on what is working for the individual. During the PCCP process, individuals can use a variety of tools and activities to explore and clarify their vision, their goals, their strengths and resources, and their understanding of barriers to achieving their goals. These tools and activities may include explorations of their values and priorities using Values Card Sorts, activities exploring their personal and community roles, explorations of their current and desired personal support networks, and assessment and reflection activities specific to a goal e.g., analyses of work history, strengths, and opportunities for growth for those with vocational goals.

As part of the process of developing a PCP, the person coordinating the PCP works with the individual participating in services to gather information regarding their goals, needs, preferences, health status, risk factors, etc. Together they review health,developmental, communication, and behavioral assessments conducted. This information and choices of available services are shared with individuals receiving services and the important people in their lives with the goal of developing a shared understanding of the person's goals and what the person is doing to work on their goals. To ensure clinical and support services reflect their personal preferences, strengths and needs, the individual is encouraged to consider what is important to him or her related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and other activities. This provides the individual with opportunities to seek employment and work in competitive integrated settings, to engage in the community comparable to individuals who do not receive Medicaid.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

The MDH website promotes the use of Psychiatric Advance Directives (PADs) forms and provides guidance for professionals and the general public. In 2023, the Person-Centered Approaches to Crisis Planning training was launched statewide. This training includes information on the development of PADs, incorporation of PADs in Crisis Planning and the development and implementation of Individual Recovery Plans, and differentiating between crisis planning as a recovery oriented intervention and PADs as legal documentation of consumers preferences, consents and appointments of health care agents as applicable. It also offers resources to assist consumers and providers with making PADs accessible.

6. Please indicate areas of technical assistance needs related to this section.

None requested.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The BHA uses two methods to pay for services under contracts with MHBG and SUPTRS subrecipients: cost reimbursement and grant awards with quarterly reconciliation. The funding agreement between BHA and the local behavioral health authorities includes the amount of Federal funds and the Catalog of Federal Domestic Assistance (CFDA) number (93.958). Prohibited MHBG/SUPTRS expenditures are also noted in the federal funding agreement between BHA and the local behavioral health authorities. The allocation of funds to the local behavioral health authorities are exempt from the Maryland procurement statutes and are awarded on a noncompetitive basis. In a separate administrative agreement between BHA and the local authorities, all applicable State and Federal terms and conditions are included in the document or attachments. This administrative agreement acts as an umbrella agreement for all agreements.

4. Please indicate areas of technical assistance needs related to this section.

None requested.

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Maryland's Public Behavioral Health System provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. The ASO also pays for residential crisis services. SUD coverage includes a comprehensive or multidimensional assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient treatment, and clinically and medically-managed high and low intensity residential SUD treatment (levels 3.7WM, 3.7, 3.5, 3.3 and 3.1 in The ASAM Criteria 3rd Edition, and levels 4, 3.7, 3.5, and 3.1 in The ASAM Criteria, 4th Edition). The ASO also pays for information and referral, prevention, and recovery support services.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational services	(●) Yes ( ) No
g)	Substance use prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Recovery Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The need for improved coordination and behavioral health integration in Maryland was recognized as early as 2010 and efforts to build on the existing strengths of the PBHS were implemented as a result of the 2011 Joint Chairmen's Report of the Maryland General Assembly. MDH convened multiple workgroups and stakeholder forums resulting in recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance use disorders." In addition, MDH began to move toward using national accreditation standards rather than state-specific regulations for provider qualifications.

The goal of integration is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:
-Improve services for individuals with co-occurring conditions;
-Create a system of care that ensures a "no wrong door" experience;
-Expand access to appropriate and quality behavioral health services;
-Enhance cooperation and engagement;
-Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
-Expand public health initiatives, and
-Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

BHA works in partnership with the University of Maryland Evidence Based Practice Center (EBPC) to encourage providers to become co-occurring capable. The EBPC supports the Maryland BHA through various activities, including: Provides training/consultation on evidence-based and evidence-supported practices, in order to ensure adherence to fidelity (faithfulness to the EBP model) so expected outcomes are obtained.

Following BHA's approval of a program to receive EBPC implementation efforts, on-site EBPC training/consultation are provided. When fully trained, a program receives a fidelity assessment by BHA Fidelity Monitors; trainers then develop Fidelity Action Plans (FAPs) in concert with the program which serves as a template for continued training/consultation activities, thus ensuring subsequent consultation addresses areas needing improvement. FAPS are shared with BHA and used during fidelity assessments.

3. Describe your state's case management services

Targeted Case Management (TCM) in Maryland serves individuals with severe mental illness, both with Medical Assistance (MA) and those who lack insurance. In Maryland there are nearly 30 programs serving over 2500 adults annually. Separate TCM programs exist for children under the age of 18. BHA facilitates the Request for Proposal (RFP) process that is required every five years for the Core Service Agency/Local Behavioral Health Authority (CSA/LBHA) to procure TCM programs. For consumers with federal Medicaid, requests for service are submitted directly to the Administrative Service Organization (ASO). Requests for consumers who are uninsured (Medicare, State MA, etc.) are submitted to the CSA/LBHA for review, and then forwarded to BHA for approval.

The BHA supports the provision of State Care coordination (SCC) to Local Behavioral Health Authorities (LBHAs) and Local Addiction Authorities (LAAs) in Maryland's 23 jurisdictions and Baltimore City. SCC is a care coordination/case management program that aims to expand access to a comprehensive array of community-based behavioral health services and faith-based community services for Maryland residents who are in early stages of recovery from a SUD or a co-occurring MH/SUD. This program coordinates care for adults and older adults transitioning to or stepping down treatment levels or recovery support services within the community. Transitions occur from various settings, including American Society of Addiction Medicine (ASAM) outpatient or residential levels of care (1, 2.1, 2.5-partial hospitalization program (PHP), 3.1, 3.3, 3.5, 3.7, 3.7wm - withdrawal management), incarceration, and homelessness.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Maryland is focused on building a continuum of crisis response services across the state (as summarized in Environmental Factors #9 Crisis Services). The goal of these services is to help people in the moment wherever they are and to prevent hospital visits for behavioral health needs.

Maryland is building a continuum of crisis services to ensure all Marylanders have Someone to Call, Someone to Respond, and a Safe Place to Go - and once stabilized, warm handoffs are made to ongoing treatment. Maryland has continued to build up the 988 Suicide & Crisis Lifeline, which received 125,000 contacts in calendar year 2024. In SFY26, an additional text/chat center is being added to meet increased demand. BHA is working with jurisdictions and providers to expand access to mobile crisis response and stabilization services. Mobile Crisis Team regulations became effective May 27, 2024, which seek to improve the quality and access to mobile crisis services. As of August 2025, there are 8 mobile crisis team providers licensed across 19 jurisdictions which provide 24/7 services. BHA is continuing to work with providers in the remaining 5 jurisdictions. These crisis services are designed to serve individuals in the community and prevent hospital visits and inpatient care.

Once individuals are in the hospital (emergency department or inpatient care), there are several initiatives underway to transition them to other clinically appropriate levels of care. For example, the 211 press 4 service is a single point of entry for hospital emergency department staff to obtain care coordination services for their most complex behavioral health patients to connect them to other levels of care. Another example is the continuation of the Brook Lane Hospital program, which has been funded by the Bipartisan Safer Communities Act Block Grant. This program provides seven beds for high-intensity complex youth between the ages of 8-17 and serves as a step-down from the hospital environment while waiting for placement.

Maryland also has a Behavioral Health Hospital Coordination Dashboard, which includes inpatient psychiatric beds that are updated three times/day to help hospital discharge planners locate available beds. We are in the process of procuring a software vendor to develop a Bed Registry and Referral IT System that will include a provider directory, real-time information on available

services, and an electronic referral system to streamline transitions of care and reduce hospital stays.

Additionally, BHA staff work closely with other State Agencies to discuss complex cases, identify system challenges and solutions, and provide technical assistance to providers working with complex patients to transition them to clinically appropriate levels of care.

BHA Treatment and Recovery Division, along with Post-Acute Care, conducts weekly consultation calls with the five psychiatric hospitals to address clients' discharges and mitigate challenges. Social workers highlight challenges and process successful discharge, as well as in real-time connect with the Local Behavioral Health Agencies to see if any documents or steps are missing. Clients are helped to be placed in all levels of care during this call, from independent housing, ACT services, Residential Rehabilitation Services, and long-term care such as Nursing facilities and Assisted Living Facilities. BHA staff works closely with the assigned social worker to ensure the client discharged to a state hospital initiative is given all wrap-around services before discharge and to reduce re-admission. Under the state hospital discharge initiative, Benefit Case Managers are assigned to each state hospital to ensure entitlements for clients are activated before discharge. This initiative helps clients receive all public behavioral health services once in the community and ensures the clients can visit a provider for both somatic and psychiatric needs once discharged. Other state hospital discharge initiatives include Permanent Support Housing, an initiative aimed at transitioning clients from Residential Rehabilitation services to independent housing and ensuring throughput in the community. Additionally, the Assisted Living facility Initiative helps clients with high somatic needs transition into long-term care. BHA partners with many Local Behavioral Health Agencies in the community for state hospital discharge initiatives to help mitigate issues once the clients have transitioned and to help lower re-admission rates for the psychiatric hospitals.

5. Please indicate areas of technical assistance needs related to this section.

Technical assistance that provides an opportunity to learn from other states lessons from their experiences with Bed Registry & Referral and care traffic control systems.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.4%	260,321
2.Children with SED	Low 6%, high 12%	80,634 - 161,280

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Incidence and Prevalence for Adults:
Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PBHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Incidence and Prevalence for Children and Adolescents:
Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating the number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each jurisdiction was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from the U.S. Census Bureau population estimates. In the past year the number of children under age 18 in the total population in Maryland has increased. This approximate gain in 2024 was 34,000 children (2.53%). During this same period the total population (both adult and child) has grown by approximately 1.6% in the year (98,500). This trend results from the aging or graying of Maryland's population. The percent of adults in 2024 increased to 78.2% from previously reported 75% in 2019.

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PBHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. BHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

-Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
-Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

3. Please indicate areas of technical assistance needs related to this section.

None requested.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

None requested.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The State of Maryland recognizes 18 out of the 24 jurisdictions as rural. Maryland's rural jurisdictions include; Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester counties. Over 1,850,000 of Maryland's residents live in rural Maryland. Maryland's rural communities face unique health care concerns that include lack of health care providers and difficulty accessing those providers due to transportation and technology barriers. Rural hospitals and health care providers, which frequently are the economic backbone of the communities they serve, deserve special consideration so that they can continue to provide high-quality services and meet the needs of rural residents.

MDH's State Office of Rural Health (SORH) and MDH's Healthcare Workforce Programs address the rural health care needs in Maryland through local and federal partnership to develop policy and programs. SORH is federally funded by the Health Resources and Services Administration's Office of Rural Health Policy (ORHP) to provide: technical assistance to rural entities throughout Maryland; coordinate rural health resources and activities in the State; encourage recruitment and retention in Maryland; collect and disseminate information; and participate in local, State, and federal partnerships. Maryland SORH's mission is to improve the quality of health care for all rural Marylanders by developing strong partnerships; building local resources; promoting relevant state and national rural health policies; and supporting efforts to recruit and retain health care providers in rural areas.

Maryland's rural local behavioral health authorities (CSAs/LAAs/LBHAs) are responsible for planning, and fiscal management at the local level to address the behavioral needs of individuals with mental illness, SUD, and other addictions. Review of their annual behavioral health plans reveals two main challenges that rural areas face in addressing the behavioral health needs of their populations: workforce shortage/adequate level of MH and SUD services and lack of transportation. In most cases, the local behavioral health entities and providers have come up with creative solutions to address these challenges. One such approach is organizing contiguous counties into a regional service provision system. Behavioral health providers in rural areas have a history of collaboration and coordination, while sharing resources across county lines and with other service related agencies, to address the behavioral health needs of the populations they serve. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of behavioral health professionals. Most of the CSA/LBHA/LAA Annual Behavioral Health Plans emphasize the workforce shortage issue as a major challenge. Some of the various measures that local jurisdictions have tried to address the issue of workforce shortage, include: increasing and improving telehealth services, workforce development training (this appears in most of the rural behavioral health plans as one of the major strategies to address workforce shortage, especially in the area of co-occurring disorders); hiring of nurse practitioners (NP) and other physicians licensed to prescribe medication to alleviate the problem in medication assisted treatment (MAT) services; efforts to integrate providers serving MH and SUD clients; using Peer Recovery Specialists (PRS) in non-traditional service provision settings. For example, PRS staff are employed by the Eastern Shore Hospital Center which is a facility for individuals with a SMI and who have been forensically involved.

To address the lack of transportation to and from behavioral health services, rural programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies provide some publicly-supported transportation. They also collaborate with the Mobility Management Program in rural counties as well as local community/support groups such as veterans and volunteers including peers in providing access to transportation and behavioral health services. Additionally, local behavioral health system authorities have some funding in their budgets for transportation services for eligible individuals.

According to the Maryland Department of Planning, over the next twenty years, the population of people 60 and over in Maryland will grow by about 30%, from approximately 1.4 to 1.8 million by 2040. The rate of growth is expected to vary from county to county with the largest population growth is expected in Cecil, Charles, Frederick, Howard, Prince George's, and St. Mary's Counties.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

The 2024 Point in Time (PIT) survey in Maryland counted 6,069 individuals experiencing homelessness and also identified 5,033 as being sheltered. BHA contracts directly with local behavioral health system authorities, which in turn contract with providers, to support those programs that provide specialized services outside of the Fee For Service (FFS) PBHS. In an effort to upload the

Mental Health Block Grant (MHBG) purpose to support efforts to promote emergency shelter and transitional housing for individuals who experience homelessness, BHA funds the following programs:

Projects for Assistance in Transition from Homelessness (PATH), in Maryland is used to provide outreach, case management, screening and diagnostic services, housing assistance and referrals to job training and other supportive services to individuals who are experiencing homelessness or at imminent risk of becoming homeless in 21 jurisdictions. In SFY 2026, it is estimated 1,217 individuals will be enrolled into the PATH program.

BHA will provide $6.0 million in Continuum of Care (CoC) Program funding for SFY 2026 to local behavioral health authorities through fourteen grants awarded from the Department of Housing and Urban Development. The CoC provides tenant and leasing assistance to individuals experiencing homelessness who have a serious mental illness and or co-occurring substance-related disorders and their families. Priorities for BHA's CoC Program are individuals experiencing homelessness who have a serious mental illness and or co-occurring mental illness and substance-related disorders.

BHA also provides $25,437 in state general funds for a Homeless Identification Project which originally was funded in 2011 through Maryland's Alcohol Tax Appropriation. This award provides funding to individuals who are experiencing homelessness or at imminent risk of homelessness to access state identification cards and birth certificates.

Maryland SOAR - SSI/SSDI Outreach, Access, and Recovery (SOAR) is a federal initiative that assists individuals experiencing homelessness or at risk of homelessness and diagnosed with a mental illness and/or co-occurring disorder apply for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Maryland's SOAR Initiative is led by Maryland's Department of Health's BHA. It has the third highest SOAR approval rate in the country. Maryland's average approval rate for initial SOAR SSI/SSDI cases is 86% and a number of the communities that use SOAR are seeing approval rates above 90%. Furthermore, SOAR also expedites the application process and the average processing time for initial SOAR claims within Maryland is about 112 days. Through training and technical assistance, the SOAR process hopes to increase the rate of approvals and decrease the time taken to decide claims. SOAR works within the existing SSA application process but uses specific tools and strategies to facilitate successful applications. SOAR focuses on helping those who are either filing initial claims or who are requesting that DDS reconsider their claim. The purpose of SOAR, however, is not just to help individuals obtain benefits. Rather, these benefits are regarded as a means to aid recovery and help individuals lead more productive and fulfilling lives. After obtaining benefits, many individuals gain housing, greater access to healthcare, and make significant improvements in their mental and physical health and in some cases obtain employment. To enable more individuals to be served through SOAR, BHA provides funding for 14 full time and 1 part time SOAR Specialists, 1 SOAR coordinator and 1 Program Manager/SOAR State Lead.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The BHA continues to implement the Pre-Admission Screen and Resident Review (PASRR) Process for Marylanders with mental illness. The PASRR determinations are delegated to the administrative services organization but program oversight is led by the Director of the Office of Older Adults and Long Term Services and Supports.

The Public Behavioral Health Systems offers behavioral health services across the lifespan. Less than 2% of PBHS consumers are 65 or older, largely due Medicare coverage that begins at that age. Medicare coverage for behavioral health services has increased in recent years, resulting in fewer Medicaid reimbursable services for that age group. The most highly utilized PBHS services for this age group are residential rehabilitation, mobile treatment, substance use disorder residential treatment, and substance use disorder intensive outpatient services. Older adults also utilize a higher amount of gambling support services and the Baltimore Capitation Program serves a large percent of older adults.

The BHA awards grants to local jurisdictions for programs that fall outside of the PBHS services. There are currently thirty- two grants awarded to eleven jurisdictions that are targeted for older adults with behavioral health conditions and/or adults with disabilities. Program eligibility, referrals, provider monitoring are managed by the Local Behavioral Health Authority or Core Service Agency. The following types of programs are funded through state general funds or through mental health block grant in certain jurisdictions: Senior Mental Health Outreach (clinical), Senior Mental Health Outreach and Training (non-clinical), Behavioral Health Assisted Living, Residential Rehabilitation Medical Complexity, Senior Peer Support (Baltimore County only), Project Home Level E (Washington County only), Hoarding Support Services (Montgomery only). It is worth noting that none of these programs are statewide. The greatest expansion in the past four years has been with the behavioral health assisted living programs. In 2021, BHA allocated federal block grant funds for the purpose of developing a behavioral health assisted living model. That initiative started two pilot programs and since that time, BHA has awarded millions more to develop these services for older patients discharging from state psychiatric hospitals and for individuals transitioning out of residential rehab programs because they require long term care. MDH (BHA, Medicaid, and Operations) received technical assistance from a federally funded technical assistance provider, Human Services Research Institute (HSRI), from October 2021 through September 2023 for the purpose of identifying a Medicaid authority for these services to expand and sustain these services for adults with SMI who require long term services and supports.

BHA has one statewide program called the Older Adult Behavioral Health PASRR program, funded through Maryland's Money Follows the Person Demonstration, where regional specialists are employed within LBHAs or CSAs to help bridge the gap between Maryland PBHS and Maryland Aging and Disability programs. This project is a partnership of BHA and Maryland's Money Follows

the Person (MFP) Project.

There are 7 regional specialists who serve as resources to community-based organizations whose clients are aging and experiencing behavioral health issues, including Aging and Disability Resource Centers Health Department, Local Maryland Access Point (MAP) sites, Behavioral health providers, Support planners, and other entities involved with care away from nursing homes and transitions from nursing home back to the community. The purpose of the project is to divert or reduce stay in institutional settings including nursing facilities and hospitals.

BHA worked with Maryland Department of Aging to issue a report during the 2021 legislative session regarding a five year plan to address the needs of a growing aging population with cognitive and behavioral health needs. That report resulted in dedicated positions within both agencies. The work, which started through a this joint legislative report, remains on-going through the work of Longevity Ready Maryland (https://aging.maryland.gov/Pages/LRM.aspx), the Commission on Behavioral Health Treatment and Access Geriatric workgroup (https://health.maryland.gov/commission-bhc/Pages/default.aspx), and the Oversight Committee on Quality of Care in Nursing Homes and Assisted-Living Facilities (https://aging.maryland.gov/Pages/OversightCommittee.aspx) as well as other special projects, such as the current effort to develop a Suicide Prevention toolkit targeted toward older adults, an interagency collaborative effort led by BHA's Office of Prevention and Promotion.

d. Please indicate areas of technical assistance needs related to this section.

None requested.

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

The BHA Finance and Fiscal Management Division oversees the areas of Finance, Grants, and Fiscal Compliance. It supports BHA through budget development, funding attainment/award distribution, the procurement of goods and services, expenditure control, accounting, reporting, and monitoring. It plays a significant role in fiscal compliance/audit activities by developing, implementing and maintaining effective internal controls to ensure the accuracy and reliability of fiscal practices, management, and records. This office is instrumental in protecting fiscal resources from fraud, waste and abuse. It provides direction and oversight to address the need for financial information, procurement, monitoring of contractual obligations, strategic planning, and assistance in the resolution of technical financial issues and problems. It works to develop robust compliance oversight to ensure fiscal accountability. The Finance unit is responsible for the development, preparation, and monitoring of the Administration's operating budgets and to assist management staff in exercising budgetary control of expenditures and revenue for the units within the Administration. This unit is also responsible for providing the day to day accounting functions within the Behavioral Health Administration, inclusive of federal grant administration. This includes giving guidance on all fiscal matters and federal grant award/compliance/documentation procedures, developing policies and procedures to enable efficient operations and effective internal controls, preparation of federal and state reports, and fulfilling legislative report requirements. Federal grant audit compliance is handled by this unit. Fee for service expenditure tracking and monitoring is also handled in this area. The Federal grant tracking system tracks each federal grant by specific grant number for each federal fiscal year. The financial management information system (FMIS) tracks all expenditures and revenue by that specific grant number and is reconciled each month when drawdowns are performed by the MDH general accounting office through PMS. BHA finance keeps multiple excel spreadsheets that track personnel charged to each federal grant, all operational costs, and all grants, contracts, and other costs as procured. The fiscal unit verifies whether these expenditures are listed in the federal budget, are applicable to that federal grant and if they are expedited in the correct fiscal year of the federal NOA. BHA finance and MDH general accounting work (GA) closely on reconciliations of the federal grants, 440 reconciliations at year end, and closing out the federal grant. The GA department sends us monthly reports from the Schedule G and we justify the expenditures with an explanation on what funds are being drawdown each month.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Maryland allows for the use of HIPAA-compliant audio/visual telehealth as well as audio-only in all but a few services, which are restricted either on the basis of involving a high degree of in-vivo skill training activity or intervention (e.g. applied behavioral analysis, biofeedback) or on the basis of the setting (e.g. certain residential or facility-based services). Consistent with this approach, in 2025, the Preserve Telehealth Act of 2025 (SB0372/HB0869) was signed into Maryland state law. This legislation repealed the limitation on the period during which certain insurers, including Maryland Medicaid, are required to reimburse for health care services covered by the Program that can be appropriately provided through telehealth, on the same basis and same rate as services provided in person; and repealed the limitation on the period during which certain audio–only telephone conversations are included under the definition of "telehealth" in this legislation.

3. Please indicate areas of technical assistance needs related to this section.

None requested.

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Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

Maryland's Public Behavioral Health Data Collection/Reporting System has been managed by an ASO since 1998. In October of 2023, a RFP was issued by the MDH and the vendor, Carelon, became the current Behavioral Health Administrative Service Organization (BHASO). The BHASO collects required data for all MH/SUD services for which it makes reimbursement, whether or not it manages those services. The BHASO system collects information on those who receive services in the managed FFS system the PBHS. The overwhelming majority of community behavioral health services, both MH and SUD PBHS community services are funded through this system. The ASO manages and reimburses both Medicaid services as well as services to uninsured individuals,

who, based on income, family size, and severity of need, may be covered with State only funds by the PBHS. The system also manages services not covered under Medicaid that are reimbursed with state funds. All required mental health Client Level Data (CLD) and substance use disorders Treatment Episode Data Set (TEDS) data elements have traditionally been built into the ASO. Data is collected and reported according to federal grant requirements. The system is driven by a combination of authorizations and claims for behavioral health services. Inherent in the implementation of the PBHS is a series of extremely comprehensive data sets. Data sets on clients' eligibility, service authorization, claims payment, and events, and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the data from the ASO process that providers complete in order to document that an individual meets the criteria to be enrolled as an uninsured individual. Unduplicated counts are facilitated by the ASO assigning a non-changing unique identifier to every individual who enters the system. Authorizations are generally made on-line and required data elements are updated as part of the request process, whether it be an initial or concurrent request. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and payment data are derived from claims files.

The PBHS data system, through a series of interrelated databases and software routines, is able to report over 200 elements for both inpatient and outpatient care, including the National Outcome Measures (NOMS). Also included among the numerous data fields, care management elements, and outcome indicators were:

- service authorizations and referrals;
- services utilized by level of care and service;
- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The ASO contract calls for the vendor to recreate over 60 standard reports to assist in general planning, policy, and decision making. The data has also been accessed to produce an unlimited range of reports via ad hoc requests. The data can be reported out by the individual or provider level. Currently, access to the PBHS data is monitored by the ASO/BHA. Based on content and appropriateness, these have been available to BHA administrators, to administrators of local systems known as CSAs for mental health, LAAs for substance use, and LBHAs, the combined authority for mental health and substance use. Data is also available to licensed providers in the PBHS.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

The BHASO system is a stand-alone platform that collects information on those who receive services in the managed fee-for-service portion of the PBHS. The overwhelming majority of community behavioral health services, both MH and SUD PBHS community services, are funded through this system. The ASO manages and reimburses both Medicaid services as well as services to uninsured individuals, who, based on income, family size, and severity of need, may be covered with State only funds by the PBHS. The system also manages services not covered under Medicaid that are reimbursed with state funds. It serves over 330,000 people (MH and SUD treatment services) annually through a network of over 3,500 individual, group, agency, and institutional service providers.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

The State does not have a centralized data warehouse for all other MDH agencies. While these systems do not use the same consumer identifiers as the ASO data system, there are elements common to both which BHA has used to establish a nearly unique identifier based on demographic variables, used to link data from the various systems. When applicable, the individual's Medicaid number is used to provide a direct link. Historically, data has been linked with other data sets like the CDC's Vital Statistics (Suicides and Unintentional Intoxication Overdose Deaths), State Hospital Census, Department of Juvenile Justice, etc. The SMHAs key data are Medicaid and State psychiatric facility data. MH service authorization information is made available to MCOs, who can then communicate it to their primary care physicians. The availability of this module has enhanced service quality and provided a rich resource to enhance data analysis efforts.

Chesapeake Regional Information System for our Patients (CRISP) is the state designated Health Information Exchange (HIE) for Maryland. This entity facilitates the electronic transfer of clinical health information and outcomes. Health care data are created and shared with CRISP, and made accessible in near real-time to participating health care providers through the CRISP tools. CRISP tools retrieve clinical data from participants and display in a series of BHA designed drug indicator dashboards for internal use. The dashboards focus on Overdose Fatalities, the Prescription Drug Monitoring Program (PDMP) and Emergency Department Overdose Events. Data is cut by basic demographic data as well as by geographic region.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and

Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

The state has the ability to report all services for which data is gathered to the individual client level, this includes ESMI and BHCS and EBPs. Through the ASO, the state can review and report on the EBPs being utilized for example, Mobile Treatment (ACT), Supported Employment and Family Psychoeducation (Multifamily Group) in our early intervention/first episode psychosis programs. Claims submitted through the ASO use a modifier code to denote that the service rendered is evidence-based. Programs are also required to submit quarterly reports, to the state, on the services rendered to include EBPs.

5. Briefly describe the limitations of the SMHA 's existing data system.

In 2019, an issue surfaced when there was a finding that Maryland's method of data collection was a violation of parity. Maryland was instructed that it could not require data collection, even those needed for CLD and TEDS, as part of its registration or authorization system, based on the rationale that it was not required for physical health. In spite of strong challenges from BHA, the ruling stands, and with the implementation of the new ASO on January 1, 2020, Maryland stopped requiring data collection to register for the system. As a result, the Outcomes Measurement System was essentially made obsolete. Maryland has since learned there is no such standing rule in any other states.

BHA understands that there are efforts at CMHS to ensure reversal of this finding. Advocates of the BHA and Maryland PBHS have recently received assurances this is underway from CMHS Director, Dr. Anita Everett. Disallowing BHA's requiring data collection as part of the ASO registration is needed for BHA's SAMHSA-required reporting. Data collection includes basic demographic data, such as the approved method of collecting data on e, employment, education, living situation, arrest data, veteran status, drug utilization data (including most recent use, age at first use, route of administration, etc.); a detailed listing of the specific elements is below (Table 1).

Given this context, Maryland must give providers the choice to "opt-out" of data elements reporting. Due to system changes and data collection issues, the State anticipates it is unable to report on approximately 50% of all required data fields that constitute the CLD and TED files. Approximately 20% of providers are reporting some additional of the data required, however, this makes the data unrepresentative of the larger system.With the transition to Carelon, a new BHASO vendor, in January 2025, the parity rule still stands. However, Carelon has engaged with Maryland Medicaid to continue to submit parity reporting to CMS.

MDH BHA can provide some basic demographic data from data extraction from claims processing and eligibility information, however, much of the other data needed for CLD and TEDS are unavailable. BHA is pursuing several avenues to require data collection. BHA is working with assistance from SAMHSA and CMS to pursue reversal of the parity "opt-out" rule. In an effort to acquire data reporting elements, the State is also investigating possibly incentivizing or paying providers to collect the required data. However, this would require a significant financial investment for which no source currently exists. Therefore, the State continues to work to identify a resolution to meeting the data collection and reporting requirements. (BHA is exploring other options as well, for example through Medicaid regulations or conditions of award for grants, etc.) The grants BHA currently receives from SAMHSA/Hendall, Inc. that help support Behavioral Health Services Information System (BHSIS)-related activities have some data from which BHA has assembled for submission of the CLD and TEDS for both FY/CY 2024. Unfortunately, the data only have basic demographics, such as date of birth, county of residence, DSM diagnosis, and service type. For TEDS data, Opioid Replacement Therapy data are available.

Another unanticipated problem that has resulted from PBHS implementation of the parity "opt-out" rule undercounts persons served. The ASO Management Information System (MIS) does not capture data for individuals who receive services covered by Medicare, unless they receive an additional service covered by Medicaid. These Medicare reimbursed services cannot be subject to authorization, and claims are not paid by the ASO, which are the two mechanisms for capturing data. The state system also does not capture behavioral health data on individuals covered by private insurance plans.

Finally, a 12 month claim lag is inherent in the Medicaid system. Providers have 12 months from the time of service in which to submit a claim for reimbursement; therefore, data are not stagnant.

6. What strategies are being employed by the SMHA to enhance data quality?

A series of data edits, quality checks, and data standards that ensure consistency, accuracy, and comparability of data are inherent within the ASO platform. Integrated validation rules and error detection logic within the data system identify and correct inaccuracies in real time. The ASO provides ongoing training to data entry staff and program personnel on best practices in data entry, validation, and reporting.

The Department, through its BHA partnerships, works closely with SoftTech, Inc., a Maryland-based technology solution company specializing in data architecture, database management, data warehousing, and Business Intelligence (BI) solutions. SoftTech utilizes the breadth and depth of its technology experience and subject matter knowledge in all aspects of healthcare systems management, including eligibility processing, provider enrollment, claims payment, fraud and waste detection, and service utilization. SoftTech provides support to database design needs and ASO system requirements.

Historical data have also been placed at the University of Maryland Baltimore, Systems Evaluation Center (SEC), where a parallel data repository is maintained. This public-academic partnership provides unique value to BHA by providing access to nationally recognized expertise in behavioral health services research and evaluation; training and implementation on evidence-based behavioral health interventions; policy analysis; in-depth knowledge and experience with the Maryland PBHS; and data

analysis/technical assistance on program design and implementation to support ongoing system improvements and data quality standards. These entities perform ongoing validation analyses on claims, authorizations, pharmacy and outcome data in conjunction with BHA and the ASO to ensure data accuracy. The State conducts routine data quality assessments, including audits and performance monitoring, to identify areas for improvement.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

At this time, there are no significant challenges limiting the State's ability to collect and report data to the federal government. BHA has assembled what data are available for submission of the CLD and TEDS for both FY/CY 2024. There is the necessary infrastructure, staffing, and policy support in place to ensure timely and accurate data reporting in alignment with federal requirements. However, due to the 2019 parity ruling explained above in the limitations section, the data has some shortcomings pertaining to the completeness of the data.

8. Please indicate areas of technical assistance needs related to this section.

None requested.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Maryland is building a continuum of urgent and acute care services to ensure that every Marylander has someone to contact, someone to respond, and somewhere safe to go. There should also be no wrong door - so that people can enter the system from various entry points, and receive warm handoffs to the appropriate services. These services provide alternatives to going to the emergency department and engagement with the criminal justice system.

In May 2024, BHA issued final regulations that established standards for Mobile Crisis Team services and Behavioral Health Crisis Stabilization

Center services and fee-for-service reimbursement for the first time in Maryland. BHA has been working closely with jurisdictions and providers to meet the new regulatory requirements and become accredited, licensed, and enrolled in Medicaid.

988 Suicide & Crisis Lifeline
Prior to December 2023, the State of Maryland provided 100% statewide coverage of hotline services across the state through the "211 Press 1" hotline system. After this time, Maryland transitioned to the national 988 Suicide and Crisis Lifeline. Calls to 211 Press 1 are now auto-forwarded 988.

There are nine Lifeline network call centers in Maryland. The Maryland 988 call centers include: Eastern Shore Crisis Response, EveryMind, Life Crisis, Inc., Frederick County Mental Health Agency, Baltimore County Crisis Response, Community Crisis Services, Inc., Grassroots, Inc., Central Maryland Crisis Response System, and Baltimore Crisis Response, Inc. Three of these call centers (Grassroots, Community Crisis Service, Inc., and EveryMind) are in-state 988 text and chat providers. A fourth chat and text center (Central Maryland Crisis Response System) will become a text/chat provider in state fiscal year 2026. Each call center handles 988 calls, texts, and chats for multiple Maryland counties.

As of May 2025, Maryland's in-state answer rate is 92%. In 2024, Maryland received 124,348 contacts which was an increase of 36,340 contacts over the previous year. In 2025, Maryland anticipates receiving over 135,000 contacts to the 988 Lifeline. The average speed to answer calls is 22 seconds. Currently, we are working on increasing awareness of 988 and improving cooperation between 911 and 988 to provide an alternative response for behavioral health calls that come into the Maryland 911 system.

Mobile Crisis Teams and Behavioral Health Responder Services
The State of Maryland has developed a strong network of on-demand community-based services provided face-to-face and deployed in real time to the location of a person experiencing an urgent behavioral health issue or crisis. This includes traditional clinician and peer-based mobile crisis teams as well as co-responder teams in partnership with law enforcement. The goal of these services is to de-escalate the individual's situation, decrease emotional distress, and ensure their safety, thereby improving behavioral health outcomes.

Activities include clinical assessment, crisis stabilization, warm hand-offs and referrals to ongoing treatment services and other supports, as well as follow-up to ensure individuals are using ongoing services. Services must reflect the needs of the individual, including individuals who are deaf or hard of hearing. Services must assist both the individual and their support network as appropriate.

Best practice guidelines prioritize resolution of crises with the least disruption, avoiding unnecessary emergency department care, psychiatric inpatient hospitalizations, and engagement with the criminal legal system due to behavioral health challenges. The opinions, preferences, and needs of identified clients are explored and taken into account in determining disposition of services. All Co-Response Teams operate in active conjunction with additional responder models to encourage least restrictive levels of care and reduction of unnecessary involvement with the criminal legal system.

Utilization of Crisis Receiving and Stabilization Centers
At present, there is one provider in Maryland that meets SAMHSA's definition of a High-Intensity Behavioral Health Emergency Center. This includes meeting all staffing/service requirements as well as accepting both voluntary and involuntary status individuals without restrictions or exclusionary criteria and operating 24/7, every day of the year. Two additional providers are in progress to meet the definition of this level of care and become licensed as Behavioral Health Crisis Stabilization Centers under Maryland regulations.

At least eleven providers in Maryland meet SAMHSA's definition of Medium-Intensity Behavioral Health Crisis Centers, which includes the ability to conduct a screening, assessment, intensive crisis stabilization, and linkage to ongoing care. Clients of these programs are served on a voluntary basis only, and services may be dedicated to specific populations (e.g. SUD primary). These medium-intensity centers have various operational hours, with some available 24/7, every day of the year. These services are provided for up to 24 hours.

In addition, there are at least 20 different providers of urgent care services in Maryland, with services provided either on a walk-in basis or via an appointment within 48 hours of referral. Urgent care services are primarily one-time assessment, therapy, and medication management with connections made to ongoing care.

The goal of all of these services is to de-escalate the individual's situation, decrease emotional distress, and ensure their safety, thereby improving behavioral health outcomes. Best practice guidelines prioritize resolution of crises with the least disruption, avoiding unnecessary emergency department care, psychiatric inpatient hospitalizations, and engagement with the criminal legal system due to behavioral health challenges. The opinions, preferences, and needs of identified clients are explored and taken into account in determining disposition of services.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☑	☐	☐

3. Briefly explain your stages of implementation selections here.

Someone to contact: Crisis Call Capacity
100% of Marylanders have access to the 988 Suicide and Crisis Lifeline via call, chat, or text. Maryland's 988 Lifeline Centers maintain a 92% call answer rate and chat and text answer rates continue to increase. A fourth center will be added to provide chat and text coverage in state fiscal year 2026. The state monitors center effectiveness through Vibrant's Quality Improvement Dashboard which shows information related to interactions reviewed by centers. In FY26, the state is requiring centers to conduct consumer satisfaction surveys on 5% of all interactions. Finally, Maryland has obtained a sustainable funding source for its 988 Lifeline Network Centers via a monthly telecom fee of 25 cents per month per telephone line.

Someone to respond:
We are pleased to share that based on state, jurisdiction, and provider efforts over the last year since the regulations were released in May 2024, nearly all jurisdictions in Maryland (22 of 24 counties) are covered by the full MCT model endorsed by the Center for Medicaid and Medicare Services (CMS). Providers became accredited, went through the BHA licensing process, and enrolled in Medicaid. Most of these counties operate their own local teams, while some utilize a regional approach for coverage. These MCT services meet Maryland's licensure requirements to operate 24/7/365, consist of two in-person responders (law enforcement not part of the two-person team), and a licensed mental health professional completing the crisis assessment preferably as part of the in-person team or as a third member via audio-visual telehealth when needed.

The two counties not covered by the full MCT model are covered by a similar level of mobile crisis response programming. In these rural counties, the team staffing models meet the MCT standard (two in-person responders including a licensed mental health professional), but the coverage hours are not able to meet the 24/7/365 requirement at this time. BHA is working with the jurisdiction to expand the hours to 24/7.

Safe Place To Be:
All jurisdictions in Maryland have access to a safe place to go for same day crisis services, including Crisis Receiving and Stabilization Centers, Urgent Care, and Safe Stations. Approximately 46% of Maryland counties (11 of 24) have a Crisis Receiving and Stabilization Center that provides robust crisis stabilization services on a walk-in basis to voluntary individuals. One county has a Center with the capacity to receive and serve individuals on an involuntary basis. In FY25, Maryland offered significant state funding to establish or expand the availability of this service type. However, very few jurisdictions sought to take advantage of this funding opportunity because of challenges identifying space and workforce. BHA is working with jurisdictions and their providers to enhance existing Medium-Intensity Behavioral Health Crisis Center services and facilities to meet the standards of a High-Intensity Behavioral Health Emergency Center (e.g. serving the lifespan, ability to receive and treat individuals on an involuntary basis).

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Maryland's vision for the Maryland PBHS is a statewide continuum of integrated, comprehensive behavioral health services made easily accessible to Marylanders across the lifespan. Maryland's efforts in this space align with SAMHSA best practices for a comprehensive crisis system. We believe a robust crisis system includes prevention of serious behavioral health challenges; someone to contact 24/7 through the 988 Suicide and Crisis Lifeline; in-person assistance in the moment of crisis wherever the person is in the community; a safe place to stabilize and get connected to ongoing care to help individuals heal and thrive.

We believe care must be person-centered, compassionate, trauma-responsive, and address the needs of the whole person. Care must build on the person's strengths and incorporate their self-defined support system. We must also ensure that caregivers have the support they need to care for loved ones. BHA has a number of efforts underway to improve the continuum of crisis services and ensure that anyone around the state can access this essential level of care.

Someone to Contact - Maryland is focused on increasing awareness of 988. We developed and are executing on a statewide Outreach and

Engagement Plan. This includes partnerships with other Departments - including the Department of Veterans and Military Families - to develop consumer-facing materials and strategies for getting the word out. We are also working with organizations around the state to get the word out. Maryland is currently doing a transit campaign in multiple counties across the state. Additionally, Maryland is conducting an analysis of Marylanders' awareness of and attitudes toward 988, which includes a survey of 1,500 residents and some focus groups including with providers. The findings will guide future outreach efforts and messaging.

Someone to Respond and Safe Place to Be -
Standard of Care. In May 2024, BHA issued regulations that outline the requirements for licensing Mobile Crisis Team Services (https://dsd.maryland.gov/regulations/Pages/10.63.03.20.aspx) and High-Intensity Behavioral Health Emergency Centers (https://dsd.maryland.gov/regulations/Pages/10.63.03.21.aspx). This is the first time Maryland has established standards for these services.

Engagement with Jurisdictions and Providers. State program staff meet bi-monthly with local behavioral health authorities and providers to support the transition of these services to a licensed model. These intensive meetings receive positive feedback from stakeholders for their transparency, technical assistance provided, and strong state-local partnership.

Performance Improvement. Maryland is developing a crisis system database to capture utilization, demographics, performance measures, and outcome measures for all crisis services, across the lifespan, for all jurisdictions. This has included reviewing all performance measures and updating them to ensure Maryland can collect comprehensive information on the crisis services being provided. Improved mobile crisis data collection will begin July 1, 2025 - data collection for the other crisis services will begin January 1, 2026. We look forward to using this data to inform future service improvements.

Standardized Training. Maryland developed and executed high quality standardized training for all crisis services providers to ensure every provider is prepared to support individuals with urgent behavioral health needs. Training modules include: Principles of Trauma-Informed Care; Navigating Substance Use and Non-Suicidal Self Injury; Crisis Assessment and De-escalation Strategies; and Supporting Individuals with Intellectual and Developmental Disabilities and Acquired Brain Injury. The latter training was informed by Maryland's interdisciplinary team that participated in a national NASDDS learning collaborative. The next training will be on Crisis Provider Safety.

The Mobile Crisis Team regulations require all providers to be trained in the Mobile Response and Stabilization Services (MRSS) model. Maryland was awarded a NASMHPD TTI grant to provide MRSS training for crisis responders. We are eager to continue to promote this evidence-based model to support youth across the state.

Crisis Continuum - Maryland is dedicated to enhancing care coordination across the entire continuum of urgent and acute behavioral health services. We are excited to be establishing a statewide Care Traffic Control system that will integrate and streamline the coordination of crisis services. This comprehensive system will have the capacity to dispatch mobile teams and provide access to a web-based bed registry. Users will include crisis counselors, mobile crisis response and stabilization teams, 988 call centers, and hospital emergency departments, thereby facilitating communication and care coordination. This system will improve transitions to different levels of care by enabling providers to quickly find and secure treatment options for clients in appropriate settings.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 9
   ii. Not in the suicide lifeline network: 16

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 9
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 24

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 48

b. Number of Emergency Departments that operate a specialized behavioral health component: 11

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 11

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The 5% set aside is slated to fund mobile crisis services that were in a pilot phase in FY25.

Maryland received a SAMHSA Planning Grant to build the CCBHC model. The State is currently establishing requirements for the CCBHC level of care, including for crisis services. Maryland is anticipating that CCBHCs will have written agreements with regional 988 call centers, will establish non-financial DCOs with existing Mobile Crisis Team providers, and will provide low-to-medium intensity crisis receiving and stabilization services within the CCBHC.

7. Please indicate areas of technical assistance needs related to this section.

None requested.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Maryland has a longstanding commitment to the principles of and supporting recovery, including BHA's efforts to define a recovery-oriented system of care and develop an integrated process for planning, policy, and services to ensure a coordinated system is available to individuals with behavioral health conditions. This system offers recovery support services serving both individuals with SMI and SUD. On the continuum, services include those for prevention, intervention, treatment, and recovery in all state jurisdictions, with recovery-oriented approaches, such as person-centered planning, self-directed care, peer support, consumer/participant/family education, and promotion and expansion of access to employment, education, wellness, and affordable housing services. Alongside, the system has promoted or provided access to training for behavioral health providers aligned with these concepts. Significant strengths for both MH/SUD are utilization of State Care Coordination, which improves recovery outcomes for individuals at high risk for returning to use. Assistance is also provided for individuals to gain access to appropriate and needed community/faith-based, medical, behavioral, and social support services including recovery assessment, care planning, referral/linkage, on-going monitoring, and follow-up.

The PBI/EI Division oversees 1915(i), a Medicaid-funded program. The 1915(i) services represent a comprehensive suite of supports designed to assist youth and their families who are experiencing significant challenges due to SMI. These challenges often impact a young person's ability to function effectively in essential areas of life, such as at school, within the family, in social relationships, and in the broader community. Recognizing the multifaceted nature of these difficulties, 1915(i) services are structured to be youth- and family-centered, ensuring that the unique needs of each individual are addressed through a collaborative and personalized approach. At the core of 1915(i) services is the development of a Plan of Care, created in partnership with the youth, their family, and a network of formal and informal support. This plan serves as a roadmap to guide interventions and ensure that services are both relevant and responsive to the goals and strengths of the family.

The array of services provided through 1915(i) includes:
Intensive In-Home Services: Designed to provide therapeutic and behavioral support within the home setting, helping to stabilize the youth and support family functioning.

Respite Services: These services offer temporary relief to caregivers, reducing stress and preventing burnout while ensuring the youth continues to receive appropriate care.

Expressive and Experiential Therapies: These therapies utilize creative modalities—such as art, music, or movement—to engage youth in non-traditional therapeutic processes that can foster emotional expression and healing.

Family Peer Support: This component connects families with trained peer advocates who have lived experience navigating the mental health system, offering guidance, emotional support, and practical advice.

Youth Peer Support: Soon to be added, this service will provide young people with access to peer mentors who can share their own experiences with recovery and resilience, fostering empowerment and connection.

These services are delivered in conjunction with Targeted Case Management, ensuring that care is well-coordinated and that families are connected to necessary resources and supports within their community. Ultimately, the primary goal of the 1915(i) program is to maintain youth in their homes and communities rather than in institutional settings. By wrapping services around the youth and their caregivers, this approach enhances family stability, promotes positive outcomes, and supports the youth in achieving success across all areas of life.
Assertive Community Treatment/Mobile Treatment (ACT) is an intensive, community-based service which provides assertive outreach, treatment, rehabilitation, and support to individuals with severe and persistent mental illness (SPMI) who may be without a home or for whom more traditional forms of outpatient treatment have been ineffective. Services are provided by a mobile, multidisciplinary team in the individual's natural environment.

Maryland's Certified Peer Recovery Specialists the State certifies individuals providing direct peer-to-peer support services to others who have MH/SUD, gambling, or co-occurring disorders with the Maryland Addiction and Behavioral Health Professional Certification Board (MABPCB). Certified Peer Recovery Specialists have lived experience and with specialized training and guidance, can embody a journey of recovery, inspire hope, and provide support to others facing similar situations. Maryland also utilizes

non-certified peer recovery specialists within PBHS. Peer Recovery Specialists (PRS) support individuals who are in the process of initiating or maintaining their recovery from SMI, SUD, or co-occurring disorders. The PRS workforce is expanding with 407 PRS positions in the PBHS, 221 of which are certified, as of January 2025. Some of the services provided by PRS include:

- accompanying individuals to appointments/12-step meetings and leisure activities;
- providing assistance with completing paperwork for social services and other support services;
- providing assistance/preparation for employment such as shopping for work related clothing and coaching to prepare for an interview;
helping individuals develop coping mechanisms, communication skills, and other life skills to support their recovery;
representing individuals' needs and rights when interacting with healthcare providers or other systems
- Facilitating recovery-focused group sessions to foster peer support and shared learning.
- Providing support and guidance during challenging situations, helping individuals manage crises and build resilience.
- Encouraging individuals to take an active role in their recovery and make choices that support their well-being.

Wellness and Recovery Action Plan (WRAP) is a project provided to consumers in partnership with On Our Own of Maryland, a statewide mental health consumer education and advocacy organization. These trainings are being conducted by the Copeland Center, the national program developer of WRAP. The training includes the core concepts of recovery, daily maintenance, early warning signs and action plans, breakdown and crisis plans, and post crisis plans that provide training in consumer-operated programs. This program is part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.

Transition-Age Youth (TAY) programming stems from systems changes implemented through state and community partnership, which continues to create developmentally appropriate and effective youth-guided/family-supported local systems of care that will improve outcomes for this population with MH and co-occurring disorders in the areas of employment, education, housing and decreased contacts with juvenile and criminal justice systems. The goals are to provide individualized services to TAY that lead to seamless transitions, including post-school employment and/or postsecondary education; to enhance collaboration among Public Mental Health System and other TAY serving systems (e.g.- school systems, foster care, rehabilitation services, criminal/juvenile justice system); to facilitate collaboration with families and other community partners to improve service delivery and inform policy issues that affect the transition process; to create a statewide infrastructure that supports TAY/young adults; and to improve community capacity to effectively serve TAY. BHA/PBHEI collaborates with existing community resources including DSS, DJS, NAMI, On Our Own Maryland, and the Maryland Coalition of Families to support and encourage self-efficacy, self-advocacy, and community attachment. TAY/young adults and families provide input to all aspects of Transition-Age Youth (TAY) programming developments. Transition planning services emphasize resilience as they assist young people (emerging adults) with mental illnesses and emotional disabilities as they prepare for adult life. Transition-age services and supports are available to youth beginning at age 16. Services and supports are designed to prepare and facilitate achievement of goals related to relevant transition domains, such as employment, career, and educational opportunities, living situations, personal effectiveness, well-being, community contribution, and life functioning. Services integrate traditional and nontraditional supports in developmentally appropriate and effective youth-guided local systems of care, with the system goal of expansion of the evidence-informed service provision throughout the state. The value placed on youth and family member participation continues as a major priority of the child and adolescent behavioral health system of care.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Maryland's PBHS prides itself on its consumer-driven, consumer-focused service system. BHA's Office of Consumer Affairs has a leadership role in both policy and program development. The office coordinates with local peer support chapters, individual consumers, and consumer advocacy groups in efforts to improve services, and empower consumers throughout their recovery. In addition, the Office, in conjunction with local behavioral health entities, can assist consumers with their complaints and/or concerns regarding services received or treatment options. Activities that support recovery and recovery supports for individuals with SMI and SUD are monitored and implemented through BHA’s Office of Consumer Affairs.

One particular service specific to individuals with SMI are the Wellness Recovery Centers (WRC). WRC are peer-operated programs normally outside of clinical settings that offer recovery support services to individuals seeking recovery from mental health conditions. These recovery supports are non-clinical in nature and are focused on reducing the isolation experienced by individuals with mental health conditions. Additionally, some centers provide individuals access to transportation, housing, health, vocational/educational and other types of supports vital to a person's success in recovery. Some of these that are specific to individuals with SUD include:

Recovery Community Centers: Community based programs offering recovery support services to individuals seeking recovery from substance use disorders. These recovery supports are non-clinical in nature and provide individuals access to transportation, housing, health, vocational/educational and other types of supports vital to a person's success in recovery.

Peer-to-peer services can be facilitated within a formal setting such as a community-based treatment program but are not exclusive to that setting. Peer-to-peer services are frequently effective in community support agencies, areas in the community where high rates of overdose, and other health challenges exist, and other settings such as hospitals, courthouses, and jails. Peer-to-peer services must be voluntary. Peer-to-peer services are guided by a recovery plan which is created and maintained by the individual

receiving the support. The peer's main function is to help the individual receiving services navigate community-based supports and resources while providing support to the individual and their recovery process.

Maryland's Certified Peer Recovery Specialist program, in conjunction with the Maryland Addiction and Behavioral health Professional Certification Board (MABPCB), provides State certification for individuals who provide direct peer-to-peer support services to others who have mental health, substance use, gambling, or co-occurring disorders. Due to their lived experience, CPRS can, with specialized training and guidance, draw from their own journey of recovery to inspire hope and provide support to others who are facing similar situations. The State of Maryland utilizes both non-certified and certified peer recovery specialists within the Public Behavioral Health System (PBHS). Peer Recovery Specialists (PRS) support individuals who are in the process of initiating or maintaining their recovery from serious mental illness, substance use, or co-occurring disorders. The PRS workforce is expanding with 407 PRS positions in the PBHS, 221 of which are certified, as of January 2025. Some of the services provided by Peer Recovery Specialist include:
accompanying individuals to appointments/12-step meetings and leisure activities;
assisting with completing paperwork for social services and other support services;
assisting/preparation for employment such as shopping for work related clothing and coaching to prepare for an interview.
Helping individuals develop coping mechanisms, communication skills, and other life skills to support their recovery.
Representing individuals' needs and rights when interacting with healthcare providers or other systems
Facilitating recovery-focused group sessions to foster peer support and shared learning.
Providing support and guidance during challenging situations, helping individuals manage crises and build resilience.
Encouraging individuals to take an active role in their recovery and make choices that support their well-being.
The Treatment and Recovery Services Division ensures an integrated system of behavioral health treatment and recovery services are available and accessible to individuals experiencing substance-related disorders. The following programs/services are offered:

Maryland RecoveryNet: develops partnerships with service providers statewide and funds access to clinical and recovery support services for individuals with substance-related disorders and substance-related disorders co-occurring with mental health conditions who have treatment and recovery support needs. All Maryland RecoveryNet service recipients receive Care Coordination through which they can access a menu of services which includes Halfway House, recovery housing, transportation, employment services, vital records reports, medical and dental services, and other unmet needs as expressed by the individual and/or identified by the Care Coordinator.

The Office of Behavioral health Services provides oversight of services and provides technical advice and guidance for pregnant women and women with children. This includes oversight of residential treatment and transitional services for pregnant women and women with children, childcare during withdrawal management initiative, recovery support specialist in pregnancy/postpartum, recovery housing for women and women with children, and several legislatively mandated initiatives including SB 512-Substance Exposed Newborns.

The Evidence-Based Practices, Housing and Recovery Supports Division provides oversight of Maryland RecoveryNet (MDRN), in which certified recovery residences reside in therapeutic, sober living housing for people who are not in treatment. However, in many instances, they are still receiving treatment. Under State law, BHA has been selected to serve as the credentialing entity to develop and administer a process for the certification of recovery residences in accordance with nationally recognized certification standards established by the National Alliance for Recovery Residences (NARR). In accordance with statute, certification by the Department is required for recovery residences to operate in Maryland if the residence receives state or federal funds; operates as a certified recovery residence; is advertised or represented by any individual, partnership, corporation, or other entity as being a certified recovery residence; or has been implied to the public to be a certified recovery residence. Maryland currently has 228 certified recovery residences.

Community Bond and Recovery Residences Grants
BHA has had a long-standing goal of supporting affordable, “independent“ and accessible housing for individuals with mental health, substance-related, or co-occurring disorders. BHA co-sponsors the “Capital Improvement Grants and Loans for Behavioral Health, Developmental Disabilities and Federally Qualified Health Centers Facilities“ (also known as Community Bond) Award Program. Priority areas are for individuals with mental health and substance use disorders. The grant supports projects that effectively expand, support, or enhance capital resources (buildings, houses, projects involving bricks and mortar) for the following priority populations:
Applicants Providing Substance-Related Disorder (SRD) Services
Applicants Providing Mental Health Services
Applicants Providing Recovery Residences

The Office of Facilities Management and Development will propose to the MDH Secretary that Community Bond is included in the Governor's capital budget in the amount of $10 million.

Children’s Services
The Primary Behavioral Health & Early Intervention (PBHEI) Division within BHA is charged with developing a system of care for young people and their families, ranging from early childhood all the way through to the time 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. The Division evaluates the network of

services that the 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 a number of 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.

Adolescent Recovery Clubhouses (ACHs)
Through the PBH/EI division, the BHA funds and provides oversight for fourteen (14) ACHs located throughout the State of Maryland, identified below. Funding sources for the ACHs have included state and federal-SAMHSA State Opioid Response(SOR) or SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG). To date, the ACHs are located in the following counties:

Anne Arundel County: (2 sites: North & South)
Baltimore City
Baltimore County
Calvert County
Frederick County
Harford County
MidShore: (2 sites: Kent County & Dorchester County)
Montgomery County
Prince George's County
St. Mary's County
Washington County
Worcester County

The ACH is a recovery-oriented, nonclinical, prevention-based program that provides sobriety support, recovery support, and continuing care for youth ages 12-17 (or up to 18 if still in high school). The ACH's criteria for admission are focused on youth currently at risk of, receiving treatment for, or following discharge from treatment for substance use/misuse, including opioid or stimulant use disorders. The clubhouses are also expected to serve as a vehicle for referrals for those youth not presently in treatment. Each clubhouse assesses youth for appropriateness at the time of intake/admission to the program, using evidence-based assessment. In addition to the use of EBPs at intake, the ACHs are expected to integrate other EBPs into their daily programming curriculum. The ACHs also utilize peers, both family peers and young adult peer recovery support specialists (YAPRSS).

5. Does the state have any activities that it would like to highlight?

A 24/7 Crisis Stabilization Center in Baltimore City serves persons intoxicated with alcohol or substances; EMS or Baltimore Crisis Response, Inc. diverts them to the center from EDs. The center provides services including:
• Biopsychosocial medical assessment and monitoring of vital signs
• Individuals are provided a place to become sober and shower
• Nurses and peer recovery specialists are available for engagement, as well as connections to treatment resources
• Discharge plans are formulated

On June 01, 2023 Maryland transitioned funding away from grant and to Medicaid fee-for-service for CPRS services facilitated in Outpatient SUD settings including IOP and PHP programs, as well as, opioid treatment programs, and federally qualified health centers serving individuals with substance use disorder. This transition represents a first for our state as historically all peer services have been grant funded using a combination of state and federal funding. This transition is expected to largely expand the availability of this service to individuals utilizing outpatient treatment and have allowed us to repurpose existing grant funds to support additional community based peer projects that are not eligible for medicaid reimbursement.

Consumer Directed Organizations
On Our Own of Maryland (OOOMD) is a statewide peer-operated behavioral health advocacy and education organization which focuses on changing attitudes and supporting recovery. It represents 23 affiliated non-profit and peer-operated organizations which provide peer services in their local jurisdictions. OOOMD works with service providers, peers, and professional and community organizations to ensure that services and systems are trauma-informed and recovery-oriented by reducing stigmatizing practices and expanding consumer involvement in M/SUD policy formation and planning at local, state, and national levels. OOOMD organizes annual conferences where different topics of interest to the recovery community are discussed.

Permanent Supportive Housing
BHA has been awarded funding for 14 Continuum of Care (CoC) grants in the State of Maryland. BHA's CoC program provides permanent housing and supportive services to individuals with disabilities and to families with children in which one adult member has a disability. Participation in the CoC program must meet the requirements of the US Department of Housing and Urban Development's (HUD) definition of homelessness. Individuals who participate in the program are linked to the services of their choosing to ensure the success of the program.324households have been served by this program.

The Permanent Supportive Housing (PSH) Initiative was started in State Fiscal Year (SFY) 2023 by the BHA. It provides rental assistance for individuals who are transitioning from a Residential Rehabilitation Program (RRP) to live independently in the

community. In the RRP, people received rehabilitation and support to learn skills to live independently. Individuals in the Permanent Supportive Housing Initiative get to put those skills into practice. Individuals are assisted in locating, securing, and maintaining housing in the community of their choice. The program pays for application fees, security deposits and moving costs. All leases in this program are in the Individual's name. After moving in, individuals continue to receive support from the PSH staff to ensure the individual is able to maintain their housing in the community.

In SFY23 the original capacity was to serve 50 individuals but due to the program's success, an additional 25 slots were awarded in SFY24, bringing the total to 75. The program presently serves 75 individuals, with 73 who are housed and 2 in the process of securing their own housing. We have a wait list of 9. Most individuals in the program have spent many years living in a structured environment and are now enjoying the independence of having their own place. The initiative is supported by the Maryland's Administration's additional investments in behavioral health care to improve care for Marylanders. The program serves individuals throughout the state of Maryland.

The program allows an individual a choice in housing and services. The EBP, Housing and Recovery Supports Division at BHA has been partnering with the Planning Division on introducing PSH in the work being done to expand permanent supportive housing through MDH's Office of Capital Planning, Budgeting and Engineering Services' Community Bond grant.

Recovery Housing
Since BHA's implementation of Maryland Certification of Recovery Residences (MCORR), Recovery Residences are increasingly viewed as a viable and cost effective alternative to established recovery-oriented systems of care. Certified Recovery Residences reduce the probability of residents in early recovery returning to environments that foster addictive lifestyles, increasing the likelihood of relapse or continued substance use. Increasing the availability of housing ensures that Maryland's systems of care are responsive to the needs of all residents during their recovery process.

Recovery residences offer a unique alternative for residents whose main goal is to obtain a sober living environment. Recovery Residences are now monitored to ensure residents are receiving services that promote a safe and healthy living environment, assist them in their recovery with substance and/or opioid use, and improve their physical, mental, spiritual, and social well-being. Individuals are developing a mutual and peer support network while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community. In addition, individuals are offered an opportunity to continually surround themselves with other individuals who are pursuing the same goal of recovery and wellness within a residence that operates according to the National Alliance of Recovery Residences (NARR) standards.

BHA is determining with the State Fire Marshall and the assigned AAG which fire codes are applicable to the classification of recovery residences. The State Fire Marshal believes that fire suppression devices or sprinkler systems are required for recovery residences with more than five residents, however, this is not always consistently enforced at the local level. It is further complicated by varying and possibly more restrictive local fire codes. Thus, recovery residences seeking BHA certification could be subject to more rigorous fire inspections than those required under the certification process, which is based on NARR standards. As a result, a number of recovery residences have reduced numbers of beds. There are 279 certified recovery residences and 2652 certified beds. Assistance with short-term scholarships or time-limited subsidies is available through Maryland RecoveryNet, or LAA/LBHA beds in the State.

In general, residents self-fund recovery residences. Recovering residents are expected to work, pay rent, or otherwise support the house as part of the program. Where residents may not be able to fully afford the cost of their stay, they may be eligible to apply for assistance, under certain circumstances.

6. Please indicate areas of technical assistance needs related to this section.

None requested.

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ( ) Yes (●) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? ( ) Yes (●) No

d) Education? ( ) Yes (●) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The BHA convenes a weekly meeting with representatives from the Department of Social Services (the state's child welfare agency),

Juvenile Justice and the Developmental Disabilities Administration to review programs and services and identify areas requiring a more integrated approach. The focus is on resource sharing to better address the complex needs of youth. Additionally, the BHA's PBHEI Division holds regular meetings with the Department of Social Services and the Maryland State Department of Education. A member of the PBHEI participates on the State Coordinating Council (SCC), an interagency body led by the Governor's Office on Children tasked with supporting children and families with complex needs.

7. Does the state have any activities related to this section that you would like to highlight?

In Maryland, the Adolescent Clubhouse (ACH) is an initiative that is recovery-oriented, nonclinical, prevention-based, and designed to provide sobriety support services to adolescents, aged 12 to 17 (18 if still in high school), who are at risk of substance use or misuse. The goal of the ACH is to reduce and/or eliminate substance use; improve academic performance; decrease inpatient hospitalization for behavioral health issues, and decrease engagement with the legal system. The initiative also enhances accessibility to behavioral health services through the implementation of recovery-oriented programming such as substance use psychoeducational groups; recovery-oriented events; recovery-focused recreational activities; vocational and educational workshops; Naloxone education groups; and peer-led support services including utilizing evidence-based practices (EBPs) as well as promising methods to deliver screening; intervention; and recovery support to assist adolescents and their families in adopting and sustaining abstinence.

Additionally, Maryland would like to highlight our First Episode Psychosis (FEP) Programs which is an evidence-based program designed as a multidisciplinary treatment team-based intervention that provides community-based, person-centered, recovery-oriented services and supports. FEP Programs have been shown to improve the quality of life for the participant and their families, increase engagement in education and employment, and improve psychosocial functioning. FEP programs also reduce the severity of symptoms, hospitalization admissions, and overnight stays. This program also provides education to families which can decrease the stigma associated with a mental illness and provides support for caregivers and family members. Services rendered through the FEP Teams include clinical evaluation, therapeutic services, medication management, supported employment/education services, recovery coaching, and peer support services. Participants who receive these services are youth and young adults ages 14-30 who are within two years of the initial onset of psychotic symptoms. In regards to technical assistance needed in this section, relating to FEP, we have seen that our clinicians could benefit from additional training from national experts on understanding differential diagnosis for autism and psychosis. In addition, training on available resources on autism in schools, so we can effectively advocate for the clients.

8. Please indicate areas of technical assistance needs related to this section.

None Requested.

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The Maryland Office of Integrated Wellness and Prevention (IWP Team) supports a wide array of prevention activities intended to reduce the incidence of suicide. Activities include community outreach and messaging, technical assistance, support for local initiatives, data system improvement, and training.

Community Outreach and Messaging: The IWP team pursues a comprehensive outreach strategy aimed at reducing suicide risk factors, strengthening protective factors, and fostering community resilience. We engage partners in schools, healthcare systems, workplaces, faith-based networks, community-based organizations, and beyond. All messaging prioritizes accessibility, relevance, and alignment with lived experience.

Key outreach activities include:
- Social media content and monthly newsletters featuring resources, data insights, and events
- Distribution of materials at fairs, events, and community gatherings
- Text-based support via MDMindHealth's Caring Contacts-style program
- Virtual hosting for open meetings of the Governor's Commission on Suicide Prevention, which strengthens and coordinates suicide prevention services in Maryland

Technical Assistance: The IWP team shares best practices and support for suicide prevention throughout Maryland. Examples of technical assistance projects include:
- Maryland Action Plan to Prevent Suicide (MAPS) K-12 School Toolkit: A comprehensive, practical guide to suicide prevention, intervention, and postvention in K-12 schools.
- Together We Care Initiatives: Collaborative initiatives for communities experiencing elevated rates of suicide risk. Initiatives include Taking Care of Us), Caring for Champions (athletes and sports settings), and Caring Out Loud
- Responding to Suicidal Ideation and Suicide for Service Members, Veterans, and Their Families (SMVF): A toolkit created collaboratively with the Maryland National Guard and military-serving agencies to support suicide prevention in SMVF communities.
- Firearm Safety Initiatives: Resources about firearm safety for suicide prevention, including materials about Extreme Risk Protection Orders (ERPO), a Firearm Safe Storage and Youth Suicide Prevention guide, and handgun licensing curricula.
- Aging and Suicide Fact Sheet and Resource Guide: A resource to advance suicide prevention, intervention, and postvention for older adults in Maryland.

Community Engagement through Local Coalitions: The IWP Team provides Quarterly Technical Assistance Meetings for local coalitions. The IWP team works closely with coalitions to identify trends and provide data-driven recommendations. Local coalitions pursue initiatives including training, outreach, strategic planning, care coordination, and postvention support.
Grants for Local Jurisdictions: During FY25 (July 2024 – June 2025), the IWP team provided 14 grants to support suicide prevention activities in the following areas:
- 6 initiatives for suicide prevention training
- 4 initiatives around Firearms and Lethal Means Safety
- 8 initiatives to spread suicide prevention awareness, with 2 initiatives for postvention for loss survivors
- 2 initiatives providing Care Coordination

Timely Data for Fatality Review: Along with regularly analyzing available data, the IWP Team supports the work of the State's Suicide Fatality Review Team (SFRT). The team launched a secure data system on October 1, 2024. The SFRT has been conducting case reviews since, providing insights into factors contributing to suicide in Maryland.

Training: Suicide prevention training programs equip individuals with the knowledge, skills, and confidence to recognize and respond to suicide-related concerns. Training offered monthly provides Continuing Education Units (CEUs) for licensed providers. Notable programs include an Annual Suicide Prevention Conference, Aging and Suicide, and Maryland Universities.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

The MDH BHA has prioritized crisis care as a central element in its comprehensive behavioral health plan. In the 2022 Behavioral Health Plan, BHA emphasized the goal to "increase access to behavioral health services and supports through the design and implementation of a statewide, integrated crisis system, enhanced care coordination, and use of technology innovations." The Governor's Commission on Suicide Prevention supports these objectives, particularly the integration of the 988 Suicide & Crisis Lifeline with crisis response services. The key strategies for achieving this goal are expanding mobile crisis teams, crisis stabilization units, and family-centered Mobile Response and Stabilization Services (MRSS) for children and adults.

Care transitions from inpatient to outpatient care are crucial in preventing suicide, especially as research indicates that the risk of suicide in the month following discharge is 200-300 times higher than for the general population. Crisis care and support after suicide deaths are critical to preventing further suicides and supporting individuals affected by suicide attempts or losses. By strengthening crisis services, enhancing care transitions, and expanding postvention resources, Maryland aims to create a robust, compassionate support system that addresses the needs of individuals and communities affected by suicide.

The BHA's 988/911 Collaboration is critical to the expansion and integration of the 988 Crisis Line in local crisis response systems. BHA is currently operationalizing the National Association of State Mental Health Program Directors (NASMHPD) 988/911 Playbook. BHA is working to finalize a Maryland-specific state coordination plan. The coordination plan includes 1) the identification of local "Crisis System Champions" for each of our 24 jurisdictions and 2) building a 911/988 Coordination Dashboard Reporting System. BHA is also offering regular regional learning collaboratives to assist crisis champions with technical questions/implementation challenges, and obtaining feedback from local implementers.

The BHA Office of Integrated Wellness and Prevention (IWP) promotes best practices in care transitions for individuals at risk of suicide, ensuring continuous follow-up post-discharge from emergency departments or psychiatric care. The IWP team shares information about key considerations in suicide prevention, including post-discharge risk. Information is shared with local coalitions through technical assistance meetings and with clinical professionals through training.

The IWP team also supports the development of resources and programs to support loss survivors and individuals who have survived a suicide attempt, focusing on peer support, grief therapy, and community-based programs. The team has created resources aimed at specific communities, including the Responding to Suicidal Ideation and Suicide for Service Members, Veterans, and Their Families Guide and the Maryland Action Plan to Prevent Suicide in K-12 Schools (MAPS) Guide. These resources include information about postvention organizations and guidance for navigating grief. Both guides also provide information on supporting an individual during and after a suicidal crisis, empowering family members and supportive peers to recognize warning signs of suicide.

Whenever possible, BHA strives to incorporate the voices of individuals with lived experience, including loss survivors, attempt survivors, and those who have utilized in-treatment services. Their insights can strengthen evaluation measures, improve program design, and provide a more supportive and empathetic environment for individuals in crisis. By integrating their perspectives, Maryland enhances the effectiveness and sensitivity of its crisis care services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Aging Safely: A Behavioral Health Toolkit for Older Adults & Their Care Communities
This project increases awareness and reduce stigma around mental health in older adults by educating providers, caregivers, and communities about suicide risk, depression, substance use, and cognitive decline. It promotes respectful, age-affirming language and equips stakeholders with practical tools to identify warning signs, communicate effectively, and support social connection. The initiative also supports integration of mental health into aging services, encourages policy change, and promotes firearm safety and use of ERPOs to reduce suicide risk.

Suicide Prevention Data Initiative – Boys & Men Under 30
This initiative examines suicide mortality, ideation, and attempt patterns among boys and men under 30 in Maryland to inform targeted prevention strategies. Over the past five years, males ages 0–29 in Maryland have consistently died by suicide at rates 3.5 to 8.5 times higher than their female peers, with a slight increase in 2023 despite overall statewide declines. This trend underscores the urgent need to address and support young males. Emergency department data (via MDH ESSENCE) shows a contrasting trend in suicide ideation and attempts: females under 30 are more likely than males to seek medical attention for suicidal thoughts or behaviors, likely reflecting differences in disclosure and help-seeking. Due to limitations in self-reporting and

surveillance, suicide attempts in males may be underdetected. This discrepancy is driven by factors such as increased use of lethal means (especially firearms), societal norms around male self-reliance, and higher suicidal intent in men.

6. Please indicate areas of technical assistance needs related to this section.

While Maryland has made significant strides in suicide prevention across populations and settings, additional federal support is critical to sustain and expand our efforts, particularly for populations at heightened risk. The Suicide Prevention program requests support in the following priority areas:

1. Sustainable Funding for Program Expansion
Our current programming has outpaced available funding. Federal support is needed to:

Scale successful community-specific initiatives (e.g., Taking Care of Us, Caring Out Loud, Farm Stress) to additional jurisdictions
Expand the Maryland Action Plan to Prevent Suicide in Schools (MAPS) with implementation grants and sustained technical assistance to all school districts
Develop age-specific suicide prevention campaigns for youth, young adults, middle-aged men, and older adults

2. Support for Clinical Workforce Development
The State of Maryland continues to see gaps in clinical training and capacity, especially in rural areas. Federal funding could support:

Training and certification for evidence-based practices (e.g., CAMS, CALM, ASIST, QPR, DBT, trauma-informed care)
Expansion of provider incentives and stipends to complete suicide-specific clinical training
Integration of suicide prevention modules into behavioral health degree programs and continuing education

3. Infrastructure for Data Modernization and Timely Surveillance
Delayed access to suicide fatality data continues to hinder proactive prevention. We need:
Support for near-real-time suicide and self-harm surveillance system upgrades
Technical assistance and tools to enhance data-sharing across state agencies and with community partners
Funding to staff and expand our Suicide Fatality Review Committees (both state and county levels) to include data analysts, grief counselors, and prevention planners

4. Capacity to Address Intersectional Risk Factors
Additional federal investment would allow us to more deeply integrate suicide prevention into programs addressing:

Substance use and overdose prevention, particularly among men under 30 and veterans
Social determinants of health (e.g., housing instability, food insecurity, firearm access)
Youth mental health

5. Public Messaging and Awareness Campaigns
We need resources to expand messaging around 988, safe storage, help-seeking, and suicide risk recognition. Specifically, we seek:

Campaigns co-developed with communities most impacted by suicide
Toolkits and outreach that reflect different levels of health literacy and digital access

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

Maryland is partnering with four new colleges and universities to reduce health challenges.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

BHA is committed to ongoing collaborations with state and local entities to coordinate services to maximize efficiency, effectiveness and cost-effective services and programs. The PBHEI Division collaborates closely with our partners through an interagency effort to support youth who are experiencing challenges in securing appropriate community placements following hospitalization and or step-down care. These placement cases are reviewed weekly to identify the most suitable options, including appropriate education settings and treatment services. This interagency effort includes representatives from the Department of Disabilities, the Department of Human Services, and the Department of Juvenile Justice. PBHEI also coordinates with other organizations to enhance efficiency, effectiveness, quality and cost- effectiveness through participation in the Interagency Rates Committee, which is responsible for establishing rates for group homes for residential child care programs as well as overseeing the certification of individuals working in these programs.

In addition, the division maintains strong collaboration with LBHAs, who serve as subject matter experts on the needs of youth and families in their communities. Division representatives also actively participate in a range of councils and committees that address various aspects of child and adolescent behavioral health. These include, but are not limited to, committees focused on early childhood, first episode psychosis, resilience and respite care. Regular meetings are also held with the Department of Social Services, the Maryland State Department of Education and divisions within MDH, such as the Public Health Division and the School-based Health Centers, to share service information and develop solutions to address emerging challenges within the identified communities.
PBHEI maintains a strong partnership with the University of Maryland School of Medicine, Department of Psychiatry. Through this collaboration, education and training are provided to a broad range of professionals both within and beyond the behavioral health field. These efforts help to expand the availability and enhance the quality of services delivered to children and adolescents in support of their behavioral health needs.

These partnerships include the Supported Employment Center at the University of Maryland (SEC) which provides training, ongoing consultation and technical assistance to existing licensed SE program sites to include all Transition-Aged Youth and First Episode Psychosis programs that have either sustained Evidence Based Practice (EBP) SE fidelity implementation or have lapsed in EBP SE fidelity implementation and are seeking to be reevaluated for EBP SE designation. The training focuses on the Individual Placement and Support (IPS) service approach to supported employment, job development and employer engagement. Furthermore, the Evidence-Based Practice Center (EBPC) at the University of Maryland, provides Consultant/Trainers who have an annual average of 575 training, consultation, and TA activities for providers throughout the Maryland Public Behavioral Health System (PBHS). EBPC also provided consultation to Local Behavioral Health Authorities (LBHAs), Core Service Agencies (CSAs), and Local Addictions Authorities (LAAs) on an average of 50 occasions per year. The University of Maryland is in the final two years of the contract, via an Interagency Agreement (IA) Modification until 2025. The work of the Systems Evaluation Center during the initial years of this contract has provided BHA with information necessary to manage and guide the Maryland PBHS. Reports produced by the SEC have been used by BHA to monitor program quality and outcomes, fulfill reporting requirements, assess stakeholder opinions on time-sensitive issues, and inform policies and procedures. During the remaining two years of the contract, the SEC continues this work through several activities to be completed in collaboration with BHA.

PBHEI/BHA partners with Kennedy Krieger, Institute's Project ECHO program to improve the mental, emotional, developmental, and behavioral health (MDEB) of children from birth to eight years old. The program emphasizes "moving knowledge, not patients" by addressing workforce shortages and building the capacity of local providers; including pediatricians, early childhood educators, community clinicians, and Local Care Team participants to identify and manage challenges in young children. Project ECHO offers a collaborative learning environment supported by a team of multi-disciplinary experts from Kennedy Krieger and Johns Hopkins, specializing in behavioral psychology, child and adolescent psychiatry, developmental and behavioral pediatrics and neurodevelopmental disorders. Each fiscal year, a comprehensive curriculum is developed to train professionals across multiple disciplines on best practices for working with young children. ECHO sessions are held in regions of the state identified as having limited behavioral health resources, helping to expand access and improve the quality of care in communities.

4. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

Behavioral Health Advisory Council (BHAC)
Pursuant to the Annotated Code of Maryland, Health General 7.5 - 305, and federal Public Law (PL) 102-321, the State established the Maryland Behavioral Health Advisory Council (BHAC) to promote and advocate for an integrated, quality behavioral health system of care across Maryland. The Council meets bi-monthly to advocate for continued and increased access to behavioral health services and promote adequate and appropriate prevention and wellness activities for individuals with mental illness, substance use, co-occurring, and other addictive disorders. The Council also receives updates from the BHA on the publicly funded inpatient and outpatient community based behavioral health services as well as legislative issues. In addition, emerging issues and priority areas are identified at the Council's meetings, and suggestions and recommendations are provided to BHA's leadership on improving the quality of and access to Maryland's PBHS.

BHAC Planning Committee Plan Review
The BHAC has established committees to further support its purpose as well as enhance full participation of members and other stakeholders in developing recommendations for input and advocacy for the PBHS in Maryland. The BHAC, its Planning Committee, and other stakeholders participate in several processes related to the development and review of State and local behavioral health plans. The BHAC Planning Committee is involved in the development, review, and final recommendations of Maryland's State Behavioral Health Plan, the Federal Combined Block Grant applications, and the Implementation Reports of these documents. The Committee also reviews BHA budgets in relation to federal block grants, SOR grants, and Crisis Services grants.

The FY 2025/2027 State Strategic Plan is the state's current plan. BHA, in partnership with the BHAC, has endeavored to create a plan to be more data driven and action focused with measurable outcomes and key priority areas which includes Increasing access to care, improving quality and outcomes and increasing programs that promote wellbeing. The State Plan draws its goals and objectives from the jurisdictional plans of the LBHAs, LAAs, and CSAs. Stakeholders and partners, including members of BHAC, take part in the local planning processes through the local behavioral health, addiction and mental health councils, and the regional stakeholder meetings that BHA usually holds annually. The Planning Committee of the BHAC is also involved in BHA's State Behavioral Health Planning process through discussions of these jurisdictional plans. After the COVID pandemic forced the BHA to move to a virtual process for input and held virtual meetings in each area of the state. It was found that moving to a virtual process expanded attendance.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — (●) Yes ( ) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD

treatment, and recovery support services?

BHA has been actively working with all 24 local jurisdictions to ensure that planning and implementation for Maryland's PHBS results in the delivery of high-quality, appropriate, person-centered behavioral health experiences in a timely manner, regardless of which "door" a person enters the system. To do this, the oversight of the PBHS cannot be fragmented or disjointed when applied to mental health services and for services provided to individuals with substance use disorders. Such integration of how the PBHS is managed ("systems management") is not a simple process. BHA, with the help of a consultant team, worked with local and statewide stakeholders to develop a Behavioral Health Systems Management Integration Plan which produced a Behavioral Health Integration Self Assessment Tool and a Public Behavioral Health Systems Manager Manual.

Implementing the plan to integrate the local systems managers involved deliberate communication and collaboration between BHA and each of the local jurisdictions, to clarify the roles and responsibilities of those who manage the PBHS and identify where more progress is needed to bring together system planning, implementation and oversight. This process included the development and operation of the Collaborative Learning Community to enable peer-learning and to inform development and updating of the procedure manual for integrated management of the PBHS. The Learning Community met bi-monthly over 2 years to finalize this process.
The results are encouraging. Since FY2023, most of the local jurisdictions have had no more than one local agency conducting PBHS planning and oversight for substance use disorders and mental health. In addition, even for those with two separate local agencies, all 24 local jurisdictions have deepened their level of systems management integration through closer coordination and collaboration to meet the needs of Maryland residents. The focus in FY2024 and going forward is to further engrain integrated approaches into BHA and all of the local jurisdictions in ways that are sustainable and embedded into organizational and ongoing operations.

Local Behavioral Health Strategic Planning
CSAs, LAAs, and LBHAs develop plans to describe how the local behavioral health authorities plan, develop and manage a full range of prevention, intervention, treatment, and recovery services. These plans include discussions that identify any issues or initiatives within the jurisdiction that are important in understanding the local plan in the context of the broader system. They also describe what activities are planned or implemented that support BHA priorities of moving toward an integrated system of care and improving access and quality of services throughout the continuum of care. The local authorities have been working with BHA in developing a new local/state planning process. FY2023 both the state and the local authorities developed a three-year strategic plan. The first year was considered a pilot year and a workgroup was developed of local and state parties to work on the progress of the last year and changes and improvements that need to be done moving forward. For FY2024 -FY2026 the local authorities will submit annual implementation reports that will provide status updates on their objectives' performance measures that were presented in their three year strategic plans.

Behavioral Health Crisis Response Grant Program
Through the passage of legislation HB682/SB551 in the 2017 session of the General Assembly, the Council in coordination with BHA has worked to develop a strategic plan for ensuring that clinical walk-in services and mobile crisis teams were available statewide. The Crisis Services Strategic Plan was presented in the 2018 Legislative Session and HB 1092/SB 703 was passed in the 2020 legislative session establishing an opportunity for local health Departments (LDHs), CSAs, LAAs, LBHAs, and community providers statewide, to apply for funding to develop and /or expand behavioral health crisis services. The funding, which expanded in each of the subsequent five years, was used to create services that provide access or linkages to treatment through mobile crisis teams, crisis walk-in services, or residential crisis beds to those in immediate, in -person crisis intervention, and stabilization. Individuals are offered the opportunity to connect with ongoing behavioral health treatment, peer and recovery support services, case management assistance and transportation as a warm handoff to additional care as needed. Key tenants of the system include services that are responsive to local needs and integrated into the behavioral health crisis care system.

In 2021, the State of Maryland Behavioral Health Administration launched the Maryland Crisis System Workgroup which was composed of over 100 stakeholders from around Maryland. This workgroup established a vision, mission and guiding principles in which to develop a comprehensive, integrated, public/private crisis system to serve individuals across the lifespan.
The outcome of this process is that Maryland now provides 100% coverage of hotline services across the state through 211 Press 1 hotline system. The State of Maryland has eight Lifeline network call centers and an additional five regional call centers that are not part of the Lifeline network. This creates a network of 25 crisis hotlines across the state, with 9 of these call centers being in the 988 Suicide and Crisis Lifeline network.

The Integrated Crisis Services System in Maryland is a comprehensive network of both traditional mobile crisis teams (clinician and peer based) as well as crisis response teams in partnership with law enforcement, fire and paramedic professionals. There are mobile crisis teams implemented or currently being implemented in every jurisdiction of the state. 100% of the state is funded through the Behavioral Health Administration (BHA) to support Crisis Intervention Team (CIT) training for law enforcement across all 24 jurisdictions in Maryland. Of these 24 jurisdictions, 21 jurisdictions operate individual county-level CIT programs, while 3 operate as regional collaborations. The regional programs include:
Mid-Shore: Caroline, Dorchester, Kent, Talbot, and Queen Anne's Counties
Wicomico/Somerset
Charles Regional: Charles, St. Mary's, and Calvert Counties

In total, this structure ensures statewide coverage with 21 stand-alone county programs and 3 multi-county regional programs working together to strengthen Maryland's crisis response system. There are 13 walk-in/urgent care centers in Maryland and Maryland is in the process of finalizing regulations for licensing of Crisis Stabilization Centers that align with CMS guidance. In order to achieve the state goals to provide immediate, recovery-oriented solutions to support individuals in crisis, avoid unnecessary hospitalization, and avoid unnecessary incarceration, Maryland is beginning to develop a crisis system database to capture utilization, demographics, performance measures, and outcome measures for all crisis services, across the lifespan, for all jurisdictions.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council has established by-laws, elected officers, and implemented a committee structure which integrates mental health and substance use disorders across the lifespan. This integration is evident by membership composition, i.e., co-chairs (one from each area) and the committees' membership. The Council is composed of consumers/participants, family members of persons with behavioral health disorders, behavioral health professionals, representatives of other State agencies, and other interested citizens who serve as important sources of advice and advocacy in Maryland. Members provide important input into the planning and policy development of the Maryland PBHS. Council meetings are open to the public and non-Council members are encouraged to participate. Non-Council members often include individuals with lived experience, community stakeholders, and experts in the behavioral health field, which provides the subcommittees with valuable input from many aspects of the system.

The Council has established committees to further support its purpose as well as enhance full participation of members and other stakeholders in developing recommendations for input and advocacy for the PBHS in Maryland. These committees also help the Council monitor the system of care, facilitate and inform the planning process and policy making decisions of BHA. Through the work of its committees, the Council maintains its connection with Local Behavioral Health entities, and its overarching mission and duties for individuals with mental health, substance use, co-occurring and other addictive disorders. The committee structures provide work that have impacted or influenced advocacy and give greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning; prevention; children, young adults and families; recovery services and supports; criminal justice; and crisis services. The Council has two standing committees and six ad hoc committees.

7. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Behavioral Health Administration
Alyssa Lord, MA MSc
Deputy Secretary Behavioral Health
55 Wade Avenue, SGHC/Voc. Rehab Building
Catonsville, MD 21228

August 15, 2025

Demetrius Mays
Public Health Advisor
Division of State and Community Systems Development (DSCSD)
Center for Mental Health Services (CMHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services (HHS)
5600 Fishers Lane, Rockville, MD 20852

RE: FY 2026-2027 Federal Block Grant Application

Dear Mr. Mays:

The Planning Council has *reviewed* the BHA FY25-27 State Strategic Plan, as well as the FFY26-27 Federal Block Grant Application and its related documents required by law for funding for integrated services for both substance use and mental health disorders. Areas of greatest focus in the past year have revolved around the continued efforts to save lives of those individuals who are subject to substance use disorders and behavioral health issues that can lead to suicide. The implementation of the 988-crisis line has been an area of great focus and Maryland has been engaged in efforts to expand its array of crisis services and make them available across the State. Some of the major barriers to these efforts have been the staff reductions at the Behavioral Health Administration (BHA) that were undertaken by the previous administration. While the new administration has taken steps to alleviate this situation, workforce shortages and a shortage of applicants exist both at BHA and throughout the provider system. In conjunction with Medical Assistance Administration, BHA has implemented reimbursement for Certified Peer Recovery Specialists as one avenue to expand support for individuals in distress and/or in recovery.

Pursuant to the Annotated Code of Maryland, Health General 7.5 - 305, and federal Public Law (PL) 102-321, the State of Maryland established the Maryland Behavioral Health Advisory Council (MBHAC) to promote and advocate for an integrated quality behavioral health system of care across the State. The

Council meets bi-monthly to advocate for continued and increased access to behavioral health services and to promote adequate and appropriate prevention and wellness activities for individuals with mental illness, substance use, co- occurring, and other addictive disorders. The Council also receives updates from the Behavioral Health Administration on the publicly funded inpatient and outpatient community based behavioral health services as well as legislative issues. In addition, emerging issues and priority areas are identified in the Council's meetings, and suggestions and recommendations are provided to BHA's leadership on improving quality of and access to the Maryland Public Behavioral Health System (PBHS).

BHAC, its Planning Committee, and other stakeholders participate in several processes related to the development and review of the state and local behavioral health plans. The Planning Committee met virtually every month in 2025. The BHAC Planning Committee is involved in the development, review, and final recommendations of the Maryland State Behavioral Health Plan, the Federal Combined Block Grant applications, and the implementation Reports of these documents. The Committee also reviews the BHA budgets in relation to the Federal Block Grants, SOR Grants, and Crisis Services.

Each year, as the BHAC review's the plan, it has been surprising that, while integrating care is focused on addiction/substance use and abuse and mental illness (formerly two separate areas of focused care), separate streams of funding from the federal level support these two areas. In addition to mental health and substance use block grants, there is SOR funding. The strict requirements around each of these funding streams greatly complicates the integration of care and rapid response to emerging problem areas such as the appearance of new substances that cause sudden epidemics of overdose deaths. We continue to ask, to better achieve parity, has there been any discussion to integrate the funding as well as the service delivery to treat these brain diseases? If so, we would be most interested in hearing about and possibly participating in those conversations. Once again, we support the proposal and will continue to work toward quality outcomes in the provision of integrated delivery of care.

Sincerely,

Kathryn G. Dilley, LCSW-C
BHAC, Chair
Maryland Behavioral Health Advisory Council

Tammy Loewe, LCSW-C
BHAC, Co-Chair
Planning Committee, Co-Chair
Maryland Behavioral Health Advisory Council

Tim Santoni
Tim Santoni (Aug 27, 2025 14:39:19 EDT)

Tim Santoni
Planning Committee, Chair
Maryland Behavioral Health Advisory Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Joseline Castanos	Advocates/representatives who are not state employees or providers		PH: 301-233-1132	JOSELINECASTANOS@GMAIL.COM
Mary Gable	State Employees		PH: 410-767-0472	MARY.GABLE@MARYLAND.GOV
Stephen Ligget-Creel	State Employees			STEPHEN.LIGGETT-CREEL@MARYLAND.GOV
Mirza Baig	Advocates/representatives who are not state employees or providers			
Lynda Bonieskie	State Employees		PH: 410-585-3731	LYNDA.BONIESKIE@MARYLAND.GOV
Jody Boone	State Employees			JODY.BOONE@MARYLAND.GOV
Perrie Briskin	State Employees			perrie.briskin@maryland.gov
Johanna Dolan	Advocates/representatives who are not state employees or providers			JOHANNA@DOLANRESEARCH.NET
Karen Duffy	Advocates/representatives who are not state employees or providers			
Johanna Fabian-Marks	State Employees		PH: 443-890-3518	JOHANNA.FABIAN-MARKS@MARYLAND.GOV
Candance Harris	Advocates/representatives who are not state employees or providers			CANDACEHARRIS01.CH@GMAIL.COM
Joyce N. Harrison	Advocates/representatives who are not state employees or providers		PH: 443-923-7000	JHARRI47@JHMI.EDU
Kathryn M. Hart	Advocates/representatives who are not state employees or providers			KATYE.HART@GMAIL.COM
Laura Kimmel	Parents of children with SED		PH: 301-758-5687	LAYOUNG3@GMAIL.COM
Alyssa Lord	State Employees			ALYSSA.LORD@MARYLAND.GOV
Sharon MacDougall	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			SHMACDOUG@GMAIL.COM

Dayna Mayo	State Employees		PH: 301-429-7845	DAYNA.MAYO@MARYLAND.GOV
Brendel Mitchell	Advocates/representatives who are not state employees or providers			BRENDEL.BJ@GMAIL.COM
Deneice Valentine	Advocates/representatives who are not state employees or providers			DVALENTINE1232@GMAIL.COM
Kimberlee Watts	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			KIMBERLEE.WATTS@MARYLAND.GOV

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Please note that disclosing membership data for categories such as individuals and family members in recovery and parents of children with SED is voluntary and not a requirement for participation in the Council. BHA Planning Staff will coordinate with the Advisory Council Members to fill existing vacancies within the next six months.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	0	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	2	
3. Parents of children with SED	1	
4. Vacancies (individuals and family members)	2	
5. Total individuals in recovery, family members, and parents of children with SED	**5**	**22.73%**
6. State Employees	8	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**8**	**36.36%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	9	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**9**	**40.91%**
16. Total membership (all members of the council)	**22**	

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Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

The FY25-27 BHA State Strategic Plan will be posted for Public Comment on September 5, 2025. The FFY26-27 MHBG and SUPTRS Block Grant Applications shared with the Behavioral Health Advisory (Planning) Council for review and request for a letter of support.

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://health.maryland.gov/bha/Pages/Behavioral-Health-Plans.aspx.

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

d) Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes: