Maryland Department of Health

UNIFORM APPLICATION
FY 2026/2027 SUPTRS BG Only Application Behavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

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.

Maryland's Behavioral Health System

The Behavioral Health Administration (BHA) is a division of the Maryland Department of Health (MDH) that oversees the Public Behavioral Health System (PBHS) and the delivery of behavioral health services through six divisions: 1) Prevention and Promotion; Primary Behavioral Health and Early Intervention; 3) Urgent and Acute Care; 4) Policy and Planning; 5) Treatment and Recovery, and 6) Post Acute Care that support a comprehensive, wrap-around system designed to improve the health and well-being of all Marylanders across the lifespan.

A top priority of Maryland is to strengthen the PBHS by prioritizing continuous improvement and ensuring a system for all by meeting the needs of residents. We are implementing a behavioral health model continuum of care that centrally addresses increasing access to services, and trauma-informed practices to strengthen our partnerships with external stakeholders and deliver data-driven, evidence-based care to Marylanders.

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

The Behavioral Health System for Children and Young Adults

The range of the behavioral health continuum of care for children and adolescents encompasses universal, selective, and indicated preventive interventions and initiatives for health and well-being promotion; primary behavioral health care ranging from outpatient to intensive community based care; crisis, urgent and acute care; treatment and recovery supports, and post acute care, including juvenile services and pre- and post-care for MDH facility discharge.

The Division of Primary Behavioral Health & Early Intervention (PBHEI). This division develops a system of care to meet the needs of young people and their families ranging from early childhood to when young people reach the age of majority to when they legally become adults who have mental health conditions, misuse substances or have SUD, or both. PBHEI evaluates the BHA-funded network of services for this age group and provides statewide planning, development, administration and monitoring of provider performance to ensure the highest quality delivery of services. The division also manages special projects and coordinates with all other state or local child serving agencies to ensure highly integrated and individualized approaches to care.

For example, 14 Adolescent Clubhouses (ACH) across the state provide recovery-oriented support for youth ages 12 – 17 (18, if still in high school), which is provided and funded through BHA. The Clubhouse system design engages youth receiving treatment for SUD, including opioid use disorder (OUD), and youth following their discharge from treatment, using evidence-based and promising practices to provide screening, intervention, and recovery support to adolescents. Each ACH employs a unique variety of SUD intervention and recovery support approaches, such as including among staff young adult peer specialists, but all ACHs are based on a psychoeducational model that supports adolescents in diminishing triggers and cues that led to past substance misuse, as well as youth-driven activities to engage youth in enriching and healthy ways.

The Behavioral Health and Substance Use System for Adults and Older Adults

The structure of the adult behavioral health and substance use services system supports the delivery of prevention, early intervention, treatment, recovery supports, and crisis services for adults and older adults with mental health and substance misuse or use disorder (SUD) needs. The delivery of high-quality care is ensured through a team of division directors and clinical, policy, and operational leaders who work together to integrate high-quality behavioral health care services across the state. Critical components of the behavioral health model continuum of care are addressing ongoing mental health and substance misuse and SUD needs, and supporting reentering individuals in their communities. Moreover, essential upstream services prevent and address trauma and promote health and well-being of all Marylanders.

The Division of Prevention and Promotion. This division improves access to behavioral health services, including consumer affairs, public awareness campaigns, family peer support, suicide prevention, and navigation. The division aims to prevent substance misuse, abuse, and addiction. One such program that this division oversees is for Peer to Peer Services. This program offers peer support services facilitated exclusively by individuals who have lived experience in behavioral health recovery. These individuals are professionally known as Peer Recovery Specialists (PRS) and Certified Peer Recovery Specialists (CPRS) when working in the credentialed status of this role. Peer-to-Peer services can be facilitated within a wide range of settings including outreach within the community, working alongside first responders, and providing connections to formal treatment services. Peer-to-peer services are frequently effective in non-traditional settings such as community support agencies, areas in the community where high rates of overdose, homelessness, and other health disparities exist, and other settings such as hospitals, courthouses, and jails. Peer-to-peer services demonstrate a high degree of flexibility and are individualized to the person receiving support. Peer-to-peer services will focus on supporting recovery and the establishment of a healthy, progressive life in the community.

The Division of Urgent and Acute Care. BHA is developing a statewide continuum of integrated, comprehensive, and urgent and acute behavioral health care services by working with and providing funds to jurisdictions and providers to ensure all Marylanders have: (i) Someone to contact when they need urgent behavioral health care services, (ii) Someone to respond to help them in that moment, and (iii) Somewhere safe to get help, stabilize, and get connected to ongoing support. An example of Someone to respond is found in Mobile Crisis Teams (MCT) in each jurisdiction of Maryland. The MCTs offer on-demand community-based services to the location of a person experiencing an urgent behavioral health issue or crisis. The goal of these services is to de-escalate the individual's situation, decrease emotional distress, ensure their safety and offer resources for follow up, thereby improving behavioral health outcomes. Additionally, MCT services seek to avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and engagement with the criminal legal system due to behavioral health challenges. Mobile Crisis Team program staff includes at least one licensed mental health professional, either via telehealth or face-to-face, who is licensed at the independent practice level, eligible to oversee the staff of the team, and eligible to complete an emergency petition.

The Division of Treatment and Recovery. The Treatment and Recovery division provides an integrated system of care for adults and older adults by directing, administering, and overseeing the statewide continuum of community-based outpatient behavioral health treatment services, including for withdrawal management, partial hospitalization programs for mental health and SUD, outpatient mental health centers and SUD outpatient or intensive outpatient treatment programs, group practices, and private licensed behavioral health practitioners. This division develops policies and regulations for related clinical services; develops, designs and/or implements federal or state-funded services and specialized programs, including culturally sensitive and responsive initiatives for individuals who are deaf and hard of hearing and/or mental health conditions; and provides administrative oversight of evidence-based practices (EBP) and clinical treatment, recovery supports, and housing supports services. The division designs, plans, directs, implements, and evaluates care management services, recovery supports services, and community resources, and identifies gaps in services and best practices to address issues to improve access and the quality of care. Finally, the division develops conditions of awards with the Local Authority and co-develops statements of work for monitoring service deliverables and network adequacy, as well as providing technical advice and guidance to the local jurisdictions.

The Office of Behavioral Health Services. Within MDH's Public Health Services, Prevention and Health Promotion Administration, the Office of Behavioral Health division provides direct support to meet the behavioral health needs of adult women, and in particular, pregnant women and women with dependent children. The office manages residential and transitional SUD treatment programs, peer support services, recovery housing, and services connected to the Sobriety, Treatment, and Recovery Teams (START) program.

The Division of Policy and Planning. This division develops and maintains the statewide public behavioral health system (PBHS) through planning, monitoring, compliance, and licensing. Offices within the Policy and Planning Division oversee licensing, certification, compliance, and monitoring of providers and/or community behavioral health programs. The division leads the development of BHA's State Strategic Plan and assists with strategic planning and centering efforts within LBHAs towards improving population health. In addition, offices in the division co-manage the contract between the Administrative Services Organization contract and Maryland Medicaid and oversee federal and state grants.

The Administrative Services Organization (ASO). Maryland uses an Administrative Services Organization (ASO) that manages a statewide network of PBHS providers that provide a wide array of behavioral health care services that are paid through, and reimbursed for by, the ASO – most of which are covered by Medicaid. Services for recovery and support include mental health case management, mobile treatment/assertive community treatment (ACT), psychiatric rehabilitation, residential rehabilitation, supported employment, respite care, and residential crisis services. In collaboration, BHA and Medicaid are designing an integrated system of mental health and substance use disorder (MH/SUD) services. Construed broadly, BHA provides leadership for clinical and systems management matters, and the Behavioral Health Unit within Medicaid provides leadership for payment rates, compliance, developing State Medicaid regulations, and the Medicaid State Plan matters.

Maryland primarily provides or funds public behavioral health services in two ways, (1) directly through its State psychiatric hospital system, or by (2) funding its managed fee-for-service (FFS) system. However, BHA and Maryland Medicaid co-monitor PBHS implementation. Effective oversight of this contract improves clinical care for individuals receiving services through the PBHS and

leads to better health outcomes for some of the most vulnerable Marylanders.

The ASO oversees (1) provider management and maintenance; (2) operation of the utilization management system; (3) service authorizations; (4) payment of all Medicaid claims and uninsured claims for individuals receiving behavioral health services; (5) provision of data collection, analysis, and management of information services; (6) making information available to participants and the public; (7) consultation, training, quality management and evaluation services; and (8) management of special projects and receipt of stakeholder feedback.

The Maryland Behavioral Health Administration Authority

The Single State Authority (SSA). The MDH's BHA is authorized as the single state governmental agency for creating a comprehensive service delivery system that provides public access to high quality and effective substance misuse prevention and SUD diagnosis, intervention, treatment, rehabilitation, as well as recovery support services that sustain individuals beyond the episode of treatment and rehabilitation. As the single state authority, BHA designates, approves, plans, and coordinates public behavioral health programming within Maryland that offers and provides the services described above, as well as establishes and develops the standards of care, governing regulations, and high-quality methods of treatment that are employed for substance misuse and SUD.

A statewide, integrated service delivery system over a continuum of care provides treatment modalities across settings to promote the health and safety of the public, including patients, families, and communities. BHA plans, develops, and funds services that prevent misuse or harmful involvement with alcohol and other drugs, provides treatment and care for individuals with SUD, and provides other supports throughout individuals' remission and recovery from SUD. Additionally, BHA gathers and maintains information, data, and statistical/other records related to SUD and disseminates related information of "science to service" services for individuals with SUD.

The Division of Policy and Planning. As described above, the division develops and maintains the statewide public behavioral health system (PBHS) through planning, monitoring, compliance, and licensing. In addition, the division oversees the local planning process, is the liaison to all Local Behavioral Health Authorities (LBHAs), and carries out site visits. Offices within the division provide systems planning for BHA.

The Division of Prevention and Promotion. The purpose of this division is the prevention of behavioral health related problems through public and behavioral health best- and evidence-based practices, strategies, and interventions. The division promotes mental health services and resources, prevents substance misuse, suicide, and problem gambling, and provides overdose prevention and outreach services for individuals who use drugs. It works to reduce stigma through public awareness campaigns and connects individuals to needed care and resources. Making available peer support services to individuals and families is a vital component of the division's work, alongside efforts to strengthen the peer workforce. Additionally, to ensure access to care, specialized linkages to behavioral health and other supportive services are provided to veterans, service members, and their families.

The Office of Overdose Prevention The office oversees the Overdose Response Program (ORP) which reduces risk of substance use -related morbidity and mortality with naloxone distribution, allocating grants to support the local implementation of overdose prevention and outreach programs that ensure statewide access to resources like naloxone and implementing various workforce development, training, and technical assistance activities.

The Office of Public Awareness develops, creates, and implements BHA-related statewide public awareness campaigns through multiple media platforms, including SUDs, Maryland's Crisis Helpline, the state's Good Samaritan Law and special projects. Working closely with BHA leadership, divisions including Treatment and Recovery and Prevention & Promotion, and advocates and stakeholders, the office identifies needs, demographics and messaging that best conveys BHA-specific information. A key lesson from the opioid crisis is the vital importance of expanding and deepening public awareness about public health and an informed citizenry. 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.

Maryland's Commitment to Veterans Initiative prioritizes efforts to address the behavioral health needs of service members, veterans and their families (SMVF). Maryland's Commitment to Veterans (MCV) is collaborative effort between BHA, 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. Also, 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.

The Division of Treatment and Recovery. This division ensures that adults and older adults facing mental health and substance use challenges receive the highest quality care through implementing evidence-based practice models that address co-occurring disorders, supporting access to 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:

The Office of Evidence Based Practice Housing and Recovery Support 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, housing first pilot, 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), Maryland Partnership for Affordable Housing (MPAH), Permanent Supportive Housing (PSH), Assertive Community Treatment (ACT), Supported Employment (SE), Person-Centered Care Planning (PCCP), and Critical Time Intervention (CTI).

The Office of Community Integration and Program Planning. This division provides statewide leadership and direction and oversees 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, including, but not limited to, Assertive Outpatient Treatment (AOT), all State Hospital Discharge Initiatives within the department, and developing standing operational procedures across divisions.

The Office of Older Adults and Long-Term Care Services and Support develops and manages an integrated system of care for adults and older adults. Functions of the division include: (1) developing policies and regulations related to clinical services for adults and older adults, (2) identifying gaps in services and best practices to enhance access and quality of care, and (3) 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.

The Office of Treatment Services 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) or have other communication needs), and oversees the federal State Opioid Response (SOR) grant. The office also monitors community-based grant funded services and provides technical assistance to local jurisdictions and constituents.

The Division of Urgent and Acute Care provides oversight of all urgent and acute behavioral health care services, including the 988 Suicide and Crisis Lifeline and call/text/chat centers, mobile crisis intervention teams (CIT), mobile crisis, mental health residential crisis, and SOR residential crisis services for individuals with opioid use disorder (OUD). 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 correctional facilities, Drug Court, and DataLink. The office oversees care coordination and implements a statewide care traffic control system to include a bed registry and referral system.

The Division of 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. PBHEI 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 ensure a highly coordinated and individualized approach to care.

PBHEI core functions include (1) development and implementation of an integrated and coordinated system of care; (2) 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; (3) 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; (4) oversight and problem resolution for local behavioral health authorities in matters related to the target population; and (5) leadership for demonstration projects to improve service delivery approaches to population and special needs groups within the child and adolescent population.

The Office of Behavioral Health Services is a part of the MDH's Public Health Services, Prevention and Health Promotion Administration, and it 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 children, and prevention services for families involved with SUD. This includes oversight of residential treatment and transitional services for pregnant women and women with children, the Pregnant Women and Women with Children MOUD Prescription Drug Opioid Addiction (PDOA) federal grant, the recovery support specialists in pregnancy/postpartum project, recovery housing for women and women with dependent children, and several other legislatively-mandated initiatives.

BHA approved residential treatment programs for pregnant women and women with children (PWWC), which are required to provide services for pregnant women within 48 hours of presenting to the program. This office also oversees recovery services for women with children, including recovery housing for pregnant and parenting women and the Recovery Support for Pregnant and Postpartum Women's (RSPPW) Program, which provides wrap-around recovery support for women in early recovery. Currently, MDH has specific 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 priority population of pregnant women and women with dependent children, including peer support services. The Level 1 MOUD programs can initiate and sustain pregnant women and women with dependent children on MOUD.

BHA's Work With External Stakeholders. In addition to internal stakeholders, BHA works with college/university and sister agencies including 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 Office of Overdose Response (MOOR), and the Governor's Office of the Deaf and Hard of Hearing (GODHH) to deliver of mental health and substance use services.

Maryland's Regional, County, and Local Organization of the Behavioral Health System

The Behavioral Health Administration, in collaboration with Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), Local Behavioral Health Authorities (LBHAs), and Administrative Services Organization (ASO), oversees the statewide behavioral health system. 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. CSAs, LAAs, ASO and LBHAs are local entities authorized and tasked with developing and managing a coordinated network of Maryland's public behavioral health services in a defined service area.

Such local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations varying in size, needs, budgets, and budget sources, with administrative, program, and fiscal authorities, and 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. Local entities conduct jurisdiction-level needs assessments, monitor providers, and develop strategic plans that align with that state's priorities and goals.

In addition, 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. 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.

Maryland counties are typically organized by (1) single local behavioral health authority structures, where one agency manages both mental health and substance use services (e.g., Baltimore City, Anne Arundel County, Allegany County), or (2) dual structures, in which a core service agency oversees mental health and a local addiction authority oversees substance use services (e.g., Harford County, Baltimore County). These entities are key collaborators with state and local partners across sectors such as (a) healthcare providers (e.g., hospitals, crisis centers, outpatient and residential programs); (b) educational institutions (e.g., school-based mental health services, behavioral health training); (c) judicial and public safety (e.g., specialty courts, crisis intervention teams, reentry programs) entities; (d) social service agencies (e.g., housing, benefits assistance, family preservation); (d) community-based organizations and peer-led recovery centers; and (e) Local Management Boards (LMBs), Drug and Alcohol Councils (DACs), and Mental Health Advisory Committees (MHACs).

Implementation of Change Management. BHA works with jurisdictions and stakeholders to integrate systems management effectively, and partners with local authorities to standardize systems integration by hosting Learning Community Collaboratives. Each jurisdiction does a self-assessment annually on their systems management integration status. The Integration Plan is built on an analysis of experiences in all 24 jurisdictions and includes financial analysis indicating increased value from systems management. BHA and several local authorities have a workgroup to update the Integration Tool and for feedback about the local strategic planning process. BHA assists with challenges such as 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.

Requirements to Serve Priority Populations

As the single state authority, BHA ensures that public behavioral health programming within Maryland is aligned with high-quality standards of care and federal and state laws and regulations. Within the Division of Policy and Planning, the Office of Planning primarily oversees administration and management of the Community Mental Health Services (MHBG) and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grants and liaises with SAMHSA. The Office of Planning manages the Behavioral Health Advisory Council (BHAC), its Planning Council, and its Planning Committee, and provides administrative support to the Joint Commission on Behavioral Healthcare Treatment and Access.

Addressing Needs of Those Experiencing or Vulnerable to Homelessness

The Treatment and Recovery Division oversees State Care Coordination (SCC) as well as the Office of Evidence-Based Practice Housing and Recovery Support, which implements evidence-based housing and homelessness initiatives, including:

(i) Permanent Supportive Housing (PSH) programs,

(ii) Continuum of Care housing programs,

(iii)Projects for Assistance in Transition from Homelessness (PATH) programs,

(iv) SSI/SSDI, Outreach, Access and Recovery (SOAR) initiatives,

(v) The Maryland Partnership for Affordable Housing (MPAH)

PSH allows individuals to choose in different approaches to housing and services. The PSH initiative began in 2023 and provides rental assistance to individuals transitioning from a Residential Rehabilitation Program (RRP) in order for them to live independently in the community. As residents in a rehabilitation program, people build skills to learn to live independently. In PSH, individuals can put their skills into practice. The PSH initiative assists with locating, securing, leasing, and maintaining housing in an individual's chosen community, funding application fees, security deposits, and moving costs. Individuals continue to receive support from the PSH staff after move-in to sustain their housing in the community.

An estimated fifty individuals were part of the pilot in 2023, but due to the program's success, an additional 25 slots were awarded in 2024, bringing the total to 75, which is the present capacity. Many of the individuals in the program have spent years in structured environments and enjoy the independence provided through the PSH initiative. The Office of Evidence-Based Practice Housing and Recovery Support also provides services for Assertive Community Treatment (ACT), Supported Employment (SE), Person-Centered Care Planning (PCCP), and Critical Time Intervention (CTI).

The Division of Treatment and Recovery also oversees the statewide care coordination (SCC) program with state care coordinators in each jurisdiction. SCC improves outcomes by providing short-term case management services that support access to recovery

support services. Individuals with substance use disorder (SUD) transitioning between settings are more vulnerable. State care coordinators work across institutions like correctional facilities, state psychiatric hospitals, a residential SUD treatment providers, to support eligible individuals through the Maryland Recovery Net (MDRN) with services that include recovery housing, facilitation of referrals to higher levels of treatment or care, and connect individuals to other resources in the community, like entitlements and employment and legal services.

Coordinators in each jurisdiction collaborate closely across the state and assist each other with "warm-hand offs" if an individual is referred to another jurisdiction. In Anne Arundel County, for example, the state served over 500 individuals with care coordination services in the state fiscal year of 2025.

Services for People Who Inject Drugs

Substance use treatment capacity does not exceed 90 percent, therefore BHA does not have a capacity management program or waitlist for PWID. However, targeted, culturally responsive outreach to older adults in the Baltimore City region, and other communities who are at high risk, is a priority at the state and city level for the BHA.

The Office of Overdose Prevention provides grants to jurisdictions that support services including outreach to people who inject drugs (PWID) and referrals to substance use treatment providers as well as primary health care and mental health. Services also can include those for case management; peer support; substance use counseling, treatment services, and recovery supports; rapid testing for HIV/Hepatitis C (HCV) and referrals to care; and transportation to necessary appointments.

Immediate Access for PWWC to Residential Substance Use Treatment

BHA develops policies and services to address the specific needs of the pregnant women and women with children (PWWC) priority population, including screening, assessment, interim services, admission, and/or referral to treatment. BHA does so through the Office of Behavioral Health Services, which was recently moved into the Prevention and Health Promotion Administration (PHPA) within the Maryland Department of Health. OGSS oversees residential substance use treatment and recovery support services for PWWC, including providing recovery housing, and the Recovery Support for Pregnant and Postpartum Women's (RSPPW) program, which provides wrap-around and recovery support services for women in early recovery.

OGSS monitors the need among the PWWC priority population and existing capacity for substance use treatment and recovery support services. In the next two fiscal years, OGSS will be conducting a pregnant and parenting women with substance use conditions needs assessment to ensure treatment and recovery services capacity aligns with need.

Pregnant women and women with children (PWWC) are given preference and have priority admission to residential substance use treatment providers. Within 24 hours of their request, PWWC can access and are approved to enter substance use treatment at BHA-approved residential treatment programs, which regularly advertise the availability of treatment and notify the public of treatment availability through jurisdictions.

All approved substance use treatment providers for pregnant women and women with children are provided with a copy of the PPW Manual, which describes the immediate access requirement in detail. The manual states, "upon completion of the [document review] process, the PPW specialty-provider will receive an Approval Letter within 24 hours. Once the PPW specialty provider receives the Approval Letter, the provider will need to seek authorization for reimbursement from the Administrative Services Organization (ASO). Once the woman is admitted into the treatment program, an Admission Letter is sent to GSS."

BHA's Treatment Compliance Unit monitors the conditions of award and PWWC residential substance use treatment providers on a quarterly or yearly basis, depending on the type of funding. The Compliance Unit ensures providers' adherence to the 24-hour admission requirement. If the program is out of compliance they are required to submit a Plan of Correction to the BHA within 30 days of the site visit.

Services for People in Substance Use Treatment At-Risk for Tuberculosis

The Maryland Department of Health's Prevention and Health Promotion Administration (PHPA) has an Infectious Diseases Bureau with the Center for Tuberculosis Control and Prevention (the MD TB Center). At the state level, the Treatment Compliance Unit at BHA liaise with the Center for Tuberculosis Control and Prevention to ensure individuals are screened for high risk for TB, provided TB services, and case management services ensure TB services are received at substance use treatment providers.

At the local level, the MD TB Center works with local health departments (LDHs), health care providers, and other entities who contribute to the control and prevention of TB in Maryland to provide policy development and technical assistance. The Maryland TB Center is 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 U.S. As part of the BHA's network, jurisdictions have awareness of the federal TB requirements and meet them with cooperating substance use treatment providers that provide screening for high risk individuals, TB services, and case management. Some LDHs contract with private entities for TB services that meet the standard of care.

BHA's Treatment Compliance Unit has monitoring tools that incorporate Specific Conditions and Requirements and create the framework for the Unit's Administrative Review process. This includes an examination of providers' admission policies, as well as determining whether providers prioritize coordinated treatment services and make referrals to address patient's medical and preventive health needs. The Unit's monitoring tool for patient records reviews whether the program completes an infectious disease assessment and/or screening (for TB, HIV, Hepatitis, and STIs) and conducts education as part of their comprehensive patient assessments. The patient record review evaluates whether there is documentation of their TB history, a TB risk assessment, and results from a TB skin test. In instances with a positive skin test result, the evaluator will review individual sessions and/or medical notes to determine if referrals and counseling were provided.

Providers found non-compliant with regulatory requirements that address health and safety risks for the patient and patient community are cited as deficiencies. These providers are required to submit Plans of Correction that are reviewed and approved or sent back for revisions by the evaluators. When the provider undergoes its next scheduled review, their review packet includes the evaluator's previous findings. If the evaluator carries out a review and determines the provider has not implemented the previously submitted Plan of Correction, and/or identifies the same health and safety risks deficiencies, the evaluator will

recommend more stringent monitoring. The Compliance Unit works with providers providing targeted technical assistance to achieve compliance in specific problem areas. Providers found in continued non-compliance may be referred to the Assistant Attorney General who can require a Directed Plan of Correction.

Two Illustrations of Intersecting Behavioral Health System Organization

Maryland's Howard County and its Mid Shore Planning Collaborative (MSPC) illustrate the regional, county and local organization of the public behavioral health system in Maryland and how mental health and substance use services meet the needs of priority populations.

Howard County Health Department's Bureau of Behavioral Health (HCHD BBH). In Howard County, HCHD BBH is the LBHA that develops, oversees, and integrates prevention, interventions, treatment, recovery services, while supporting a broad network of services tailored to meet the needs of Howard County residents. The county's 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 SUD, Howard County offers a continuum of care. Naloxone training and overdose prevention 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. Humanim serves adults through Targeted Case Management and supports through the LEAD program. Other mental health partners include NAMI Howard County, On Our Own of Howard County, and providers like Way Station and Ellie Mental Health.

This 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 redirects 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.

The county's 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 children with serious emotional disturbance (SED) and individuals with serious mental illness (SMI), individuals with SUD, including pregnant women and women with dependent children, as well as military personnel and their families.

School-based MH services are embedded in HCPSS through programs such as Sources of Strength (SOS) and through peer recovery support, build protective factors and promote 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. Finally, youth suicide prevention is a major priority, with campaigns such as "It's Ok to Ask" raising awareness and promoting help-seeking behaviors.

Adults with SMI receive support through Targeted Case Management, Residential Rehabilitation Programs, LEAD, and Behavioral Health Court. Peer support is integrated across crisis, recovery, and school settings to promote long-term engagement and empowerment. The county delivers a robust mix of overdose prevention and outreach, 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 are provided services through the Family OPTIONS Program that serves first-time mothers aged 19 or younger who are pregnant or parenting a child under age 2 and reside in Howard County. This program focuses on helping participants thrive academically and connects high-risk mothers to outpatient mental health services. It also offers in-person services, including home visits and group sessions. Military personnel (active, guard, reserve, and veteran) and their families are engaged through community events like "Good Vibes and Voices: Concert and Event." 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 Planning Collaborative (MSPC). Incorporating five counties in the rural, mid-shore region, the MSPC includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The Collaborative is coordinated through a regionally integrated and collaborative approach and 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, outreach 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 disparities, 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 (LDAAC), and employs a dedicated Overdose Prevention and Outreach Coordinator serving the entire region. The 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 an LAA responsible for managing the PBHS locally, while participating in MSPC's regional planning and implementation efforts. Local Health Departments (LHDs) are essential partners in delivering overdose prevention and outreach 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 young people. 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.

Related to priority populations such as individuals with SMI, Dorchester County, for example, has several individuals that identify as homeless, which makes mobile treatment the most appropriate referral for services that support these individuals in the community. For individuals with mental health and SUD 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. Finally, for 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.

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.

The Maryland Behavioral Health Administration Authority

The Single State Authority (SSA). The MDH's BHA is authorized as the single state governmental agency for creating a comprehensive service delivery system that provides public access to high quality and effective substance misuse prevention and SUD diagnosis, intervention, treatment, rehabilitation, as well as recovery support services that sustain individuals beyond the episode of treatment and rehabilitation. As the single state authority, BHA designates, approves, plans, and coordinates public behavioral health programming within Maryland that offers and provides the services described above, as well as establishes and develops the standards of care, governing regulations, and high-quality methods of treatment that are employed for substance misuse and SUD.

A statewide, integrated service delivery system over a continuum of care provides treatment modalities across settings to promote the health and safety of the public, including patients, families, and communities. BHA plans, develops, and funds services that prevent misuse or harmful involvement with alcohol and other drugs, provides treatment and care for individuals with SUD, and provides other supports throughout individuals' remission and recovery from SUD. Additionally, BHA gathers and maintains information, data, and statistical/other records related to SUD and disseminates related information of "science to service" services for individuals with SUD.

The Division of Policy and Planning. As described above, the division develops and maintains the statewide public behavioral health system (PBHS) through planning, monitoring, compliance, and licensing. In addition, the division oversees the local planning process, is the liaison to all Local Behavioral Health Authorities (LBHAs), and carries out site visits. Offices within the division provide systems planning for BHA.

The Division of Prevention and Promotion. The purpose of this division is the prevention of behavioral health related problems through public and behavioral health best- and evidence-based practices, strategies, and interventions. The division promotes mental health services and resources, prevents substance misuse, suicide, and problem gambling, and provides overdose prevention and outreach services for individuals who use drugs. It works to reduce stigma through public awareness campaigns and connects individuals to needed care and resources. Making available peer support services to individuals and families is a vital component of the division's work, alongside efforts to strengthen the peer workforce. Additionally, to ensure access to care, specialized linkages to behavioral health and other supportive services are provided to veterans, service members, and their families.

The Office of Overdose Prevention The office oversees the Overdose Response Program (ORP) which reduces risk of substance use -related morbidity and mortality with naloxone distribution, allocating grants to support the local implementation of overdose prevention and outreach programs that ensure statewide access to resources like naloxone by, and implementing various workforce development, training, and technical assistance activities. The ORP authorizes government agencies and community-based organizations as ORPs, which allows them to provide overdose education and dispense naloxone to the community.

The Office of Public Awareness develops, creates, and implements BHA-related statewide public awareness campaigns through multiple media platforms, including SUDs, Maryland's Crisis Helpline, the state's Good Samaritan Law and special projects. Working closely with BHA leadership, divisions including Treatment and Recovery and Prevention & Promotion, and advocates and stakeholders, the office identifies needs, demographics and messaging that best conveys BHA-specific information. A key lesson from the opioid crisis is the vital importance of expanding and deepening public awareness about public health and an informed citizenry. As part of the MDH, BHA in conjunction with the LBHAs, CSAs, and LAAs is developing creative ways to keep the public aware and informed 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 Initiative is embedded within the Office of Community Based Access and Support and drives a recovery-oriented system of care by 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, we can assist individuals with their concerns and/or complaints regarding services received or treatment provided.

Maryland's Commitment to Veterans Initiative prioritizes efforts to address the behavioral health needs of service members, veterans and their families (SMVF). Maryland's Commitment to Veterans (MCV) is collaborative effort between BHA, 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. Also, 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.

The Division of Treatment and Recovery. This division ensures that adults and older adults facing mental health and substance use challenges receive the highest quality care through 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:

The Office of Evidence Based Practice Housing and Recovery Support 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, housing first pilot, 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), Maryland Partnership for Affordable Housing (MPAH), Permanent Supportive Housing (PSH), Assertive Community Treatment (ACT), Supported Employment (SE), Person-Centered Care Planning (PCCP), and Critical Time Intervention (CTI).

The Office of State Hospital Discharge Initiative provides transitional programs that support individuals that are discharged from state hospitals into community programs.

The Office of Community Integration and Program Planning. This division provides statewide leadership and direction and oversees 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, including, but not limited to, Assertive Outpatient Treatment (AOT), all State Hospital Discharge Initiatives within the department, and developing standing operational procedures across divisions.

The Office of Older Adults and Long-Term Care Services and Support develops and manages an integrated system of care for adults and older adults. Functions of the division include: (1) developing policies and regulations related to clinical services for adults and older adults, (2) identifying gaps in services and best practices to enhance access and quality of care, and (3) 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.

The Office of Treatment Services 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 oversees the federal State Opioid Response (SOR) grant. The office also monitors community-based grant funded services and provides technical assistance to local jurisdictions and constituents.

The Division of Urgent and Acute Care provides oversight of all urgent and acute behavioral health care services, including the 988 Suicide and Crisis Lifeline and call/text/chat centers, mobile crisis intervention teams (CIT), mobile crisis, mental health residential crisis, and SOR residential crisis services for individuals with opioid use disorder (OUD). 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 correctional facilities, Drug Court, and DataLink. The office oversees care coordination and implements a statewide care traffic control system to include a bed registry and referral system.

The Division of 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. PBHEI 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 ensure a highly coordinated and individualized approach to care.
PBHEI core functions include (1) development and implementation of an integrated and coordinated system of care; (2) 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; (3) 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; (4) oversight and problem resolution for local behavioral health authorities in matters related to the target population; and (5) leadership for demonstration projects to improve service delivery approaches to population and special needs groups within the child and adolescent population.

The Office of Behavioral Health Services is a part of the MDH's Public Health Services, Prevention and Health Promotion Administration, and it 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 children, and prevention services for families involved with SUD. This includes oversight of: (a) residential treatment and transitional services for pregnant women and women with children, (b) the Pregnant Women and Women with Children MOUD Prescription Drug Opioid Addiction (PDOA) federal grant, (c) Sobriety Treatment and Recovery Teams (START), (d) the childcare during withdrawal management initiative, (e) the recovery support specialists in pregnancy/postpartum project, (f) recovery housing for women and women with dependent children, and (g) several other legislatively-mandated initiatives.

BHA approved residential treatment programs for pregnant women and women with children (PWWC), which are required to provide services for pregnant women within 48 hours of presenting to the program. This office also oversees recovery services for women with children, including recovery housing for pregnant and parenting women and the Recovery Support for Pregnant and Postpartum Women's (RSPPW) Program, which provides wrap-around recovery support for women in early recovery. Currently, MDH has specific 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 priority population of pregnant women and women with dependent children, including peer support services. The Level 1 MOUD programs can initiate and sustain pregnant women and women with dependent children on MOUD.

BHA's Work With External Stakeholders. In addition to internal stakeholders, BHA works with college/university and sister agencies including 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 Office of Overdose Response (MOOR), and the Governor's Office of the Deaf and Hard of Hearing (GODHH) to deliver of mental health and substance use services.

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 Regional, County, and Local Organization of the Behavioral Health System

The Behavioral Health Administration, in collaboration with Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), Local Behavioral Health Authorities (LBHAs), and Administrative Services Organization (ASO), oversees the statewide behavioral health system. 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. CSAs, LAAs, ASO and LBHAs are local entities authorized and tasked with developing and managing a coordinated network of Maryland's public behavioral health services in a defined service area.

Such local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations varying in size, needs, budgets, and budget sources, with administrative, program, and fiscal authorities, and 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. Local entities conduct jurisdiction-level needs assessments, monitor providers, and develop strategic plans that align with that state's priorities and goals.

In addition, 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. 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.

Maryland counties are typically organized by (1) single local behavioral health authority structures, where one agency manages both mental health and substance use services (e.g., Baltimore City, Anne Arundel County, Allegany County), or (2) dual structures, in which a core service agency oversees mental health and a local addiction authority oversees substance use services (e.g., Harford County, Baltimore County). These entities are key collaborators with state and local partners across sectors such as (a) healthcare providers (e.g., hospitals, crisis centers, outpatient and residential programs); (b) educational institutions (e.g., school-based mental health services, behavioral health training); (c) judicial and public safety (e.g., specialty courts, crisis intervention teams, reentry programs) entities; (d) social service agencies (e.g., housing, benefits assistance, family preservation); (d) community-based organizations and peer-led recovery centers; and (e) Local Management Boards (LMBs), Drug and Alcohol Councils (DACs), and Mental Health Advisory Committees (MHACs).

Implementation of Change Management. BHA works with jurisdictions and stakeholders to integrate systems management effectively, and partners with local authorities to standardize systems integration by hosting Learning Community Collaboratives. Each jurisdiction does a self-assessment annually on their systems management integration status. The Integration Plan is built on an analysis of experiences in all 24 jurisdictions and includes financial analysis indicating increased value from systems management. BHA and several local authorities have a workgroup to update the Integration Tool and for feedback about the local strategic planning process. BHA assists with challenges such as 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.

Requirements to Serve Priority Populations

As the single state authority, BHA ensures that public behavioral health programming within Maryland is aligned with high-quality standards of care and federal and state laws and regulations. Within the Division of Policy and Planning, the Office of Planning primarily oversees administration and management of the Community Mental Health Services (MHBG) and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grants and liaises with SAMHSA. The Office of Planning manages the Behavioral Health Advisory Council (BHAC), its Planning Council, and its Planning Committee, and provides administrative support to the Joint Commission on Behavioral Healthcare Treatment and Access.

Addressing Needs of Those Experiencing or Vulnerable to Homelessness

The Treatment and Recovery Division oversees State Care Coordination (SCC) as well as the Office of Evidence-Based Practice Housing and Recovery Support, which implements evidence-based housing and homelessness initiatives, including:
(i) Permanent Supportive Housing (PSH) programs,
(ii) Continuum of Care housing programs,
(iii) Projects for Assistance in Transition from Homelessness (PATH) programs,
(iv) SSI/SSDI, Outreach, Access and Recovery (SOAR) initiatives,
(v) The Maryland Partnership for Affordable Housing (MPAH)

PSH allows individuals to choose in different approaches to housing and services. The PSH initiative began in 2023 and provides rental assistance to individuals transitioning from a Residential Rehabilitation Program (RRP) in order for them to live independently in the community. As residents in a rehabilitation program, people build skills to learn to live independently. In PSH, individuals can put their skills into practice. The PSH initiative assists with locating, securing, leasing, and maintaining housing in an individual's chosen community, funding application fees, security deposits, and moving costs. Individuals continue to receive support from the PSH staff after move-in to sustain their housing in the community.

An estimated fifty individuals were part of the pilot in 2023, but due to the program's success, an additional 25 slots were awarded in 2024, bringing the total to 75, which is the present capacity. Many of the individuals in the program have spent years in structured environments and enjoy the independence provided through the PSH initiative. The Office of Evidence-Based Practice Housing and Recovery Support also provides services for Assertive Community Treatment (ACT), Supported Employment (SE), Person-Centered Care Planning (PCCP), and Critical Time Intervention (CTI).

The Division of Treatment and Recovery also oversees the statewide care coordination (SCC) program with state care coordinators in each jurisdiction. SCC improves outcomes by providing short-term case management services that support access to recovery support services. Individuals with substance use disorder (SUD) transitioning between settings are more vulnerable. State care coordinators work across institutions like correctional facilities, state psychiatric hospitals, a residential SUD treatment providers, to support eligible individuals through the Maryland Recovery Net (MDRN) with services that include recovery housing, facilitation of referrals to higher levels of treatment or care, and connect individuals to other resources in the community, like entitlements and employment and legal services.
Coordinators in each jurisdiction collaborate closely across the state and assist each other with "warm-hand offs" if an individual is referred to another jurisdiction. In Anne Arundel County, for example, the state served over 500 individuals with care coordination services in the state fiscal year of 2025.

Services for People Who Inject Drugs

Substance use treatment capacity does not exceed 90 percent, therefore BHA does not have a capacity management program or waitlist for PWID. However, targeted, culturally responsive outreach to older adults in the Baltimore City region, and other communities who are at high risk, is a priority at the state and city level for the BHA.

The Office of Overdose Prevention provides grants to jurisdictions that support services including outreach to people who inject drugs (PWID) and in some cases, referrals to substance use treatment providers as well as primary health care and mental health. Most jurisdictions provide direct services to PWID, and in some jurisdictions, these importantly include medical or wound care referrals – a current concern due to adulterants in the drug supply like xylazine. Services also can include those for case management; peer support; substance use counseling, treatment services, and recovery supports; wound care; rapid testing for HIV/Hepatitis C (HCV) and referrals to care; referrals for medical and mental care; and transportation to necessary appointments. These services can be provided at fixed locations, mobile units, or street teams.

Immediate Access for PWWC to Residential Substance Use Treatment

BHA develops policies and services to address the specific needs of the pregnant women and women with children (PWWC) priority population, including screening, assessment, interim services, admission, and/or referral to treatment. BHA does so through the Office of Behavioral Health Services. The Office oversees residential substance use treatment and recovery support services for PWWC, including providing recovery housing, and the Recovery Support for Pregnant and Postpartum Women's (RSPPW) program, which provides wrap-around and recovery support services for women in early recovery.

The Office monitors the need among the PWWC priority population and existing capacity for substance use treatment and recovery support services. In the next two fiscal years, the Office will be conducting a pregnant and parenting women with substance use conditions needs assessment to ensure treatment and recovery services capacity aligns with need.

Pregnant women and women with children (PWWC) are given preference and have priority admission to residential substance use treatment providers. Within 24 hours of their request, PWWC can access and are approved to enter substance use treatment at BHA-approved residential treatment programs, which regularly advertise the availability of treatment and notify the public of treatment availability through jurisdictions.

All approved substance use treatment providers for pregnant women and women with children are provided with a copy of the PPW Manual, which describes the immediate access requirement in detail. The manual states, "upon completion of the [document review] process, the PPW specialty-provider will receive an Approval Letter within 24 hours. Once the PPW specialty provider receives the Approval Letter, the provider will need to seek authorization for reimbursement from the Administrative Services Organization (ASO). Once the woman is admitted into the treatment program, an Admission Letter is sent."

BHA's Treatment Compliance Unit monitors the conditions of award and PWWC residential substance use treatment providers on a quarterly or yearly basis, depending on the type of funding. The Compliance Unit ensures providers' adherence to the 24-hour admission requirement. If the program is out of compliance they are required to submit a Plan of Correction to the BHA within 30 days of the site visit.

Services for People in Substance Use Treatment At-Risk for Tuberculosis

The Maryland Department of Health's Prevention and Health Promotion Administration (PHPA) has an Infectious Diseases Bureau with the Center for Tuberculosis Control and Prevention (the MD TB Center). At the state level, the Treatment Compliance Unit at BHA liaise with the Center for Tuberculosis Control and Prevention to ensure individuals are screened for high risk for TB, provided TB services, and case management services ensure TB services are received at substance use treatment providers.

At the local level, the MD TB Center works with local health departments (LDHs), health care providers, and other entities who contribute to the control and prevention of TB in Maryland to provide policy development and technical assistance. The Maryland TB Center is 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 U.S. As part of the BHA's network, jurisdictions have awareness of the federal TB requirements and meet them with cooperating substance use treatment providers that provide screening for high risk individuals, TB services, and case management. Some LDHs contract with private entities for TB services that meet the standard of care.

BHA's Treatment Compliance Unit has monitoring tools that incorporate Specific Conditions and Requirements and create the framework for the Unit's Administrative Review process. This includes an examination of providers' admission policies, as well as determining whether providers prioritize coordinated treatment services and make referrals to address patient's medical and preventive health needs. The Unit's monitoring tool for patient records reviews whether the program completes an infectious disease assessment and/or screening (for TB, HIV, Hepatitis, and STIs) and conducts education as part of their comprehensive patient assessments. The patient record review evaluates whether there is documentation of their TB history, a TB risk assessment, and results from a TB skin test. In instances with a positive skin test result, the evaluator will review individual sessions and/or medical notes to determine if referrals and counseling were provided.

Providers found non-compliant with regulatory requirements that address health and safety risks for the patient and patient community are cited as deficiencies. These providers are required to submit Plans of Correction that are reviewed and approved or sent back for revisions by the evaluators. When the provider undergoes its next scheduled review, their review packet includes the evaluator's previous findings. If the evaluator carries out a review and determines the provider has not implemented the previously submitted Plan of Correction, and/or identifies the same health and safety risks deficiencies, the evaluator will recommend more stringent monitoring. The Compliance Unit works with providers providing targeted technical assistance to achieve compliance in specific problem areas. Providers found in continued non-compliance may be referred to the Assistant Attorney General who can require a Directed Plan of Correction.

Two Illustrations of Intersecting Behavioral Health System Organization

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Howard County Health Department's Bureau of Behavioral Health (HCHD BBH). In Howard County, HCHD BBH is the LBHA that develops, oversees, and integrates prevention, interventions, treatment, recovery services, while supporting a broad network of services tailored to meet the needs of Howard County residents. The county's 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 SUD, Howard County offers a continuum of care. Naloxone training and overdose prevention 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. Humanim serves adults through Targeted Case Management and supports redirection through a program called, LEAD program. Other mental health partners include NAMI Howard County, On Our Own of Howard County, and providers like Way Station and Ellie Mental Health.

This 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.

The county's 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 children with serious emotional disturbance (SED) and individuals with serious mental illness (SMI), individuals with SUD, including pregnant women and women with dependent children, as well as military personnel and their families.

School-based MH services are embedded in HCPSS through programs such as Sources of Strength (SOS) and through peer recovery support, build protective factors and promote 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. Finally, youth suicide prevention is a major priority, with campaigns such as "It's Ok to Ask" raising awareness and promoting help -seeking behaviors.

Adults with SMI receive support through Targeted Case Management, Residential Rehabilitation Programs, LEAD, and Behavioral Health Court. Peer support is integrated across crisis, recovery, and school settings to promote long-term engagement and empowerment. The county delivers a robust mix of overdose prevention and outreach, 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 are provided services through the Family OPTIONS Program that serves first-time mothers aged 19 or younger who are pregnant or parenting a child under age 2 and reside in Howard County. This program focuses on helping participants thrive academically and connects high-risk mothers to outpatient mental health services. It also offers in-person services, including home visits and group sessions. Military personnel (active, guard, reserve, and veteran) and their families are engaged through community events like "Good Vibes and Voices: Concert and Event." 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 Planning Collaborative (MSPC). Incorporating five counties in the rural, mid-shore region, the MSPC includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The Collaborative is coordinated through a regionally integrated and collaborative approach and 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, outreach 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 barriers, inadequate healthcare and behavioral health workforce, internet and broadband access disparities, 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 (LDAAC), and employs a dedicated Overdose Prevention and Outreach Coordinator serving the entire region. The 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 an LAA responsible for managing the PBHS locally, while participating in MSPC's regional planning and implementation efforts. Local Health Departments (LHDs) are essential partners in delivering overdose prevention and outreach 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 young people. 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.

Related to priority populations such as individuals with SMI, Dorchester County, for example, has several individuals that identify as homeless, which makes mobile treatment the most appropriate referral for services that support these individuals in the community. For individuals with mental health and SUD 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. Finally, for 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.

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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.

Identifying Unmet Needs and Gaps in Care

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.

Maryland's continuous assessment to identify unmet needs and locate gaps in care is derived from several data platforms that determine the service needs of consumers who are part of Maryland's PBHS. The foundation of BHA's needs assessment is based on analysis of claims data from the Behavioral Health ASO. The ASO collects required data for all SUD services for which it reimburses, whether or not it manages the services. The ASO manages and reimburses services to Medicaid enrollees and uninsured individuals, who based certain criteria may be covered with state-only PBHS funds. This system is driven by a combination of authorizations and claims for behavioral health services, and all required SUD Treatment Episode Data Set (TEDS) data elements have been built into the ASO traditionally. This continuous data analysis is the foundation that guides the design and implementation of new, appropriate strategies to address behavioral health disparities in the PBHS in Maryland, and it is vital to improving the quality and effectiveness of a strong system, including addressing SAMHSA's priority areas and populations .

Emerging Trends in the Behavioral Health

To identify and continually align with emerging trends and threats in behavioral health, BHA is implementing a recurring behavioral health needs assessment, is aiming to rely further on state-level epidemiological data to inform prevention efforts in future years, including continued focus on using epidemiological data and/or real-time, public facing analysis of fatalities by suicide or unintentional overdose, including the 2025 Opioid Overdose Dashboard tool, and continued work assessing trauma, including adverse childhood experiences (ACEs)-related trends in Maryland through the Behavioral Risk Factors and Youth Risk Behavior Surveillance Systems; this is described briefly below before the needs assessment.

Recurring Behavioral Health Needs Assessment. BHA's new Behavioral Health Recurring Needs Assessment (BH-RNA) determines key gaps and challenges in service delivery for Maryland's PBHS and will be conducted every three years with key metrics updated on an annual basis. The design, implementation plan, and protocols for the assessment were completed in May 2025. The first assessment is planned for the Fall of FY2026. The University of Maryland Baltimore Systems Evaluation Center (SEC) and BHA have designed a process and methodology for a statewide BH-RNA to: (1) meet SAMHSA's requirements and inform Block Grant planning and development efforts, (2) inform the strategic allocation of state and federal resources to where they are needed most, (3) support local planning with LBHAs, and monitoring and management decisions, (4) identify gaps in services and disparities in 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 incorporates multiple federal and state data sources, including measures relating to population demographics (e.g. 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. The assessment will derive estimates in two areas related to SUD, (1) overall need for individuals with SUD, (2) need for individuals with OUD and also include estimates for mental health and SMI/SED. Primary data sources include the National Survey on Drug Use and Health (NSDUH), individuals who receive buprenorphine prescriptions in PDMP, data on unintentional overdose fatalities, individuals diagnosed with SUD in ASO claims data, and individuals who receive hospital inpatient or outpatient treatment services in the HSCRC case mix data. Need estimates are based on a multi-data source methodology adapted from a New York study that estimated the prevalence of opioid use. The BH-RNA will be conducted every three years with key metrics updated on an annual basis with the first assessment in fall FY2026.

Using Epidemiological Data to Inform Prevention Efforts. MDH's BHA is aiming to increasingly use epidemiological data, as recommended, in future years. Epidemiology discerns measurable, population-level outcomes and provides a crucial foundation shaping substance use/misuse prevention efforts. Epidemiological data informs decision making and helps to identify areas and populations most impacted by substance misuse and its consequences. Additionally, epidemiological data assists with targeting grantees' limited prevention resources toward key contributing factors in their communities. Ultimately, using epidemiological data will also permit BHA to monitor and evaluate prevention efforts and track successes and highlight areas for needed improvements.
Collecting Primary Prevention Population Level Measures: Minimum Data Set. The Office of Prevention and Promotion makes an annual assessment to determine the most strategic utilization of its prevention resources to meet the prevention needs of Maryland youth. Future efforts may include data collection and review through a Maryland State Epidemiological Outcomes Workgroup (SEOW), other data sources, and soliciting and utilizing input from the Behavioral Health Advisory Council. All funded prevention program providers are required to collect and report prevention data using the Minimum Data Set (MDS), which collects information on primary prevention programs, activities and strategies. The MDS is centralized at the state level, collecting very specific process and group level information in Maryland. A small set of well-defined data are retained about each prevention service, with all information collected about service participants at the whole-group level. MDS data includes the type of service, target population, group and activity information, dates the service was performed, applicable CSAP strategy, item counts, participant demographics, IOM category and state-defined data. The MDS data collection system is uniform across the state and implements extensive validations to ensure it is internally consistent. It serves as a model for a standardized prevention data collection system that allows the state and prevention service providers to quantify and compare the number and type of primary prevention and early intervention services delivered, while also permitting county prevention coordinators and prevention service providers to generate onsite reports and analysis relating to services offered, target populations and staff resource deployment.

Fatality By Suicide or Unintentional Overdose Fatality Data. MDH's BHA has multi-pronged approaches that both track and prevent fatalities by suicide and unintentional overdose (OD). For example, BHA matches records of fatalities by suicide and overdose to PBHS service utilization and shares analysis of group fatality characteristics and demographics with BHA stakeholders, including the majority of BHA staff and staff members of the local system authorities. Fatality demographics of individuals active in the PBHS are very similar to the population of OD deaths compared to the overall population. Those fatalities who received both specialty MH and SUD services were more likely to experience a fatal overdose.

The BHA launched an interactive, public-facing Opioid Overdose Dashboard tool in 2025 that contains current data on fatal and non-fatal OD events and other opioid related indicators. The dashboard will be an increasingly essential tool for MDH BHA and Public Health Services to monitor OD events, identify emerging risks and service needs, and inform system and program planning. BHA's real time reporting system also provides early identification of community-based epidemics, and these reports are made available to LBHAs to identify OD admissions, as well as admissions by individuals who have attempted death by suicide.

Hospitals and LBHAs have hired peers to work with individuals who have gone to the emergency department as a result of OD. These peers work with individuals to engage in treatment. In addition, all ODs are reviewed by Local Overdose Fatality Review

Teams (LOFRTs), which are multi-agency groups composed of multi-disciplinary experts who review all fatalities by OD, identify possible risk factors, and suggest potential interventions that may have prevented fatality by OD.

Trauma-Informed Services & Behavioral Risk Factor & Behavior Risk Surveys. The Behavioral Risk Factor Surveillance System (BFRSS) is a critical population-based survey tool used in Maryland to monitor public health trends among adults that provides valuable data on a wide range of health-related issues and behaviors, including adverse childhood experiences (ACEs). BHA regularly uses BRFSS data to assess mental and physical health quality of life in the state's adult population and to examine the relationship between exposure to ACEs and MH/SUD issues. BRFSS data also include alcohol and drug use, and social determinants of health – such as life satisfaction, mental quality of life and physical health quality of life, transportation, and housing stability. In the context of a needs assessment, 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 policymaking to improve health outcomes across Maryland's communities.

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 MH/SUD issues. BHA used BRFSS data 2020-2023 for a study through the Building Healing Systems Initiative that examined the relationship between exposure to ACEs and mental and somatic health indicators. The results indicated 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). The survey results also indicated that approximately one-half of all Maryland adults experience problems with mental health for a significant period of time throughout the month.

The Youth Risk Behavior Surveillance System (YRBSS) is key to understanding high school-aged youth health behaviors and experiences in Maryland by providing population-level data on critical indicators such as alcohol and drug use, mental health status, suicidal ideation and behavior (including plans and attempts), and increasingly, the prevalence and impact of ACEs. This is essential for identifying at-risk youth, tracking trends over time, and uncovering disparities across demographic groups. In a needs assessment context, BHA uses YRBSS data to help address the root causes of trauma among youth populations by working to design targeted prevention efforts and enhance support for prevention in school systems, public health agencies, and community organizations.

YRBSS includes questions to youth about ACEs, however, it does not give an overall ACEs score, ACEs related questions such as exposure to violence, family substance use, and experiences of neglect or abuse provide valuable insight into the types and prevalence of trauma that youth may experience but are analyzed separately. YRBSS data guides the development of trauma-informed interventions and policies aimed at improving the health and well-being of high school-aged youth by informing needs assessments and identifying trends. Furthermore, YRBSS highlights risk and protective factors, and therefore informs strategies promoting resilience and supporting the well-being of adolescents across Maryland.

Continuous Needs Assessment of Behavioral Health Care. BHA's foundation for identifying unmet needs and gaps in care is state-level ASO claims data, as described above. 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 portion or approximately 20% of providers report additional data, making it unrepresentative of the larger system.

One of the challenges to local health departments from the lack of ASO data in delivering quality care services is they are unable to synthesize data on demographics of individuals who access services from local service providers. With the transition to a new BHASO vendor (Carelon) on January 1, 2025, the parity ruling has not changed. Carelon, however, has engaged with Maryland Medicaid to continue to submit parity reporting to the Center for Medicare and Medicaid Services (CMS). The system also manages services not covered under Medicaid that are reimbursed with state funds. During FY24 over 330,000 individuals (MH and SUD treatment services) were served through a network of over 3,500 individuals, groups, agencies, and institutional service providers.

University of Maryland Baltimore (UMB) – Systems Evaluation Center (SEC) & SoftTech, Inc. Among BHA's key data support efforts include the provision of data analysis and programming activities with various state and local partners such as Maryland Medicaid, the local system authorities and the SEC working closely with SoftTech, Inc. It is a technology solution company specializing in data architecture, database management, data warehousing, and Business Intelligence solutions that supports database design needs and ASO system requirements, and provides appropriate support and consultation as required.

The work of the SEC at UMB helps to identify key gaps in the delivery of quality services. The SEC, which is funded through MHBG, performs a wide range of activities, including (a) designing and conducting required evaluations for MHBG and SUPTRS Block Grants, (b) providing technical support for federal data reporting requirements, (c) performing Program Evaluations and Data Analyses to support BHA priority programs and initiatives, (d) performing program effectiveness evaluations and focusing on data studies of federal grant programs, (e) collecting and reporting data and responding to inquiries from grant managers related to data and evaluations, and (f) providing technical assistance and data analysis to support behavioral health integration efforts and state reporting requirements, such as conducting research on system capacity.

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.

Key Unmet Needs and Critical Gaps in Access to Care

Overdose Fatalities: Maryland has identified the tracking of overdose fatalities and provision of services to address such a priority. In 2024, Maryland recorded 746 fewer overdose deaths than in 2023, which represents a 29% decrease. Previously, Maryland saw a 17.65% increase in overdose fatalities during COVID. At the end of 2021, the number of fatal intoxication overdoses leveled off and marked the onset of three periods of decline. From October 2024 to September 2025, deaths related to fentanyl accounted for approximately 71.6% of overdose deaths. To continue to address overdose deaths, access to services for individuals with SUD and/or mental health conditions within the PBHS is critical. Based on data from 2016 to 2022, more than one-half (53.7%) of intoxication decedents were engaged in the public behavioral Health system.

Access and Utilization 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 increasing 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 barriers 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).

Substance Use Disorder (SUD) Treatment Gaps

The total number of individuals receiving SUD treatment services in the Maryland PBHS was nearly 115,000 in FY 2024, and total PBHS expenditures for SUD services in FY 2024 amounted to over $873.6 million. Over half served in PBHS for substance use received Level 1 or outpatient care, while 22.5% received treatment services for OUD. An estimated 3,000 uninsured individuals received SUD treatment services, and individuals from rural jurisdictions accounted for 36% of SUD treatment services in the PBHS. In FY 2024, there was an increase of 5.3% of individuals receiving SUD treatment services in the PBHS, however that represents a 2% decrease from FY 2019 - FY 2024.

Maryland has identified two major themes in SUD treatment gaps:

(1) A critical gap exists in post-discharge support to decrease readmission rates.

In FY2024, 18.8% of the approximately 17,000 unduplicated individuals who had a SUD Residential treatment admission were readmitted within 30 days of discharge. While this met the goal of the State Strategic Plan’s goal of not exceeding 20%, only 54.8% of individuals receive SUD follow-up services within seven days of leaving a residential facility. Although the post discharge follow-up rate has grown by 12% since FY 2021, the fact that nearly half (45.2%) of individuals lack timely aftercare remains a significant barrier to sustained recovery.

(2) Need for better transition to treatment services for individuals interacting with the Emergency Department and Emergency Medical Services.
From CY 2022 to 2023, there was a 9.1% increase in the amount of naloxone administered during Emergency Medical Services (EMS) prehospital transport. The rise highlights the growing need for interventions and follow-up care for individuals experiencing opioid overdose.

Need to Focus Upstream

In a recent study, 2020-2023 Behavioral Risk Factor Surveillance System (BRFSS) data was used to examine the relationship between exposure to Adverse Childhood Experiences (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 that would make them vulnerable to poor mental health or potential SUDs.

Identified Unmet Needs for Specific Populations and Geographic Gaps

Geographic Gaps of Services: A 2024 White Space analysis based on 2022 ASO and 2024 jurisdiction grant data, confirmed that behavioral health services are heavily concentrated in the population centers of the state, including the Baltimore Metropolitan region and the Capital area (Montgomery and Prince George's Counties), while services are fare more limited in most rural areas along the Eastern Shore and Western Maryland.

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 in the Medicaid population was that 82,867 women with children needed SUD services in Maryland. However, only 12,083 (14.5%) were served.

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People Who Inject Drugs

In FY2024, it is estimated that 7,189 individuals receiving SUD services in the PHBS who have identified as IV drug users.

Individuals Experiencing Homelessness

In FY2024, 114,485 people served in the PBHS were treated for substance use. Approximately 7.7% experienced homelessness in the past three months. Twenty-six percent of all individuals experiencing homelessness receiving SUD treatment in the fiscal year were from a rural county.

The Adolescent/Youth Population

There are an estimated 4,700 youth receiving SUD treatment services in FY 2024, which is a 29.8% increase from the prior five years. 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.

Families often faced long wait lists for PBHS services due to lack of provider capacity and access across the state. The number of distinct providers serving the SUD youth population in Maryland's PBHS has increased 49% from FY 2021 to 2024, with the number of provider site locations increasing by 29% during the same time frame, but only 23% of providers actively billing the PBHS served a youth age 0-17 with a SUD treatment service in FY 2024. Evidence-based prevention services currently reach 77,094 individuals, and Student Assistance Programs serve 9,678 students, indicating significant room for expanding the capacity of this program.

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 (32,800) additional workers 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.

Cross-Cutting Strategies Addressing Multiple Priority Areas and Populations

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 disparities, and improve access to care for Maryland's priority populations including pregnant women and women with dependent children, persons who inject drugs, persons in need of recovery support services, individuals with co-occurring disorders, persons experiencing homelessness, and individuals in need of substance use primary prevention.

Assisted Outpatient Treatment (AOT) Strategy

The first major strategy is Assisted Outpatient Treatment (AOT), focused on court-ordered and voluntary treatment engagement for individuals with SUDs and co-occurring mental illness to prevent high-intensity service utilization through community-based care. The statute allows for the petitioning of individuals over 18 with severe and persistent mental illness diagnoses for court-ordered outpatient services based on a circuit court finding of clear and convincing evidence that they meet AOT eligibility criteria, like a history of nonadherence to outpatient services and utilization of inpatient services. Evidence from other states suggests AOT is associated with decreased inpatient utilization in such individuals. At this time, MDH is drafting regulations, developing clinical and operational guidance, and engaging stakeholders. This 2024 legislation requires AOT to be operational statewide by July 1, 2026.

Housing and Community Integration Strategy

A second approach, Housing and Community Integration, is focused on reducing readmissions and disparities. This includes increasing the number of individuals referred to permanent supportive housing programs and independent housing, expanding Residential Rehabilitation Programs to help individuals transition from RRP to live independently in the community, and specifically targeting recovery housing for pregnant and parenting women through the Recovery Housing for Pregnant Women and Women with Children Program.

Expansion of Peer Recovery Support Services Strategy

A third crosscutting strategy is proliferation of Peer Recovery Support Services. Peer Recovery Specialists 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 services and community resources. Certified Peer Recovery Specialists are deployed in emergency departments, homeless shelters, recovery community centers, and high-need community settings to conduct outreach and motivational engagement.

Buprenorphine Expansion Strategy

The fourth strategy encompasses Buprenorphine (BUP) Expansion, which will expand buprenorphine treatment access through mobile and community-based settings. This strategy incorporates (i) same-day prescribing when possible, (ii) telehealth options for continuity, and (iii) rapid linkage to ongoing PBHS treatment services. The BUP Expansion Strategy also utilizes peers to maintain regular contact with individuals during the first 30 days post-discharge to support medication adherence, address transportation and pharmacy access, and connect individuals to recovery support services.

Maryland Addiction Consultation Service (MACS) Technology Transfer Workforce Development Sub-strategy
An aligned workforce development strategy, Maryland Addiction Consultation Service (MACS) Technology Transfer, is an expansion of a collaboration between BHA and the University of Maryland School of Medicine, Department of Psychiatry to disseminate best practices and policies to optimize the quality and capacity of the primary care and specialty prescriber workforce to identify and treat SUD, specifically with medications for OUD. MACS' expansion will offer statewide technology transfer and technical assistance, leveraging telemedicine to increase access to rural areas, and educate an emerging workforce through telephone consultation, training, education, and assistance with referral identification.

Specialized Population Outreach Strategy
Specialized Population Outreach represents a fifth cross-cutting theme with several targeted approaches. Military/Veteran coordination through the MCV Strategy increases proactive engagement of Service Members, Veterans, and their families by embedding Resource Coordinators in community events, VA facilities, and veteran-serving organizations. Services for pregnant and parenting women include both treatment access and recovery housing components. Children with SED receive expanded access through changes to 1915(i) State Plan Amendment eligibility requirements. Engaging consumers focuses on reducing disparities in service access and utilization.

Crisis Services Integration Strategy

The sixth strategy focuses on Crisis Services Integration through a comprehensive crisis response system that encompasses (a) mobile crisis teams, (b) walk-in crisis centers, (c) emergency department coordination, and (d) 24/7 accessibility. The first residential crisis program in Maryland for youth who overstay inpatient hospital units or emergency departments was recently piloted by BHA, which is a step-down bridge care program for youth from the hospital environment until 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. ED Care Coordination engages individuals in emergency rooms to link them with mental health community treatment services and recovery support, connecting them to rural psychiatric and MH services, AOT, Health Homes, and pro bono MH counseling services. Mobile crisis teams provide 24/7 response capabilities, while crisis walk-in centers offer immediate access points for individuals in crisis.

Case Management and Care Coordination Strategy

Finally, a seventh major strategy, Case Management and Care Coordination, crosscuts priorities through several mechanisms. State Care Coordinators engage individuals in SUD residential facilities 7 days prior to discharge to link them with community services or recovery residences. Targeted Case Management provides services for individuals 30 days prior to discharge, linking them to wrap-around community resources. The Behavioral Health Systems Access and Coordination system links individuals to SUD services. Additionally, efforts are underway to expand the reach and access to Targeted Case Management and 1915(i) services through distribution of accessible information regarding eligibility requirements, review of current provider and service user distribution to target resources to areas with greatest needs, and work with jurisdictional partners to ensure consistent service delivery based on best practices.

Other programs that provide case coordination include the Stop, Triage, Engage, Educate and Rehabilitate (STEER) Program, which is a pre-booking drug treatment linkage program aiming to deflect individuals from conventional arrest. STEER assigns individuals care coordinators who focus on rapid access to treatment, and retention, motivation, engagement, and completion.

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Footnotes:

*Additional federal data sources include National Substance Use and Mental Health Service Survey (N-SUMHSS); Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE); and the CDC Social Vulnerability Index. Additional Maryland data sources include Maryland Substance Use Vulnerability Index (MD-SUVI); Prescription Drug Monitoring Program (PDMP); Chesapeake Regional Information System for our Patients (CRISP); Behavioral Risk Factor Surveillance System (BRFSS); Health Services Cost Review Commission Hospital Case Mix (HSCRC); Vital Statistics Administration Intoxication Death Data and Suicide data sets; and data from the BHA CHRS.

#McNeely, J, Gourevitch, MN, Paone, D, Shah, S, Wright, S & Heller, D. Estimating the prevalence of illicit opioid use in New York City using multiple data sources, BMC Public Health, 12:443. 2012.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Post Discharge Support/Readmission Rates

Priority Type: SUT

Population(s): PWWDC, PWID, TB, PRSUD

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 utilization of high-intensity SUD services by engage individuals with serious and persistent mental illness and co-occurring substance use disorders in lower level-of-care community-based services through court-ordered and stipulated voluntary AOT treatment plans.

Treatment Services: State Care Coordinators will engage individuals with in SUD Residential Facilities 7 days prior to discharge to link them with SUD community services or recovery residences. In addition, Target Case Management will be provided for individuals 30 days prior to discharge on linking them to wrap-around community resources. In addition the Behavioral Health Systems Access and Coordination (Formerly Information & Referral) will link individuals to SUD services.

Peer Recovery Strategy – Deploy Certified Peer Recovery Specialists to engage participants prior to discharge and continue peer support immediately upon return to the community. Peers will accompany individuals to first outpatient appointments, facilitate connection to recovery groups and community resources, and provide ongoing motivational support during the initial 30-day period, helping to maintain stability and prevent early readmission.

BUP Expansion Strategy – Ensure continuity of buprenorphine treatment during the transition from residential care to the community by coordinating same-day linkage to low-threshold buprenorphine prescribers and offering telehealth options when in-person appointments are not immediately available. Certified Peers within the BUP program will maintain regular contact with individuals during the first 30 days post-discharge to support medication adherence, address barriers (e.g., transportation, pharmacy access), and connect individuals to recovery support services, thereby reducing risk of readmission.

MCV Strategy – MCV Resource Coordinators will educate residential discharge planners on the availability of PBHS outpatient, community-based, and veteran-specific SUD resources. Coordinators will offer technical assistance and resource guidance during the discharge process and provide follow-up outreach to the individual during the first 30 days post-discharge to reinforce engagement in outpatient care and reduce the likelihood of readmission.

Stop, Triage, Engage, Educate and Rehabilitate (STEER) Program is a pre-booking diversion drug treatment linkage program aiming to deflect individuals from conventional arrest. STEER assigns individuals care coordinators who focus on rapid access to treatment, and retention, motivation, engagement, and completion.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The readmission rate wil not exceed 20% to the same or different SUD Residential Treatment facility.

Baseline measurement (Initial data collected prior to and during 2026): 18.80%

First-year target/outcome measurement (Progress to the end of 2026): 19%

Second-year target/outcome measurement (Final to the end of 2027): 19%

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 #: 2

Priority Area: Access and Utlization Gaps

Priority Type: SUT

Population(s): TB, PRSUD, Other

Goal of the priority area:

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

Strategies to attain the goal:

Buprenorphine Expansion (BUP) Strategy – Increase the percentage of PBHS recipients receiving OUD services by expanding access to low-threshold buprenorphine initiation sites across the state, including mobile units and community-based settings. Certified Peer Recovery Specialists will conduct targeted outreach to individuals at risk of OUD, facilitate rapid linkage to buprenorphine prescribers, and provide ongoing support to promote retention in care. In partnership with community providers, the program will offer same-day prescribing whenever possible and coordinate follow-up to ensure continuity, thereby driving at least a three-percent annual increase in OUD service utilization.

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

Treatment Services: Targeted Case Management services will engage individuals in SUD treatment facilities to provide wraparound services. In addition, individuals will be linked with Substance Related Hotline Counselors, Stop, Triage, Engage, Educate, and Rehabilitate (STEER), and Addictions Case Management services. The Behavioral Health Systems Access and Coordination (Formerly Information & Referral) will engage and link individuals to community SUD services.

Overdose Prevention and Response Initiatives -- Naloxone education and overdose prevention and infectious disease prevention and treatment access.

MCV Strategy – Increase proactive engagement of Service Members, Veterans, and their families by embedding MCV Resource Coordinators in community events, VA facilities, and veteran-serving organizations to identify individuals with SUD needs and directly connect them to PBHS treatment services, while offering follow-up support during the treatment entry process.

Peer Recovery Strategy – Deploy Certified Peer Recovery Specialists in emergency departments, homeless shelters, and recovery community centers to conduct outreach and motivational engagement with individuals experiencing substance-related crises. Peers will guide individuals through treatment enrollment, accompany them to initial appointments, and provide ongoing peer support to promote treatment retention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals receiving SUD treatment services in the PBHS will increase 3% in the SFY.

Baseline measurement (Initial data collected prior to and during 2026): 114485

First-year target/outcome measurement (Progress to the end of 2026): 117920

Second-year target/outcome measurement (Final to the end of 2027): 121458

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: Preventing Overdose Deaths

Priority Type: SUT

Population(s): PWID, PRSUD

Goal of the priority area:

Maintain and increase the number of individuals receiving behavioral health services in the PBHS.

Strategies to attain the goal:

Increasing OUD Services by 3%: Utilize the state's overdose data dashboard to identify gaps, and targeted outreach to populations demonstrating high need yet low Opioid Use Disorder (OUD) service utilization. Once identified, employ statewide digital campaigns to mitigate stigma and enhance client engagement. Lastly, continued investment in the state's workforce development to address the shortage of qualified, trained professionals in the field of substance use disorders.

Treatment Strategy: Services such as Health Homes, Methodone Home Delivery will delivery services to individuals and Mobile Methodone Van will engage individuals in the community.

Buprenorphine Expansion (BUP) Strategy – Increase the percentage of PBHS recipients receiving OUD services by expanding access to low-threshold buprenorphine initiation sites across the state, including mobile units and community-based settings. Certified Peer Recovery Specialists will conduct targeted outreach to individuals at risk of OUD, facilitate rapid linkage to buprenorphine prescribers, and provide ongoing support to promote retention in care. In partnership with community providers, the program will offer same-day prescribing whenever possible and coordinate follow-up to ensure continuity, thereby driving at least a three-percent annual increase in OUD service utilization.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: People receiving services for opioid use disorder (OUD) will increase annually by 3%.

Baseline measurement (Initial data collected prior to and during 2026): 22.3%

First-year target/outcome measurement (Progress to the end of 2026): 25.3%

Second-year target/outcome measurement (Final to the end of 2027): 28.3%

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: Pregnant Women and Women with Dependent Children

Priority Type: SUR

Population(s): PWWDC

Goal of the priority area:

Reduce the rates of SUD among pregnant and parenting women in Maryland.

Strategies to attain the goal:

Expand outreach and engagement efforts for recovery housing for women and children while working to identify additional recovery houses to join the program.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of pregnant and parenting women who access recovery support services through the Recovery Housing for Pregnant Women by 20%.

Baseline measurement (Initial data collected prior to and during 2026): 73

First-year target/outcome measurement (Progress to the end of 2026): 80

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

Census Reporting Data, Maryland Recovery Housing for Pregnant Women and Women with Children Program

Description of Data:

Self-reported data is systematically collected from recovery housing facilities through standardized weekly census reports submitted by all jurisdictions operating recovery housing programs for pregnant and postpartum women.

Data issues/caveats that affect outcome measures:

Inconsistent reporting practices, including delayed submissions, compromise the reliability of real-time bed availability data. This creates operational challenges for referral agencies attempting to facilitate timely placements for women requiring recovery housing services.

Priority #: 5

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Reduce rates of SUD among pregnant and parenting women in Maryland.

Strategies to attain the goal:

Increase the number and size of residential treatment programs serving pregnant and parenting women in Maryland and reduce barriers to access for these services.

Conduct further needs assessment to understand where additional services are needed for PWWDC in Maryland.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of pregnant women entering SUD treatment in outpatient and residential settings in Maryland.

Baseline measurement (Initial data collected prior to and during 2026): 280

First-year target/outcome measurement (Progress to the end of 2026): 283

Second-year target/outcome measurement (Final to the end of 2027): 285

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:

The FY24 data are not final, as providers have 12 months from the time of service 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 #: 6

Priority Area: Follow-up Treatment

Priority Type: SUR

Population(s): PRSUD

Goal of the priority area:

Maintain and increase the number of individuals treated in the PBHS.

Strategies to attain the goal:

SUD Follow-Up Services: Pre-discharge (7-days): State Care Coordinators will collaborate with SUD residential treatment facility providers to discuss pre-discharge planning 1 week/7-days before discharge. The State Care Coordinator/Peer Recovery Coach will serve as a care transition coordinator to schedule follow-up appointments prior to discharge, and then provide a warm hand-off. If available, provide transportation and recovery support mapping to community supports. Post-discharge (7-days): SCC/Peer Recovery Coach will follow-up with patient, attend first appointment, utilize an accountability log/tracking system to assist with reviewing recent discharges. Implement system-level enhancements to include MOUs with residential providers and data-sharing agreements. In addition, SCC will link individuals to recovery support services. Targeted Case Management will link individuals to wrap around services. Individuals will be linked to Addictions Case Management, Stop, Triage, Engage, Educate, and Rehabilitate (STEER) and Substance Related Hotline Counselor.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The % of PBHS SUD service recipients who receive follow-up treatment within 7 days of discharge from a SUD residential treatment facility with meet or exceed 45%.

Baseline measurement (Initial data collected prior to and during 2026): 54.8%

First-year target/outcome measurement (Progress to the end of 2026): 55%

Second-year target/outcome measurement (Final to the end of 2027): 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 #: 7

Priority Area: Youth and Adolescents

Priority Type: SUT

Population(s): PRSUD, Other

Goal of the priority area:

Maintain and increase the number of individuals treated in the PBHS.

Strategies to attain the goal:

The BHA allocated funding for the Residential Substance Use Disorder Treatment for Minors (RSUD-M) program that launched in August 2024, creating access to Level 3.7 Medically Monitored High-Intensity Inpatient Services in Maryland for adolescents. The typical age range served is 13-21 years old.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the % of providers actively treating children and youth ages 0-17 in the PBHS by 2% each SFY.

Baseline measurement (Initial data collected prior to and during 2026): 23%

First-year target/outcome measurement (Progress to the end of 2026): 25%

Second-year target/outcome measurement (Final to the end of 2027): 27%

Data Source:

*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 #: 8

Priority Area: Geographic Gap/Rural Access

Priority Type: SUT

Population(s): PRSUD, 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 BHA will facilitate the access and expansion to telehealth technology through the promotion and education of available telehealth resources and information on overarching policies to providers and service recipients in rural jurisdictions and areas with limited service access and availability.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In each fiscal year, 30% or more of rural SUD outpatient service recipients receive services via telehealth.

Baseline measurement (Initial data collected prior to and during 2026): 34.9%

First-year target/outcome measurement (Progress to the end of 2026): 37%

Second-year target/outcome measurement (Final to the end of 2027): 38%

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 #: 9

Priority Area: Workforce

Priority Type: SUT

Population(s): PRSUD

Goal of the priority area:

Increase capacity of clinical workforce

Strategies to attain the goal:

Train clinical staff on diagnosing and treating SUDs with the Maryland Addiction Consultation Service (MACS).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: # of trainings for clinicians in SUD diagnosis and treatment

Baseline measurement (Initial data collected prior to and during 2026): n/a

First-year target/outcome measurement (Progress to the end of 2026): n/a

Second-year target/outcome measurement (Final to the end of 2027): 4

Data Source:

Programmatic reports.

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 10

Priority Area: Reduce Overdose Deaths

Priority Type: SUP

Population(s): PP, PWID, PRSUD

Goal of the priority area:

Promote health and wellness initiatives in the PBHS.

Strategies to attain the goal:

Expand Access to OEND - Train community members and providers on overdose recognition and response, using culturally relevant materials.
Increase Drug Checking Services - Expand drug checking (e.g., fentanyl/xylazine test strips, RAD pilot expansion) to detect counterfeit pills marketed as prescribed opioids.
Prescriber and Health Care Collaborations - Promote academic detailing or provider training on CDC opioid prescribing guidelines and tapering practices.
Promote Recovery Pathways and Peer Support - Support Certified Peer Recovery Specialists in outreach to those misusing prescription opioids, especially those aging out of acute care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of prescribed opioid-related deaths in the state fiscal year.

Baseline measurement (Initial data collected prior to and during 2026): 277

First-year target/outcome measurement (Progress to the end of 2026): 266

Second-year target/outcome measurement (Final to the end of 2027): 255

Data Source:

Maryland Department of Health (MDH), Vital Statistics Administration (VSA).

Description of Data:

The Maryland Vital Statistics Administration collects and reports all unintentional intoxication overdose deaths that occur in the state of Maryland.

Data issues/caveats that affect outcome measures:

Data is current through May 2025. Data are subject to change as death investigations are finalized.

Priority #: 11

Priority Area: Transitions to Care from EDs

Priority Type: SUT

Population(s): PRSUD

Goal of the priority area:

Reduce repeated ED visits by facilitating access to care.

Strategies to attain the goal:

The case managers at admission will track individuals who have more than 3 BH-related ED visits by identifying reasons for those visits so that individuals can be linked with State Care Coordination and Targeted Case Management for community programming/services. If an individual served by a mobile crisis team is transported to the ED during the treatment episode, the team will follow-up upon discharge to support crisis stabilization and provide community-based deflection from the emergency department for future crisis situations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The % of PBHS service recipients with 3 or more behavioral health-related ED visits will not exceed 5%.

Baseline measurement (Initial data collected prior to and during 2026): 1.2%

First-year target/outcome measurement (Progress to the end of 2026): 1.4%

Second-year target/outcome measurement (Final to the end of 2027): 1.4%

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 service in the Maryland PBHS, reimbursed by Medicaid or State of MD 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 #: 12

Priority Area: Prevent Harmful Opioid Use/Upstream

Priority Type: SUP

Population(s): PWID, EIS/HIV, PRSUD

Goal of the priority area:

Expand outreach efforts related to preventing harmful use of opioids by increasing the # that access ODPOPs.

Strategies to attain the goal:

ODPOP Site Expansion and Geographic Equity - Identify geographic gaps and expand brick-and-mortar and mobile ODPOPs to high-need jurisdictions using data from overdose deaths, RAD alerts, and social vulnerability indices.
Enhance Wraparound Services at Existing ODPOPs - Integrate additional health and wellness services into ODPOPs—HIV/HCV testing, MAT linkage, and behavioral health screening.
Make it easier to access to treatment by expanding hours and decentralizing delivery models.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase # of individuals exposed to prevention of harmful opioid use that access ODPOPs by 4%.

Baseline measurement (Initial data collected prior to and during 2026): 18,944

First-year target/outcome measurement (Progress to the end of 2026): 19,702

Second-year target/outcome measurement (Final to the end of 2027): 20,490

Data Source:

Opioid-Associated Disease Prevention and Outreach Programs (ODPOP) Quarterly report, administered by MDH BHA Office of Prevention and Outreach.

Description of Data:

"How many individual participants (unduplicated) has your program served during the current fiscal year?" (since 7/1/2023

Data issues/caveats that affect outcome measures:

Data from Apr-Jun 2024 reports as of 7/30/25. Data reflects only registered participants and does not include individuals reached through secondary exchange.

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Footnotes:

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 awarenes 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
The MDH BHA works to reduce substance-related morbidity and mortality for people who use or inject drugs (PWUD, PWID). The Office optimizes MH/SUD services for PWUDs through programs that include the Overdose Response Program (ORP) and prevention and outreach grants. Almost 300 ORPs conduct community-based overdose prevention education and naloxone distribution across the State.

Maryland Health-General §3101-109 authorizes government and community-based organizations as ORPs, allowing them to provide overdose prevention education and to dispense naloxone across communities. OHR centrally purchases naloxone and rapid drug-testing equipment, including fentanyl and xylazine test strips that enable safer choices. Populations at elevated risk of

overdose, based on demographics and location, 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 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.

Some ORPs are supported through the prevention and outreach grants program to provide direct services to PWID/PWUD and referrals to the full SUD continuum of care. Above the ORP services otherwise provided, these ORPs provide case management, peer support, SUD counseling, treatment services and recovery supports, wound care, rapid testing for HIV/Hepatitis C (HCV) and treatment referrals, referrals for medical and MH care, transportation to appointments, and more. Overdose Prevention and Outreach grantees provide lifesaving services at fixed sites, through and in mobile settings.

Maryland's Office of Overdose Response (MOOR) is the primary coordinating office for the state's response to the overdose crisis. As outlined in Executive Order 01.01.2023.21, MOOR coordinates all state and local agency work addressing substance use and overdose prevention in all Maryland jurisdictions in alignment with the State's strategic priorities. MOOR coordinates its work across State partner agencies, including in the areas of prevention, treatment, recovery, and public safety. State partners serve as subject-matter experts on collaborative initiatives and are responsible for program development and implementation within their agencies. Non-governmental partners, including health care systems and associations, community and faith-based organizations, professional associations, and nonprofits and businesses, also play a vital role in the whole-community approach in the state.

(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, systemic inequities, 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: (1) 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. (2) 988 Suicide & Crisis Lifeline Implementation: Maryland continues to strengthen its 988 infrastructure, improving data collection, expanding multilingual marketing campaigns, and conducting community outreach to ensure that individuals experiencing suicidal crises or substance-related emergencies receive timely and culturally competent care. (3) 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. (4) 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 promoting culturally and linguistically responsive services, expanding workforce training, and reducing stigma.

Substance Use Primary Prevention (20% SUPTRS Set-Aside): (i) SUPTRS funds are distributed to all 24 jurisdictions and 4 University Alcohol, Tobacco, and Other Drug (ATOD) Prevention Centers in Maryland; (ii) 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; and, (iii) these efforts emphasize preventing first substance use and promoting safe storage and disposal of controlled medications.
Opioid Misuse Prevention Program (OMPP): Funds are supporting 18 Maryland jurisdictions, including a regional team, that is implementing opioid-specific initiatives, including state PDMP education for providers, prevention education targeting youth, naloxone awareness and usage training, SBIRT (Screening, Brief Intervention, and Referral to Treatment) expansion, and training for law enforcement to support efforts for access to care.

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: (i) training in evidence-based practices, including CAMS-care, DBT, QPR, ASIST, CALM, and CBT; (ii) anti-stigma campaigns at the community-level promoting acceptance of help-seeking and illuminate available peer support; (iii) 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 equitable, trauma-informed, and coordinated care. Federal support is sustaining these critical initiatives 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), and 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: (a) Helping local behavioral health authorities resolve problems in cases related to early childhood up to age 25; (b) Improving service delivery approaches to population and special needs groups within the child and adolescent population by leading for Medicaid waiver demonstration projects; (c) Continually improving targeted case management (or TCM/1915(i)) services expanding utilization by decreasing eligibility and accessibility service barriers; (d) Expanding and implementing use of evidence-based practices for MH/SUD and shaping and improving outcomes in programs for the targeted population; (d) 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; (e) 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; and (f) 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.

(i) 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, hard of hearing, have other communication needs who are in SUD treatment center, in which services must be routed in evidence-based practice, and for those with who need ASL interpretation services that focuses 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.

MDH has been providing annual analysis of compliance between the State's Medicaid and Children's Health Insurance Program (CHIP) and the MHPAEA and Affordable Care Act, 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 that 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.

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 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, and
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, outreach to underserved areas, 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 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, overdose prevention and outreach 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-defeaned to facilitate or make provisions for American Sign Language interpretation.

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. It promotes long-term recovery among eligible adults and older adults with SMI who meet medical necessity criteria (MNC) outlined by the Administrative Service Organization (ASO). Adult TCM is an FFS rather than a 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 by providing access to necessary resources for moving forward in their recovery, which helps them achieve their individual goals. The primary aim of Adult TCM services is prevention of homelessness and incarceration, preventing 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 the 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, assisting with navigating entitlement services, providing travel for delivering services offsite when individuals are unable to access onsite crisis services, facilitating 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 increases access to 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 recovering from 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 help adolescents advance through 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 promoting abstinence from substance use. The program helps adolescents understand their motivations for substance use, evaluate the pros and cons of substance use behaviors, learn skills to develop healthier habits, and take responsibility for individual behavior change. Program outcomes include reducing or eliminating substance use, improving academic performance, decreasing inpatient hospitalizations for behavioral health issues, and decreasing 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 the 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 to achieve expected outcomes. This partnership provides on-site EBPC training and consultation, as

well as training and consultation for SUD Specialists Team Leaders and Assertive Community Treatment (ACT) teams, to enhance the teams' Dual-Diagnosis Capability (DDC) in collaboration with the ACT Consultant/Trainer. Additionally, intensive training and consultation are 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, as well as monitor and implement fidelity using these tools. Behavioral health care providers can also access training on using scientifically validated screening and assessment instruments, which are 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. MCCJT has a critical role supporting local correctional facilities to meet the 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 to accredit community-based agencies as a prerequisite for licensure applications. The Office gathers and maintains data, accreditation-based licensing and provides technical assistance with the licensing process 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, which builds on an experiential analysis from all 24 state jurisdictions, as well as financial data indicating that systems management was an opportunity to increase value. While most local jurisdictions have established an LBHA, all jurisdictions continue on their integration journey. Integration must address differences in cultural, 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 of this Learning Community is the distribution of a Systems Manager Procedural Manual 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 the 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). Additionally, an eMedicaid online portal serves as 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 as 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.

   N/A

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Footnotes: