THE 2020 ANNUAL REPORT OF

THE MARYLAND BEHAVIORAL HEALTH ADVISORY COUNCIL

HB § 7.5-305 and SB0174/Ch. 328 (2015)

Barbara L. Allen
Co-Chair

Lauren Grimes
Co-Chair

INTRODUCTION

This report is the annual report of Maryland's Behavioral Health Advisory Council, which, according to statute, is due to the Governor at the end of each calendar year.

Senate Bill 174 (2015), codified as Health-General Article (HG) § 7.5–305, established the Council as of October 1, 2015, to promote and advocate for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state. Also, the Council will promote and advocate for a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The Council consists of 55 members: 28 in statute ex-officio members (or designees) representing state and local government, the Judiciary, and the Legislature; 13 members appointed by the Secretary of the Maryland Department of Health, representing behavioral health provider and consumer advocacy groups; and 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. According to HG § 7.5–305, membership is appointed/selected to be composed of balanced representation from areas of mental health and substance use disorders and a range of geographical areas of the state. Membership is also representative of ethnic, gender, cultural, and across the lifespan (parents of young children with behavioral health disorders) diversity.

The following pages include the membership list, highlights, and activities of the Council for FY2020.

Maryland Behavioral Health Advisory Council

Barbara L. Allen, Co-Chair
Community Advocate for Substance Use Disorders

Lauren Grimes, Co-Chair
Community Behavioral Health Association of Maryland

Makeitha Abdulbarr
The Maryland County Behavioral Health Advisory Councils

Barbara L. Allen
Community Advocate for Substance Use Disorders

Robert Anderson
The Maryland Department of Juvenile Services

Dori S. Bishop
Family Member

Lynda Bonieskie
The Maryland Department of Public Safety and Correctional Services

Lori Brewster
The Maryland Association of County Health Officers

Andrea Brown
The Black Mental Health Alliance for Education and Consultation Inc.

Mary Bunch
Family Member (Child)

Kenneth Collins
The Maryland County Behavioral Health Advisory Councils

Kathryn Dilley
The Maryland County Behavioral Health Advisory Councils

Catherine Drake
The Maryland Division of Rehabilitation Services

The Hon. Adelaide Eckardt
Maryland State Senate

Kate Farinholt
The National Alliance on Mental Illness of Maryland

Ann Geddes
The Maryland Coalition of Families for Children's Mental Health

Lauren Grimes
Community Behavioral Health Association of Maryland

Roseanne Hanratty
The Maryland Department of Aging

Carlos Hardy
The Maryland Recovery Organization Connecting Communities

Dayna Harris
The Maryland Department of Housing & Community Development

Joyce Harrison
Academic/Research Professional
Johns Hopkins, Kennedy Kreiger

Jim Hedrick
The Governor's Office of Crime Prevention, Youth, and Victim Services

Brooke Holmes
The Office of the Secretary, Maryland Department of Health

Helene Hornum
The Maryland Department of Human Services

Aliya Jones
The Office of the Deputy Secretary for Behavioral Health, Maryland Department of Health

Jennifer Krabill
The Children and Youth Division (formerly the Governor's Office for Children), Governor's Office of Crime Prevention, Youth, and Victim Services

Sylvia Lawson
The Maryland State Department of Education

Sharon M. Lipford
Community Advocate

The Hon. George Lipman
The Maryland Judiciary District Court

Michelle Livshin
On Our Own of Maryland, Inc
Consumer (Adult)

Tammy Loewe
The Maryland Association of Behavioral Health Authorities (MABHA)

Dan Martin
Mental Health Association of Maryland, Inc.

Jonathan Martin
Maryland Department of Budget and Management

The Hon. Dana Moylan Wright
The Maryland Judiciary Circuit Court

Caterina Pangilinan
The Maryland Health Benefit Exchange

Luciene Parsley
Disability Rights Maryland

Mary Pizzo
The Office of the Public Defender

Keith Richardson
The National Council on Alcoholism and Drug Dependence of Maryland

Kirsten Robb-McGrath
The Maryland Department of Disabilities

Jose Rosado
The Maryland County Behavioral Health Advisory Councils

Jacob Salem
The Governor's Office of Deaf and Hard of Hearing

Dana Sauro
Consumer (Youth/Young Adult)

Sabrina A. Sepulveda
Medical Professional
Calvert County Health Dept.

Jeffrey P. Sternlicht
Medical Professional
GBMC

Deneice Valentine
Consumer

Mary Vaughn
Family Member (Child)

Vickie Walters
The Maryland Association for the Treatment of Opioid Dependence

Ambrosia Watts
The Behavioral Health Unit, Maryland Medicaid, Maryland Department of Health

Anita Wells
Academic/Research Professional
Morgan State University

Kim Wireman
The Maryland Addiction Director's Council

Behavioral Health Administration Staff Support: Division of Systems Management, Division of Planning: Cynthia Petion, Sarah Reiman, Tsegereda Assebe, Doris Chen and Greta Carter.

Highlights and Activities of Maryland's Behavioral Health Advisory Council

Maryland's Behavioral Health Advisory Council (MBHAC or Council) met bi-monthly (five times during the year). One meeting was in person, four were virtual meetings and the March meeting was canceled due to circumstances related to the COVID-19 pandemic. Various presentations occurred that helped to inform Council members of various activities and initiatives across the state that included: legislative updates; recommendations for Maryland Medicaid regarding Mental Health (MH) and Substance Use Disorder (SUD) treatment via telehealth; modernizing Maryland's psychiatric care by adding nurse practitioners to the list of eligible providers; efforts to address Maryland's opioid epidemic; discussions related to behavioral health equity and harm reduction; and committee discussions to address criminal justice, prevention, cultural and linguistic competency, planning, and children and adult services issues in the Public Behavioral Health System (PBHS). In January the Council welcomed Lauren Grimes as the newly elected Co Chair. BHA, who staffs the Council, also welcomed a new Deputy Secretary, Dr. Aliya Jones, MD, MBA.

Legislative Highlights

Representatives from the Council continued to update the Council on legislation pertinent to the PBHS that was presented during the 2020 Legislative Session. BHA updated the Council on several bills that passed including HB547/SB455, which refers eligible children with a history of trauma or posttraumatic stress disorder to a nonprofit training entity that engages in the training of service/support dogs or trained therapy horses for use by children. In conjunction with ~~The~~ Mental Health Association of Maryland (MHA), HB 332/SB 441 was passed, clarifying that the MDH may include behavioral health crisis response centers on its list of designated emergency facilities that accept individuals for mental health evaluation. This was a recommendation from the Council's 2017 Strategic Plan for 24/7 walk-in and mobile crisis services.

Ann Ciekot from Public Policy Partners updated the Council on several pieces of legislation. HB488/SB402 passed as an emergency measure to establish a uniform, statutory framework authorizing healthcare practitioners to use synchronous and asynchronous telehealth to provide services. HB1208/SB502, an emergency bill that allows mental health services delivered via telehealth to Medicaid clients in their homes to be reimbursed, was also passed. Other bills discussed were ones related to Collateral Consequences, Parity Compliance, Overdose Prevention Sites, Decriminalization and the BH Registry and Referral System. The Maryland Coalition for Families updated the Council on the pending status of HB1140/SB624. This bill is the result of MDH's work with the Children and Families subcommittee of the Lt. Governor's Commission on Behavioral Health to develop a MRSS system for children in Maryland; a system specifically tailored to meet the needs of children and families, and much more than crisis services.

The National Alliance on Mental Illness (NAMI) Maryland informed the Council about the bills they supported that have a focus on their #1 priority issue, which include improving the criminal

justice system’s response to individuals with mental illness and their families and increasing diversion from criminal justice to community services. HB 607/SB 305 – CIT Center of Excellence passed. For the past several years NAMI Maryland has worked with the CIT subcommittee of the Behavioral Health Criminal Justice Partnership to create a statewide resource on Crisis Intervention Teams (CIT). This year, a CIT Center of Excellence will be created in the Governor's Office for Crime Prevention, Youth, and Victim Services to help create a more robust CIT network and to support the ongoing CIT work at state agencies and local jurisdictions. This will bring together law enforcement, behavioral health, and the resources necessary to help divert individuals with mental illness from the criminal justice system and into the treatment they need.

MBHAC Strategic Plan

One of the objectives of the Work Plan developed at the July 2019 BHAC Strategic Planning Retreat was to come up with specific priorities to pursue in FY 2020-2021. Each of the BHAC subcommittees was asked to submit three areas of focus for FY2020 in line with the developed Work Plan. The committees worked over the last year on narrowing down their priorities and each Committee came up with their top three priorities. These priorities were sent out by email for a Council vote. 38 members responded and voted to approve the priorities as written. The BHAC priorities have formally been adopted and they will be the driving force for each of the committees over the next year until July 1, 2021. The five priorities identified were:

BHAC Priorities:
Recovery Services & Supports Committee: Advocate for the expansion of the continuum of care specifically focusing on recovery residences/housing and services.

Planning Committee: Review and respond to the results/progress of the implementation of the BHAC's Steering Committee's recommendations for 24/7 Walk-In Crisis and Mobile Crisis Team Services.

Criminal Justice/Forensics Committee: Monitor and advocate for compliance with statutory requirements on the competency and 8-507 areas.

Children, Youth & Families Committee: Support the development of Mobile Response and Stabilization Services (MRSS) for children and youth across the state.

Cultural and Linguistic Competency Committee: Review local plans and make recommendations to BHA on the progress local behavioral health authorities are making in implementing the National Culturally and Linguistically Appropriate Services (CLAS) standards and cultural and linguistic competency goals set forth by BHA and the Cultural and Linguistic Competency Committee.

Council Presentations and PBHS Updates

The Council was consistently informed of BHA's overdose prevention efforts. BHA continues to look at overdose prevention efforts in an attempt to mitigate increases in overdoses; this is especially relevant considering increased stress, unemployment and other factors that may be related to the current COVID-19 pandemic. A Multiagency Group has been established to meet monthly and review overdose data, discuss programming and meet with local jurisdictions that have been significantly impacted by overdose deaths. The goal of the workgroup is to create real-time strategies and form collaborations. The Multiagency Group convened community providers who are experts to provide guidance to a clinical advisory team.

BHA informed the Council on various grants and funding opportunities. The Maryland State Opioid Response (SOR) Initiative continues with funding of $33 million dollars for a two year period. The funding began on September 30, 2019. Year 2 Report was submitted to SAMSHA on June 30, 2020. BHA is currently working on a 12 month no cost extension. The year 1 grant ends on September 29, 2020.

This funding supports a comprehensive response to the opioid epidemic and expands access to treatment and recovery support services. Its purpose is to increase access to Medication Assisted Treatment (MAT), reduce unmet treatment needs, and, ultimately, to decrease opioid deaths. The money provides funding for numerous projects such as Crisis Walk-In Centers, Safe Stations, Harm Reduction, and Young Adult Recovery Housing. Money will also be used for projects that were not funded in the past or that had limited funding such as sign language services, services for pregnant women and women with children, and workforce development projects.

BHA will be expanding SOR programming though SOR 2 Grant funding. BHA has been awarded $50.7 million. The difference about the grant this year is that in addition to projects for persons who have opioid use disorder, the grant can also be used for those who have stimulant use disorders. This will allow BHA to expand the scope of work by providing treatment and recovery support services to a wider group of individuals with substance use disorders.

In response to the recommendation from the Council's 2017 Strategic Plan for increased 24/7 walk-in and mobile crisis services, BHA has been focusing more on crisis services and has been reviewing various crisis models, comparing what currently exists, how these could be enhanced, as well as what this might look like in Maryland. A crisis services committee was formed to compare the Crisis Now Model versus SAMHSA~~'s~~ evidence-based toolkit. The committee is creating a crosswalk between the two models and Maryland's current services and is working to develop a strategic plan and framework which will engage stakeholders.

During the full Council meetings, members received and shared pertinent information from BHA leadership, people in recovery, families, and other involved stakeholders through presentations

on a variety of topics from the areas of mental health, substance use, and other addictive disorders. Information regarding various conferences, such as the Tuerk Conference on Mental Health and Addiction Treatment and the Racism and Mental Health Symposium, were shared with Council members. There were several formal presentations offered to the Council members this past year that included:

- **Nurse Practitioners: Modernizing Maryland's Psychiatric Care in 2020**
  The presenters suggested that improvement in access to care and a significant reduction in cost can be achieved if nurse practitioners (NPs) are added to the list of providers who are eligible to conduct capability/capacity evaluations and evaluations for a certificate of competency(guardianship of a disabled person).

- **Behavioral Health Equity**
  BHA created the BH Equity workgroup. Their goal is to inform and engage in shared learning activities and to develop a strategic plan that will analyze current policies, programs and pathways, and will examine how to address social determinants of health. The group is working with the Maryland Office of Minority Health and Health Disparities and is talking to other agencies that have been looking at this same issue. They plan to educate minority populations and community-based organizations that serve minority populations through training, including Mental Health First Aid.

- **Harm Reduction Services**
  The Center for Harm Reduction Services (CHRS) program was formed last February 2019. The program was started to consolidate the Department's resources for those who are actively using drugs and the resources were put under one roof. Their strategic goal is to reduce substance-related morbidity and mortality by optimizing services for people who use drugs. They offer the following programs:
  - Overdose response programs
  - Syringe service programs
  - Access harm reduction grants
  - Capacity building, including Regrounding Our Response and law enforcement assisted diversions.

The Council has continued to help monitor the progress of goals and efforts of the BHA as it continues to shape and refine the process of behavioral health integration. The Council has been closely following these efforts through interface with BHA's Executive Director who is an appointed member of the Council and who provides updates on the PBHS, also known as "The Director's Report," to the Council. Through the Director's Report, information is shared regarding various state and federal grants that BHA monitors, the Legislative Session, and progress within the PBHS related to integration. A few of the updates provided to the Council by the Executive Director are as follows:

Public Behavioral Health System Updates

- ***Response to the COVID-19 Pandemic***

The Governor's Proclamation of the State of Emergency in response to COVID-19 went into effect on March 5, 2020. Since this time, BHA has taken action to address concerns within the PBHS related to the pandemic and to keep providers, staff, and consumers and their families up to date on these efforts to sustain safe treatment services and the eventual safe re-opening of the State.

BHA's top priority has and remains limiting the spread of COVID-19 while ensuring individuals with behavioral health disorders continue to get the help they need and ensuring provider sustainability during and after this crisis. One way BHA has done this has been by establishing some exemptions to regulatory requirements and expansion of Medicaid regulations, including:

  - Allowances for telehealth and telephonic services; and
  - Extension of certificates and licenses to address the continuum of care.

BHA has also obtained blanket exemptions for take home medications for opioid treatment programs (OTPS), developed a COVID-19 informational/resource page on their webpage to make it easier to find resources and identified unspent grant funds to assist with obtaining Personal Protective Equipment (PPE).

BHA developed, on a continuous basis, weekly FAQs and several Public Service Announcements. These are updated as necessary, posted on BHA and the ASO websites, as well as distributed to all their BH partners. They have also hosted and/or co-sponsored a number of provider weekly webinars to provide up-to-date information as well as cohesive and consistent responses. In addition, BHA is increasing their ability to have greater awareness as to COVID- 19 positivity amongst behavioral health providers who are providing residential care services or daily services and opioid treatment programs. BHA has issued several short surveys about client wellbeing, access to treatment, and telehealth impact during the pandemic.

- ***Administrative Services Organization (ASO) Transition***

BHA transitioned to a new ASO, Optum Maryland, on January 1, 2020. BHA is working with the ASO and providers to ensure that services are being provided and payments are being made. BHA is also reaching out to providers to ensure that they are registered with Optum. The performance of the system is improving on a daily and weekly basis. The process of reconciling estimated payments with actual claims paid is ongoing, and BHA, along with Medicaid, continues to monitor the ASO performance. Optum Maryland implemented the reactivation of the provider portal on July 1, 2020. Optum Maryland and the Maryland Department of Health (MDH) are initiating the process for reconciling estimated payments and claims for the period from Jan-Jun 2020 to ensure accuracy.

- ***State Behavioral Health Plan***

The FY 2020-2021 Behavioral Health Plan final draft was shared with Council members to review and provide feedback. The plan was also reviewed by the BHAC Planning Committee meeting. This plan is based on the state behavioral health priorities and has been informed by the four regional stakeholder meetings that BHA held in April and May 2019. Recommendations and priorities identified through the regional stakeholder consultation processes are included in the current draft. The plan also informs BHA's application for Federal Block Grant and aligns with SAMHSA's priorities. Unfortunately, we had to cancel this year's Regional Stakeholders meetings due to the COVID 19 situation, however comments from the Planning Committee members and others have been incorporated as appropriate. The plan is currently being reviewed by BHA's Office of Communications. Once this review is completed, the plan will be posted on BHA's website and BHA will continue to accept public comments through December 31. Comments and feedback will be used to inform BHA's ongoing planning processes and work, and the next multi-year plan that BHA will be working on starting in January 2021.

- ***Local Systems Management Integration Plan***

BHA continues to work with all 24 local jurisdictions to implement the Local Systems Management Integration Plan to improve health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care. The goal of integrated systems management is to support the delivery of high-quality, culturally and linguistically appropriate, person-centered behavioral health experiences in a timely manner, regardless of which "door" a person enters the system.

The systems integration approach involves three phases and it is currently in Phase 3. Progress to date includes: implementation of the Learning Community for the Maryland Association of Behavioral Health Authorities (MABHA), development of standardizing policies and procedures using MDH's Acadia platform and completion of a self-assessment of each local authority of their systems management integration status. In February, BHA began the annual review process of the core service agencies (CSA), local addiction authorities (LAA), and local behavioral health authorities (LBHA) FY 2021 plans.

- ***Updates on the Maryland Federal Block on Mental Health and Substance Abuse Services***

  Mental Health Block Grant

  - Maryland's FY 2020 Mental Health Block Grant Allotment was $13,548,728. States are required to set aside 10% for early intervention or first episode psychosis services. The remaining funds support crisis response systems/services, implementation of evidence-based practices, school-based mental health, and other recovery services.

  Substance Abuse Block Grant

  - Maryland's FY 2020 Substance Abuse Block Grant Allotment was $34,081,826. States are required to set aside 20% for prevention services and 5%

for HIV Early Intervention Services. The remaining funds support substance use treatment, prevention, and intervention services.

Maryland Behavioral Health Advisory Council Committees

The Council has established committees to further support its purpose, as well as to enhance full participation of members and other stakeholders, in developing recommendations for input and advocacy for the PBHS in Maryland and its overarching mission and duties for individuals with mental health, substance use, and other addictive disorders. There are two standing committees and six ad hoc committees. Committee participation is open beyond Council membership. The following section highlights committee activities and conversations for the period covering May to October 2020. Each Committee also kept the Council informed on how COVID-19 is impacting their organizations or populations served.

- **Planning Committee: Co-Chairs Dori Bishop and Senator Adelaide Eckardt**

The duties of this committee include participation in a year-long planning process comprising development, review, and final recommendation of BHA's Behavioral Health Plan and Federal Block Grant Applications, which may be used to inform special projects. The committee, which is a standing committee, also identifies focus areas and issues to be monitored, and makes recommendations to the Council.

Over the past year, the Planning Committee met on two occasions to review, comment and make recommendations on several policy documents including the Federal Block Grant application, the 2020-2021 Behavioral Health Plan, and the FY 2021 BHA Block Grant Spending Plan. The Committee reviewed the Goals and Objectives for the 2020–2021 Behavioral Health Plan, as well as the recommendations from BHA's regional stakeholder meetings for strategies to address goals for this plan.

The Planning Committee developed a priority area which they plan to be their focus for FY 2021. The priority developed was:

- Review and respond to the results/progress of the implementation of the BHAC's Steering Committee's recommendations for 24/7 Walk-In Crisis and Mobile Crisis Team Services.

- **Children, Young Adults, and Families Committee: Co-Chairs Ann Geddes and Mary Bunch**

The duties of this Committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a system of care of behavioral health services and support for children, young adults and families.

The focus of the Committee is on current programs for young adults, the need for expansion of services, especially substance use services, and their role in advocating for this. The Committee is collaborating with the Children, Adolescent, and Young Adult unit at BHA to look at developing additional club houses and recovery residences for youth, reducing PRP services, and increasing crisis services for children and young adults. Another huge focus of the Committee over the last year has been addressing the many concerns that have arisen due to the COVID-19 pandemic, particularly the challenge of telehealth services for this population.

Between January and October 2020, the committee met two times (owing to COVID), in January and September. In January they finalized the recommendations that they wanted to make to the full Council:

1. Support the development of a Mobile Crisis and Stabilization Services System for Children and Adolescents (Priority).

2. Address the gap in care for youth with serious substance use disorders (there being no residential substance use treatment for adolescents in Maryland). Is this a parity issue, since Maryland has residential treatment for kids with mental health disorders? Is it an EPSDT issue? The Council needs to look into this.

In their September meeting they had a presentation from Dr. Maria Rodowski-Stanco, the Director of the Child, Adolescent and Young Adult Division of BHA. The members discussed youth overstays in hospitals, substance use treatment for adolescents, crisis services designed for children and youth, and PRP services. The Committee will be following up with Dr. Rodowski-Stanco.

The Committee identified some next steps for FY2021:

- Continue to pursue the two above issues, with a main focus on their priority: Support the development of Mobile Response and Stabilization Services (MRSS) for children and youth across the state.

- Continue dialogue with the CAYAS division of BHA.

- **Recovery Services and Supports Committee: Co-Chairs Barbara Allen and Carlos Hardy**

The duties of this ad hoc Committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of behavioral health services and supports for youth, adults and older adults.

The Committee focused on addressing MDRN funding concerns. Some recovery residences have not received funding that they are supposed to be getting, which is putting a strain on the programs. There are also some recovery residences that have expressed concerns about the impact of COVID-19 on their programs, including difficulties of enforcing social distancing and

other measures. The Committee put much of their focus on developing their priority for FY 2021, which is to:

- Advocate for the expansion of the continuum of care specifically focusing on recovery residences/housing and services.

Next steps for FY 2021 are to address the Committee's priority.

- **The Cultural and Linguistic Competence Committee: Co-Chairs Jacob Salem and Dayna Harris**

The duties of the Cultural and Linguistic Competence Committee are to assist the Council in its role of gathering and disseminating information about the role diversity—including language and culture—plays in the delivery of behavioral health services in the PBHS. This includes efforts to generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services and efforts to shape and inform strategies for the BHA Cultural and Linguistic Competency Plan.

This past year the Committee has developed their Vision and Mission statements. Their main focus has been to begin to review local jurisdictions' annual cultural and linguistic strategic plans. The Committee will make recommendations to BHA on the progress local behavioral health authorities are making in implementing the National Culturally and Linguistically Appropriate Services (CLAS) standards, and cultural and linguistic competency goals set forth by BHA and the Cultural and Linguistic Competency Committee.
The Committee also addressed challenges of the COVID- 19 pandemic for the population they serve, particularly the lack of specialized providers to address the needs of deaf and hard of hearing individuals.

In FY 2021, the Committee will focus on their developed priority:

- Review local plans and make recommendations to BHA on the progress local behavioral health authorities are making in implementing the National Culturally and Linguistically Appropriate Services (CLAS) standards, and cultural and linguistic competency goals set forth by BHA and the Cultural and Linguistic Competency Committee

- **Criminal Justice/Forensics Committee: Co-Chairs Hon. George Lipman and Kathleen O'Brien, Ph.D.**

The purpose of this ad hoc committee is to advise the Council and BHA regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems, including those who are court-ordered to focusing on in MDH for evaluation, commitment, or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to MDH for a substance related evaluation or for substance use disorders treatment; are released into the community from a MDH facility under court-mandated conditions of release; or have psychiatric, substance use, or co-occurring disorders and are incarcerated, or are at risk of incarceration, in jails, prisons, or juvenile detention facilities.

Over the course of meeting the past year, the Committee focused primarily on competency, ~~and~~ 8–507's and residential treatment. Due to the COVID-19 pandemic, systems for remote hearings or status conferences on individuals who are in jail have been put in place. It was a challenge to get tele hearings, tele meetings and telemedicine into the detention centers but it was done successfully. The Committee worked on developing their priority fo rFY 2021. In addition to working on their priority, the Committee will also work on coordination of services back into the community, crisis services, and housing issues.

The Committee developed their priority for FY 2021:

- Monitor and advocate for compliance with statutory requirements on the competency and 8-507 areas.

- **Prevention Committee**:

The purpose of the Prevention Committee is to meet the Substance Abuse and Mental Health Services Administration's (SAMHSA) requirement of the Strategic Prevention Framework (SPF) grantees to form a Strategic Prevention Framework Advisory Committee (SPFAC). This committee, acting as a SPFAC, monitors the progress of BHA's SPF grant and strengthens and informs grant activities by making recommendations to the BHA, if needed. Additionally, the duties of this committee include providing guidance and advocacy in the areas of prevention across the lifespan.

The Prevention Committee was on hiatus this past year due to the reorganization of BHA's Prevention Unit; the Prevention Unit shifted from BHA to the Public Health Services (PHS) Division in February 2019. The PHS Division of the Maryland Department of Health (MDH) will assume responsibility for areas of opioid response aligned with existing public health activities, which includes health promotion and prevention. While Prevention is now under PHS, BHA still continues to play a central role in supporting PBH treatment services and will be working closely with PHS to fully integrate treatment services and public health activities and maximize the effectiveness of operations. Efforts are under way to reconvene the Committee and the Council welcomed a new member, the Department's new staff with the Office of Population Health Improvement. This member will serve as a vital resource to the Committee.

Appendix

MBHAC BYLAWS

PURPOSE:

Pursuant to HG § 7.5–305, and Federal Public Law (PL) 102–321, the State of Maryland has established MBHAC to promote and advocate for:

(i) planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence–based practices, and cost-effective strategies that enhance behavioral health services across the state; and
(ii) a culturally and linguistically competent and comprehensive approach to publicly-funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

Article I: Guiding Principles

1. All activities and efforts of MBHAC take into consideration cultural and linguistic competence, diversity, and gender identity.

2. Serve as a forum for the dissemination and sharing of information concerning the PBHS among: MDH; BHA staff; behavioral health advocates; including consumers and providers of mental health, substance-related disorders (SRDs), other addictive disorders services in Maryland; and other interested parties.

3. Advocate for a comprehensive, broad-based, person-centered approach to provide the social, economic, and medical supports for people with behavioral health needs; as mandated by HG § 7.5–305 and by PL 102–321.

4. Serve as a linkage with state agencies seeking collaboration for improved behavioral health services.

Article II: Duties

The Council shall:

1. Review and make recommendations to the state on the behavioral health plan and federal grant documents/applications developed in accordance with any applicable state and federal law.

2. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of behavioral health services and funding; as mandated by PL 102–321.

3. The Council may consult with state agencies to carry out the duties of the Council.

4. Submit an annual report of its activities to the Governor and, subject to § 2–1246 of the State Governor Article, to the General Assembly.

5. Receive and review annual reports submitted by the County Advisory Committees as mandated by HG § 7.5–305.

Article III: Membership

In adherence to PL 102–321, the membership should include:

1. Representatives of certain principal state agencies—behavioral health, education, vocational rehabilitation, criminal justice, housing, and social services.

2. Certain public and private entities concerned with need, planning, operation, funding, and use of behavioral health services and related support services.

3. Family members of adults with a behavioral health disorder and children involved with the behavioral health system.

4. Adults who are currently or formerly involved with behavioral health services.

Not less than 50% of the members of the planning Council are individuals who are not state employees or providers of behavioral health services. The ratio of parents of children, with a serious emotional disorder to other members of the planning Council should be sufficient to provide adequate representation of such children in the deliberations of the Council.

The composition below, as stated in Maryland Senate Bill (SB) 174, satisfies the federal law.

A. **Composition**

1) MBHAC consists of 28 Ex-Officio Members (or designees) representing state and local government, the Judiciary, and the Legislature. They are listed in statute as:

One Member of the Senate of Maryland
One Member of the House of Delegates
The Secretary of Maryland Department of Health
The Deputy Secretary for Behavioral Health
The Director of the Behavioral Health Administration
The Executive Director of the Maryland Health Benefit Exchange
The Deputy Secretary for Health Care Financing
The Secretary of Aging
The Secretary of Budget and Management
The Secretary of Disabilities
The Secretary of Housing and Community Development
The Secretary of Human Services
The Secretary of Juvenile Services
The Secretary of Public Safety and Correctional Services
The Executive Director of the Governor's Office for Children
The Executive Director of the Governor's Office of Crime Control and Prevention
The Executive Director of the Governor's Office of the Deaf and Hard of Hearing
The Public Defender of Maryland
The State Superintendent of Schools
The Assistant State Superintendent of the Division of Rehabilitation Services
Two representatives of the Maryland Judiciary: a District Court Judge and a Circuit Court Judge, appointed by the Chief Judge of the Court of Appeals
The President of the Maryland Association of County Health Officers
Four representatives from County Behavioral Health Advisory Councils, one from each region of the state

2) The Council also consists of 13 members, appointed by the MDH Secretary, representing behavioral health providers and consumer advocacy groups. One representative shall be appointed by the Secretary from each of the following organizations:

Community Behavioral Health Association
Drug Policy and Public Health Strategies Clinic
University of Maryland Carey School of Law
Maryland Addictive Disorders Council
Maryland Association of Boards of Education
Maryland Association for the Treatment of Opioid Dependence
Maryland Black Mental Health Alliance
Maryland Coalition of Families
Disability Rights Maryland
Maryland Recovery Organization Connecting Communities

Mental Health Association of Maryland
National Alliance on Mental Illness of Maryland
National Council on Alcoholism and Drug Dependence of Maryland
On Our Own of Maryland

Additional representatives or individuals designated by the Council may also be appointed by the MDH Secretary.

3) The Council shall also consist of 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. These representatives should not be state employees or providers of behavioral health services. Two individuals, representing the mental health and the substance-related disorder treatment community, shall be appointed by the Governor from each of the following:

Academic or research professionals
Medical professionals
Individuals formerly or currently in receipt of behavioral health services
Family members of individuals with mental health or substance-related disorders
Parent of a young child with behavioral health disorders
Youth between the ages of 16 and 25 years with a behavioral health disorder
Individuals active in behavioral health issues within their community

Members appointed by the Governor shall be representative, to the extent practicable, of: (1) geographic regions of the state; (2) at-risk populations; (3) ethnic, gender, across-the-lifespan, and cultural diversity; and (4) balanced representation from areas of mental health and substance-related disorders.

B. **Term of Membership**

1. Ex-Officio Members serve as long as the member holds the specified office or designation.

2. Members appointed by the MDH Secretary may serve as long as the organizations they represent wish to have them as a representative of the organization.

3. Members appointed by the Governor: serve a three-year term; may serve for a maximum of two consecutive terms; and after at least six years have passed since serving, may be reappointed for terms that comply with the original appointment. At the end of a term, a member may continue to serve until a successor is appointed and qualifies.

4. Terms of Governor-appointed members can be staggered so that one third of members’ terms end each year. If a member is appointed by the Governor after a

term has begun, he or she may serve only for the rest of the term and until a successor is appointed and qualifies. If appropriate, the Council may recommend that he or she may qualify him or herself, through the Governor's Office of Appointments, for the option of serving a second full-term.

5. Notwithstanding any other provisions of this subsection, all members serve at the pleasure of the Governor and with the consent of the Council.

C. Attendance

It is the expectation of this Council that members attend the majority of the meetings, participate in Council activities, and exercise the duties and responsibilities of the Council on a regular basis.

Governor-Appointed Members

Members of the Maryland Behavioral Health Advisory Council, who are appointed by the Governor, are subject to the Maryland State Government Code Annotated 8-501(2013) which states:

(a) Member deemed to have resigned—A member of a state board or commission [applicable to this Council as well] appointed by the Governor who fails to attend at least 50% of the meetings of the board or commission during any consecutive 12-month period [*] shall be considered to have resigned.

(b) Notice to Governor—Not later than January 15 of the year following the end of the 12-month period, the chairman of the board or commission shall forward to the Governor:

(1) the name of the individual considered to have resigned; and

(2) a statement describing the individual's history of attendance during the period.

(c) Appointment of successor—Except as provided in subsection (d) of this section, [just below] after receiving the chairperson statement the Governor shall appoint a successor for the remainder of the term of the individual.

(d) Exception—If the individual has been unable to attend meetings for reasons satisfactory to the Governor, the Governor may waive the resignation if the reasons are made public.

*This Council will meet six times per year. Fifty percent attendance means at least three meetings per year are attended.

Ex-Officio Designees and Department-Appointed Members

In the event an ex-officio designee or Department-appointed representative on the Council fails to attend 50% of the meetings during any period of 12 consecutive months (three meetings per year), the Co-Chairs/Executive Committee shall send a letter of reminder to the head of the agency/organization/department of the member. If, after a reasonable period of time, there is no attendance, then the Co-Chairs/Executive Committee shall send a

letter to the head of the agency/organization/department of that member recommending that he or she be replaced. If the agency member has been unable to attend meetings as required for reasons satisfactory to the Executive Committee or MDH Secretary, such resignation may be waived if such reasons are made public.

Suspension or Removal of Governor-Appointed Members
Additionally, as excerpted from the Maryland State Government Code Annotated § 8–502 (2013), "A member of a State board or commission shall be suspended…from participation in the activities of the board or commission [applicable to this Council for Governor Appointed Members] if the member is convicted of or enters a plea of nolo contendere to any crime that: (i) is a felony; or (ii) is a misdemeanor related to the member's public duties and responsibilities and involves moral turpitude for which the penalty may be incarceration in any penal institution. The suspension shall continue during any period of appeal of the conviction. If the conviction becomes final, the member shall be removed from the office and the office shall be deemed vacant. Reinstatement—If the conviction of the member is reversed or otherwise vacated … the member shall be reinstated to the office for the remainder, if any, of the term of office during which the member was so suspended or removed…."

Article IV: Meetings and Voting

A. **Meetings**

Times and Location
The Council shall meet at least six times a year. The location to be determined as coordinated through Council Support Staff. The recommended schedule is once (day to be set as coordinated through Council Support staff) during each of the following months: September, November, January, March, May and July. Special meetings, or meetings of the Council to replace meetings postponed due to inclement weather or other circumstances, shall be authorized by the Executive Committee.

Teleconferencing will be available and counts as attendance.

Agenda and Notice of Meetings
Notice of regular meetings shall be announced by email (by mail for those without computer access). When appropriate and available, an agenda will be included in the announcement.

Official Record
The minutes of the Council meeting shall be the official record of the Council. The minutes shall be distributed to all members of the Council and to the Director of BHA within four to six weeks following a meeting. After final adoption, minutes will be distributed to local behavioral health authorities. All minutes, recommendations, and related materials will be posted on BHA's Web site.

Ad hoc and standing subcommittee meetings may be convened whenever necessary. If necessary, the Executive Committee or any other committee can meet and converse by telephone when it is not feasible to convene and/or when an immediate decision is required. Decisions reached by telephone shall be recorded as meeting minutes for that date and considered official meeting minutes.

Travel Allowance

Council members whose transportation costs are not reimbursed by an agency, group or organization, and who need financial assistance in order to attend a Council meeting and/or when officially representing the Council at other meetings, are eligible for reimbursement by BHA. Members may not receive compensation as a member of the Council; but are entitled to reimbursement for travel expenses as provided for in the state budget. Travel expenses shall be consistent with the Standard State Travel Regulations and are dependent upon resource availability. Council members are responsible for completing all expense reporting forms in a timely manner, and submitting appropriate accompanying documentation as required.

B. **Voting**

1. Ex-Officio Members in statute and Appointed Members are all considered voting members.

2. A majority of the voting members of the Council is a quorum. A simple majority of those present at a meeting (face-to-face or by teleconferencing) is sufficient to adopt a motion.

3. The Executive Committee may call for a Council-wide vote on issues of greater import. If a quorum is not present at the meeting specified for the vote, the Executive Committee shall determine the method and timeline to collect the additional votes.

4. Council Officers shall be elected according to a balanced (mental health and substance- related) slate presented by the Nominating Committee every two years or as required.

Article V: Officers

A balanced representation of areas comprising the behavioral health system should be taken into consideration. Also, it is encouraged to consider at least one officer to be a recipient or former recipient of behavioral health services or a relative of such an individual. Officers shall serve for one two-year term. However, an officer’s term may be extended due to unusual circumstances by a vote of the full Council.

A. **Co-Chairs**

The two co-chairs shall be elected from among the full membership of the Council. The co-chairs shall serve for one two-year term. Elections shall be held bi-annually in December and the term shall begin on January 1 through December 31 of the following year.

The co-chairs shall be responsible for:

1. Calling and presiding over all full meetings of the Council;

2. Coordinating the activities of the Council, including preparation of the required state and federal reports;

3. Collaborating in the preparation of the agenda for the meeting of the Council;

4. Serving on the Executive Committee;

5. Appointing the chairpersons or co-chairs and members of the Nominating Committee and the chairpersons or co-chairs of standing and ad hoc committees;

6. Signing, when appropriate, in the name of the Council, all letters and other documents;

7. Serving as Ex-Officio on standing and ad hoc committees, except for the Nominating Committee; and

8. Representing the opinion of the Council to the public.

B. **Committee Chairs**

The Council co-chairs will designate a chair or co-chair for each committee from among the Council membership. Chairs and co-chairs of each committee must be members of the Council. Committee co-chairs or chairs shall serve as members of the Executive Committee. Additionally, committee co-chairs or chairs may be called upon to be responsible for the duties of the Council co-chairs in the absence of either or both officers.

Committee chairs or co-chairs are expected to convene, attend, and preside over all committee meetings of their respective group (by teleconferencing, if necessary) and designate the means for an official record (summary or minutes) to be generated of meetings held. Committee chairs or co-chairs shall: follow the policy for and monitor the attendance of committee members.

Article VI: Committees

MBHAC's committee structure will consist of standing committees and ad hoc committees to facilitate the Council's role of gathering and disseminating information. Membership on committees is not limited exclusively to Council members except the Executive and Nominating committees. The Council may adopt procedures necessary to do business, including the creation of committees or task forces. Standing and ad hoc committees may be convened as determined by the Council Co-Chairs and agreed upon by the Executive Committee. The committees will make recommendations that will enhance aspects of the behavioral health system and to ensure a coordinated, culturally and linguistically competent, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies in the delivery of behavioral health services state-wide.

Council members are requested to serve on at least one committee. A focus on the following themes will remain central to committee operations:

1. Facilitate a balance between mental health and substance-related disorder services and systems; maintain the understanding that representation across the behavioral health service system is required and needed and promote discussion about the ongoing concerns and care coordination associated with the behavioral health integration process.
2. Focus on information sharing and committee coordination to avoid the duplication of effort, since multiple Council members work on other projects and stakeholder groups. Also, the Council must maintain clarity in terms of the role and duties of MBHAC.
3. Each committee must report how it is moving toward achieving the Council's mission and core priorities and issues.
4. An official record such as minutes or a summary of actions must be taken at all standing and ad hoc committee meetings.

Policies and Procedures for Committees:

Standing Committees

A. **Executive Committee**

The Executive Committee shall be composed of the Council Co-Chairs, together with any standing committee and ad hoc committee chairs and co-chairs. The Executive Committee shall meet.as needed. The Executive Committee responsibilities include, but are not limited to, preparing, reviewing or approving testimony or other public presentations/documents/reports submitted on behalf of the Council when sufficient time does not permit review and approval of the entire Council and timing is of critical importance, etc. Another duty of the Executive Committee will be to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide

oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

B. **The Planning Committee**

The Planning Committee will address efforts that comply with the Federal Mental Health Block Grant requirement. The duties of this committee include participation in a yearlong planning process comprising development, review, and final recommendation of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The committee shall also identify focus areas/issues to be monitored and make recommendations to the Council. Also, the committee shall participate in the development of the Annual Report, which summarizes the activities, priorities, and recommendations of the Council and is submitted to the Governor annually. On an ongoing basis, the Planning Committee will give input to identify workgroups and targeted projects for the Lifespan Committees and, as needed, give input toward the action plans of ad hoc committees and/or special studies/workgroups committees to ensure they are in concert with the BHA's goals and priorities.

C. **Prevention Committee**

This committee will address efforts that comply with the Federal Substance Abuse Block Grant and Strategic Prevention Framework Grant (SPFG) which is currently in phase 2. The SPFG began in September 2015 and ended in September 2020 at $1.6 million per year. The focus during the second phase of the initiative is to prevent and reduce underage drinking and youth binge-drinking. The Prevention Committee will serve as Maryland's required Strategic Prevention Framework Advisory Committee (SPFAC), a requirement for Strategic Prevention Framework grants from SAMHSA for monitoring progress and strengthening the initiative by making recommendations to BHA if needed. Additionally, the duties of this committee include providing guidance and advocacy in the areas of prevention across the lifespan. This may include areas such as substance-related prevention, suicide prevention, and addictive behaviors such as gambling. This committee may examine data, research, identify risk factors, evidence-based resources, and make recommendations or suggest strategies to the Administration as appropriate and/or as elements for further study.

<u>Ad Hoc Committees</u>

These committees will be formed, as needed, to address specific duties, needs, or issues as deemed appropriate by the Executive Committee or Council. The Council Co-Chairs may appoint temporary committees or Council representatives for a specified purpose and time. Upon completion of the task, the committees shall be dissolved. Another duty of the Executive Committee will be to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

A. **Children, Young Adults, and Families Committee**

The duties of this committee will be to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of care of behavioral health services and support for children, young adults and families.

B. **Recovery Services and Support Committee**

The duties of this committee will be to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of behavioral health services and supports for youth, adults and older adults.

C. **The Cultural and Linguistic Competence Committee**

The primary objective of the Cultural and Linguistic Competence Committee will be to assist the Council in its role of gathering and disseminating information about the role culture plays in the delivery of behavioral health services in the behavioral health system. The Cultural and Linguistic Competence Committee will generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services important for the behavioral health system, providers, and communities across the state. Recommendations and concepts generated by the committee will be general and will also make reference to specific cultural groups and communities across the state of Maryland, including those related to gender, gender identity, and disability. The recommendations and concepts made by this committee will be used to shape and inform strategies that are part of state, federal, and local planning processes.

D. Criminal Justice/Forensics Committee

The purpose of this committee is to advise BHA regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems, including those who: are court-ordered to MDH for evaluation, commitment, and/ or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to MDH for a substance-related evaluation and/or for substance-related disorders treatment; are released into the community from a MDH facility under court-mandated conditions of release; or have psychiatric, substance-related, or co-occurring disorders and are incarcerated, or are at risk of incarceration, in jails, prisons, or juvenile detention facilities.

E. The Nominating Committee

Composition

The Nominating Committee shall consist of a chairperson and four other members, all appointed by the Council Co-Chairs. Members shall represent a balance in the areas of mental health and substance-related disorders.

Slate

The Nominating Committee shall convene bi-annually in September and conduct a search for the offices of Council Co-Chairs from among the Appointed and Ex-Officio Membership. If the present officers are deemed eligible to serve a second term, it is appropriate that the Nominating Committee take their names into consideration for the slate. Additionally, the Committee must consider the need to maintain the balance between the areas of mental health and substance-related disorders when considering names for the slate. The slate shall consist of up to two names for Co-Chairs.

Voting

The slate shall be presented electronically to the full Council, bi-annually in October, and voted to be approved or not approved the following November during a meeting with a quorum of Council members present. If the slate is approved, those named will begin their term on the following January 1. If the slate is not approved, then the Nominating Committee will be requested to develop an alternate slate of names.

F. Ad Hoc Committees and Workgroups

Additional ad hoc committees or special studies workgroups may be convened to: address a specific behavioral health priority area identified by the Council for review, presentation, and possible advocacy recommendation; or to meet the requirements of other legislative processes or task forces.

The membership of ad hoc committees or special studies/workgroups may include an individual(s) representing the Council on various BHA or other agency or organization-sponsored task forces, workgroups, etc.

Membership on committees is not limited exclusively to Council members. Non-Council members may serve on committees, ad hoc committees, and specialty workgroups, except the Executive and Nominating committees.

Article VII: Support Services

BHA shall provide support staff for administrative coordination, as necessary, to support the functions of the Council.

Article VIII: Amendments

The By-laws may be amended by recommendations of the Executive Committee and two-thirds of the voting members of the Council who are present, provided that copies of the proposed amendments and notice for consideration have been mailed to every member at least two weeks before the date of the meetings, during which adoption of the amendment(s) would be considered. The amendment goes into effect immediately upon its adoption unless otherwise specified.

MBHAC Bylaws were amended and approved September 18, 2018.