Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth and Families

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This Roadmap was prepared by the Maryland Coalition of Families and Manatt Health for the Maryland Department of Health Behavioral Health Administration.

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About Maryland Coalition of Families

Maryland Coalition of Families is a statewide non-profit, based in Columbia Maryland, that offers Family Peer Support services, at no cost, to families, caregivers, and/or loved ones of individuals experiencing behavioral health challenges. For more information, visit mdcoalition.org.

About Maryland Department of Health Behavioral Health Administration

The Behavioral Health Administration, as part of the Maryland Department of Health, oversees community behavioral health services to help Marylanders with mental health, substance use, and more. For more information, visit health.maryland.gov/youthbehavioralhealth.

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Executive Summary

The Behavioral Health Administration (BHA) partnered with the Maryland Coalition of Families (MCF) and Manatt Health to develop a Roadmap for strengthening the public behavioral health system (PBHS) to better meet the needs of Maryland children, youth, and families; prioritize equity; and with a focus on strengthening the access to quality and equitable home and community-based care. Building upon work already underway, the Roadmap sets forth a vision for the PBHS, as well as goals and specific strategies to achieve this vision (the Roadmap).

The Roadmap was developed in response to the urgent need for further reform. Data from recent years indicates that thirty percent of Maryland middle and high school students report feeling sad or hopeless, the state is losing more than 100 young people a year to drug and alcohol overdoses, behavioral health patients board in emergency departments at a median time of 33.7 hours, and suicide is the third leading cause of death among young people ages 10 to 24.[1] The Roadmap puts forward five key goals and ten specific strategies to enhance the PBHS and better meet the behavioral health needs of Maryland children, youth, and families.

Strategies	Goals
• Support youth and families in navigating the system • Further establish robust cross-agency collaboration	**Coordinated and Accessible**
• Leverage EPSDT to support early intervention • Continue to expand crisis services to mitigate emergency department boarding and inpatient stays	**Focused Upstream**
• Invest in the behavioral health workforce • Develop a financing plan to maximize the efficient use of federal and state funds	**Efficient and Sustainable**
• Continue to strengthen in-home and intensive community-based care • Develop pilot initiatives for special populations (e.g., I/DD, LGBTQIA+, military families)	**Comprehensive and Equitable**
• Engage youth and families in policy design • Expand access to youth and family peer support services	**Youth and Family-Centered**

Future State

Maryland children, youth and families confronting behavioral health challenges persevere and thrive

The Roadmap recognizes that BHA cannot achieve sweeping improvements in isolation or overnight— to drive forward meaningful change, it will require continued, coordinated effort by BHA, other state agencies, and community partners, as well as ongoing engagement with youth and families impacted by the PBHS. In addition to committed partners, BHA will need an implementation approach that prioritizes the most urgent, impactful, and feasible changes and a financing strategy to ensure proposed changes can be implemented and sustained using a combination of local, state, and federal funds.

This Roadmap is intended to serve as a guide as BHA continues striving towards a youth- and family-centered, accessible, equitable and sustainable PBHS for Maryland children, youth and families.

> *"Our first emergency department visit was positive—the doctor really helped her figure out her options and decide between inpatient and community-based care. I just wish there was more consistency and that my kid and I were always treated with respect."*
>
> Focus Group Participant

Introduction

In early 2024, BHA partnered with the MCF and Manatt Health to develop a Roadmap for strengthening the PBHS. The goal is to provide better support to Maryland's children, youth, and families who are navigating a complex ecosystem for those with behavioral health needs, including mental health, substance use, and somatic issues. This Roadmap is based on MCF and Manatt Health's review of the data on Maryland's PBHS, policies and procedures, insights from over eighty stakeholders,[2] and the frontline perspectives of a diverse set of youth and family members shared during seven focus groups conducted across the state.

The Roadmap:

- Describes the current state of the PBHS, including how the PBHS is administered and current data on utilization and spending on behavioral health services among Maryland children and youth;
- Identifies five goals for the role of the PBHS in supporting the behavioral health of children, youth, and families; and
- Proposes a logic model with ten specific strategies for how BHA and its partner agencies can promote the desired changes and achieve the stated goals.

The Roadmap reflects that there is an urgent need for change. Maryland's children and youth are experiencing behavioral health challenges at high rates (see Box 1), including depression, anxiety, suicidal ideation, self-harm, and substance use disorders (SUDs). As in the rest of the country, these issues garnered significant attention in Maryland during the COVID-19 pandemic; however, they began long before the pandemic and, despite some diminution in recent years, remain at high levels. In light of this, the Roadmap includes some short-term strategies that BHA could consider for a more immediate impact along with larger systems-level reforms.

Box 1. Behavioral Health Challenges Among Maryland Children and Youth

In fiscal year 2023, almost 318,000 people were treated by Maryland's PBHS.[3] Of those, over 80,000 (approximately 25 percent) were children and youth up to age 17.[4]

In 2024, Maryland ranked 31st among states in youth mental health, dropping from 14th in 2023.[5] Rates of depression, substance use, and suicidality are even higher among those from historically marginalized groups, including, but not limited to, Black and Latino youth and those who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA+). In the 2021–2022 period, the number of middle school and high school students reporting feelings of sadness and hopelessness grew by 11.3 percent and 7.2 percent, respectively, when compared to 2018-2019.[6] As of 2023, nearly 15 percent of youth between the ages of 12 and 17 in Maryland reported suffering at least one major depressive episode.[7] In addition, a 2022 survey found that 43 percent of LGBTQIA+ youth in Maryland seriously considered suicide in the past year.[8]

Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) also indicate that close to half (46 percent) of young people ages 12 to 17 in Maryland with a major depressive episode did not receive any mental health services in the prior year, suggesting that navigation issues, along with other barriers to care, are resulting in many young people not receiving needed services.[9]

Understanding the Roadmap

The Roadmap offers a vision for how Maryland's PBHS could better help children, youth, and families to thrive and describes five high-level goals and ten specific strategies BHA could pursue to achieve this vision. Many of the strategies require system modifications, extended time to implement, and local, state, and federal resources. They will also require collaboration with partner agencies, including, but not limited to, Medicaid and Healthcare Financing, the Maryland State Department of Education, the Department of Human Services, and the Department of Juvenile Services. BHA and its partner agencies will also need to collect data and evaluate outcomes from any new initiatives on an ongoing basis to understand what is most effective and where additional work needs to be done.

To assist BHA in determining how to prioritize and phase implementation of these strategies, the Roadmap offers insight into the expected complexity, resource intensity, and timeline associated with each of the strategies, as well as initial implementation steps. The Roadmap is intended to be a living document—one that evolves over time as new data, insights, and community feedback become available.

The Roadmap is:

1. **A Strategic Plan (3–5 Year Vision):** The Roadmap outlines a vision for the future of behavioral health services in Maryland. It identifies key priorities, goals, and strategies to create a more accessible, equitable, and effective system of care over the next three to five years.
2. **Informed by Data and Family Voice:** The Roadmap is built on data-driven insights and family feedback. It incorporates the lived experiences of youth and families and is grounded in evidence that highlights where improvements can be made within the existing PBHS.
3. **Recommendations for Systemic Improvement:** While the Roadmap suggests specific initiatives and reforms, these are recommendations and not mandates or commitments by BHA. These recommendations are designed to guide policy, practice, and funding decisions.
4. **A Living, Evolving Document:** The Roadmap is not set in stone; it is a dynamic document that will continue to evolve as new challenges, opportunities, and resources emerge. Regular updates will ensure that the Roadmap remains relevant and responsive to changing needs.
5. **A Guide, Not an Implementation Plan:** The Roadmap is designed to guide future work and decision-making, as well as to provide initial implementation steps to support BHA in improving the PBHS.

The Roadmap is intended to support BHA's decision-making and strategic planning in the coming years. It serves as a Roadmap in the true sense—helping leaders and communities chart a course toward a better, more integrated behavioral health system. By utilizing the Roadmap, BHA, partner agencies, and key stakeholders can continue to work together towards building a system that better meets the needs of Maryland children, youth, and families, prioritizes equity, and strengthens community-based care.

Vision, Mission and Goals

This Roadmap proposes a set of goals and specific strategies to move the PBHS towards a vision for a "future state" in which Maryland children, youth, and families confronting behavioral health challenges can thrive. It draws on the mission of BHA to promote equity, resiliency, recovery, health, and wellness for individuals who have or are at risk of behavioral health disorders to improve their health and wellbeing. To achieve this vision, the Roadmap identifies five goals for the "future state" of the PBHS:

1. **Coordinated and Accessible:** The PBHS offers coordinated services and support and, to the maximum extent possible, works in partnership with other agencies to assist in coordinating services for families instead of relying on them to navigate siloed systems. Youth and families know where to turn for support and how to get help; once they know what they need, they can access services in a timely way.
2. **Focused Upstream:** The PBHS includes robust prevention and early intervention programs to identify issues early and avert the onset of more serious behavioral health conditions.
3. **Efficient and Sustainable:** A diverse workforce, an accountability structure, and appropriate financing are in place to ensure the behavioral health system can function effectively on the ground in a sustainable way.
4. **Comprehensive and Equitable:** A full continuum of services is available to address the needs of Maryland's children, youth, and families. The services reflect the unique circumstances and specialized needs of children and youth at heightened risk for behavioral health challenges, including, but not limited to, those who are LGBTQIA+, have intellectual and/or developmental disabilities (I/DD), are involved in foster care, and/or are part of military families.
5. **Youth and Family-Centered:** BHA and its partner agencies maintain a dedicated focus on what children, youth, and families need in terms of support and services and respect their lived experience, diversity, and values in individual treatment decisions and policymaking.

To achieve these goals, the Roadmap details ten specific strategies for Maryland to consider to enhance the PBHS and better meet the behavioral health needs of Maryland children, youth, and families (see Figure 1). While the Roadmap categorizes each strategy into one of the five goals listed above, in practice, the strategies support multiple goals, reflecting the inter-related nature of the issues confronting the PBHS (see Figure 2).

Figure 1. Logic Model for Roadmap

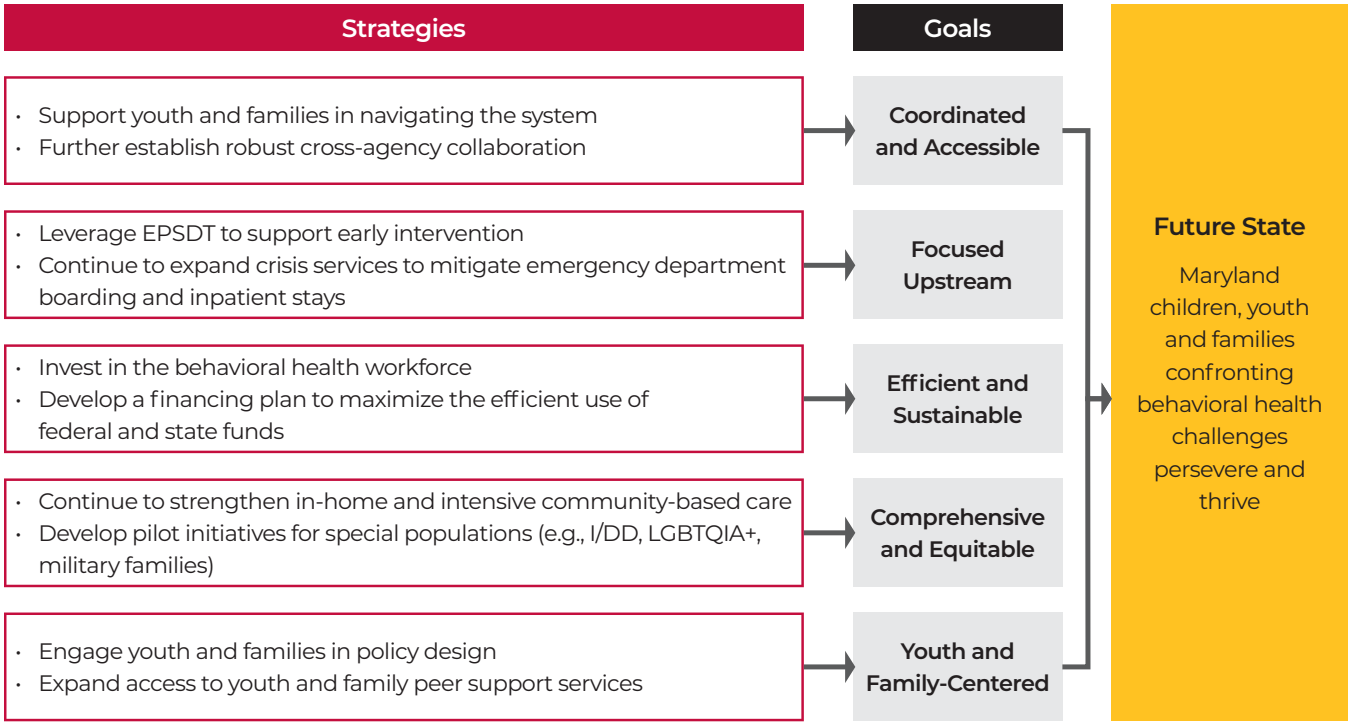


Figure 2. Mapping of Roadmap Goals & Strategies

	Support youth and families in navigating the system	Further establish cross-agency collab-oration	Leverage EPSDT to support early inter-vention	Continue to expand crisis services to mitigate emergency department boarding and inpatient stays	Invest in the behavioral health workforce	Maximize efficient use of federal and state funds	Strengthen intensive in-home and community-based care	Develop tailored pilot initiatives	Engage youth and families in policy design	Expand access to youth and family peer support services
Coordinated & Accessible	✓	✓	✓	✓	✓	✓	✓	✓		✓
Focused Upstream	✓	✓	✓	✓	✓	✓		✓	✓	✓
Efficient & Sustainable		✓		✓	✓	✓			✓	
Comprehensive & Equitable	✓		✓		✓	✓	✓	✓	✓	✓
Youth & Family-Centered	✓	✓	✓	✓			✓	✓	✓	✓

Methodology

To prepare the Roadmap, Manatt Health and MCF reviewed data on behavioral health needs and service utilization among Maryland youth, analyzed current PBHS policies and practices, and conducted a series of focus groups and interviews with Maryland families and other behavioral health stakeholders. In addition, Manatt Health and MCF reviewed national research on the youth mental health crisis and work underway in other states to improve behavioral health outcomes for children, youth, and families.

Between June 2024 and November 2024, MCF facilitated seven focus groups with youth and family members from across Maryland with lived experience with the PBHS, including a meeting with Spanish-speaking families and a "town hall" with young people. The use of small focus groups made it possible to have frank discussions with youth and families about their experiences.

Focus group sessions were complemented by meetings with representatives from state agencies, provider organizations, and advocacy and consumer groups, and presentations to the Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access. Following the focus groups and large-group presentations, participants had the opportunity to share follow-up written feedback through surveys collected and reviewed by Manatt Health and MCF. In total, approximately 160 youth, family members, and other stakeholders contributed to the development of the Roadmap. A complete list of interviewees and additional information about the focus groups are included in Appendix 1, and summaries of focus group findings are in Appendix 2 and Appendix 3. A glossary of acronyms used in this Roadmap is in Appendix 4.

Current Behavioral Health System

In Maryland, the vast majority of behavioral health services are "carved out" from other publicly funded and administered health care services. Medicaid Managed Care Organizations (MCOs) cover mental health and SUD services provided by an enrollee's primary care provider. Specialty mental health and SUD services for Medicaid-covered and uninsured Maryland residents that are not part of a primary care visit are provided by the PBHS. BHA is responsible for the management and oversight of services delivered through the PBHS. BHA works in collaboration with a behavioral health Administrative Services Organization (ASO) and Maryland's Medicaid program to manage the delivery of behavioral health services to eligible individuals. The ASO is responsible for overseeing service authorization, data collection, and claims processes for the PBHS. Maryland's local behavioral health authorities (LBHAs) and core service agencies (CSAs) that represent all 24 Maryland jurisdictions also support the management of the PBHS, helping to plan, monitor, and oversee the PBHS at the local level.

The PBHS covers a wide array of mental health and SUD services and supports.[10] These range from early intervention programs and outpatient therapy to crisis services, inpatient, and residential treatment when needed. For children and youth with the most significant or complex needs, the PBHS also provides targeted case management (TCM) support, which utilizes a tiered approach based on the level of need. Those with the most complex needs have access to the highest tier of TCM services (Level III TCM) and automatically qualify for intensive in-home services and other wraparound support through Maryland's Medicaid-covered 1915(i) program.[11]

While the PBHS covers a broad range of services and supports, utilization data and on-the-ground reports from youth and families show that challenges remain in accessing behavioral health services in Maryland. In fiscal year 2022, approximately 115,000 children, youth and young adults up to age 25 received PBHS services.[12] Among children, youth and young adults receiving PBHS services, the vast majority (94.5 percent) received outpatient mental health treatment services, such as group and family therapy, psychosocial rehabilitation, and case management. Significantly fewer children, youth, and young adults utilized higher intensity services, including inpatient and residential treatment and intensive community-based services. In fiscal year 2022, 6,267 children and young adults had one or more psychiatric-related hospitalizations (5.4 percent of child, youth, and young adult PBHS recipients), and 278 were treated in one of Maryland's six residential treatment centers. In the same period, 34 children and youth were enrolled in the 1915(i) program. There is no widely agreed upon metric by which to measure the appropriateness of the rate at which children in Maryland use intensive behavioral health services, but research suggests there is a nationwide shortage of pediatric psychiatric inpatient capacity[13] and Maryland families that participated in the focus groups reported delays in receiving higher intensity services.

At the same time, there are workforce shortages that exacerbate challenges in accessing care, particularly for intensive, community-based services, including, but not limited to, respite care and 1915(i) services. In fiscal year 2023, 1,440 providers billed for mental health outpatient treatment services delivered to children and youth ages 0–17. In contrast, only ten providers offered 1915(i) services.

Family members that participated in focus groups noted that there can be significant challenges in navigating the PBHS and getting connected with the services and supports their child or young person needs. In many cases, families reported that it took months or years to determine how to get help and that they faced long wait lists for PBHS services due to lack of provider capacity and access across the state.

> *"Referrals for therapy take several months to schedule an assessment and obtaining psychiatric services requires a wait of almost 6 months. Our children cannot and must not wait for immediate services."*
>
> Survey Respondent

> *"We need more ways to make the system more accessible to all."*
>
> Young Adult Town Hall Participant

Goal 1 | Coordinated & Accessible

The PBHS offers coordinated services and supports and, to the maximum extent possible, works in partnership with other agencies to assist in coordinating services for families instead of relying on them to navigate siloed systems. Youth and families know where to turn for support and how to get help; once they know what they need, they can access services in a timely way.

Strategy: Support youth and families in navigating the behavioral health system

One of the most prominent themes from stakeholder interviews and focus groups is that Maryland families and young people often do not know where to turn for help. Families adopt a "trial and error" approach to determine what is happening with their child, identify resources, and find providers. If they cannot find community-based care, families feel they have no option but to turn to emergency departments or 911. In a town hall session, young adults shared they would rather search for solutions online than tackle navigating the behavioral health system without support.

Current State

Maryland is committed to better supporting youth and families in navigating the PBHS. To date, Maryland has developed a number of resources to help families navigate the behavioral health system, including, but not limited to:

- **ASO Consumer Assistance.** Beginning in 2025, Carelon, the new ASO supporting the PBHS, is operating a call center from 8 a.m. to 6 p.m. on weekdays staffed by fully trained and appropriately licensed or certified personnel. The ASO is expected to treat all callers with equal respect, including understanding how cultural diversity and disparity impact health outcomes of specific populations.[14]
- **988 and 211 Hotlines.** Currently, there are two hotlines in Maryland that can be used by families when they need help: 988 and 211. 988 is designed for those who have an urgent behavioral health need or are in crisis, while 211 can help families access food, housing, and other resources and connect families to 988 if they have an urgent behavioral health need.[15]
- **Bed Registry and Referral and Care Traffic Control System.** Maryland is in the process of establishing an online behavioral health provider bed registry and referral system that includes a searchable inventory of public and private behavioral health providers, an electronic referral system, and a crisis call center with the ability to deploy mobile crisis services and secure same-day or next-day outpatient clinical services.[16]
- **Local Care Teams.** Multidisciplinary Local Care Teams operate at the jurisdictional level in Maryland to establish local care coordination and assist families with identifying appropriate resources across agencies. The Local Care Teams serve as the conduit for care coordination, and local behavioral health authority representatives participate in the teams. They are expected to utilize a child- and family-centered approach and are staffed by representatives from county-level human services agencies, advocates, peers, and representatives from other state agencies.[17]
- **Other Initiatives.** Maryland is one of 11 states that launched a Youth Mental Health Corps to bring youth into the mental health workforce and help connect them with mental health supports and resources they need.[18] The Maryland Behavioral Health Integration in Pediatric Primary Care

(BHIPP) program also helps support youth and families to find behavioral health support and services through their primary care provider.[19] It provides training and education on how primary care providers can offer some behavioral health support directly to youth and families and information on how they can connect families to specialized services. Finally, Maryland supports the Kennedy Krieger Institute's Maryland Early Childhood Development and Mental Health Project Extension for Community Healthcare Outcomes (ECHO) program. The ECHO program is a collaborative educational model focused on allowing multidisciplinary teams to share best practices related to diagnosis, managing, and treatment of behavioral health conditions for young children. The program provides a learning community for Maryland primary care providers to increase knowledge about behavioral health supports within the communities they serve.

Despite the wide range of services and supports available to help youth and families in navigating the PBHS, families report that resources are not easily accessible or widely communicated. They often lack information on the available resources and, even when they do know about them, report that some of the existing resources are unhelpful. For example, a number of families in the focus groups reported that existing call centers like 211 and other local resources were unhelpful when they needed to find behavioral health services.

> *"I just learned about the Local Care Team. My daughter has had several hospitalizations and we have been trying to find her help for years. Why did it take years for someone to tell us about this resource?"*
>
> Focus Group Participant

> *"When we were trying to find care for my daughter, it felt like guesswork. I didn't know which questions to ask or whom to ask them of, and what resources were available."*
>
> Focus Group Participant

> *"Sometimes we only learn about resources because someone is having a good day and remembers to tell you about a resource when you explain your problem to them."*
>
> Focus Group Participant

Recommendations

While BHA has established a wide range of navigational supports, there is an opportunity to further build out and streamline behavioral health navigation resources for Maryland residents to help them find and access the treatment they need. To make it clear where and how to get help, BHA could streamline existing supports through the Bed Registry and Referral and Care Traffic Control System (BRSS).

BHA could establish the BRSS as a unified web portal for Marylanders who need either routine or urgent behavioral health support. The BRSS could include 988 and associated crisis services, as well as access to clinical staff that could support with initial screenings and identify community-based resources. It could leverage the existing 988 hotline and its associated public-facing list of mental health and SUD resources and be expanded to add additional non-crisis capabilities. To ensure

Maryland residents are aware of and able to easily access this resource, BHA could invest in outreach and engagement strategies to ensure youth, families, and providers are knowledgeable about the BRSS and recognize it as the key navigational resource related to behavioral health. Finally, the BRSS could also serve to connect families to Local Care Teams or family peer partners.

Key functions of a more streamlined, integrated navigational resource could include:

- Providing support from trained clinicians, peer support specialists, and other behavioral health professionals who can screen callers for behavioral health care needs and identify appropriate community-based resources (e.g., outpatient behavioral health services or crisis support);
- Offering warm handoffs to external resources, such as help scheduling an outpatient visit or dispatch of a crisis provider with follow up contact;
- For families with young people, advising them on how and why to secure behavioral health assessments and connecting them to a family peer support specialist or other system navigator;
- Providing information about available services across each region of the state; and
- Providing information about behavioral health providers that can support youth and families who do not speak English or have other specialized needs.

BHA would need to evaluate available local, state, and federal dollars that could be used to support the development and maintenance of a more robust, streamlined behavioral health navigation service.

Complexity: High

Resource Intensity: High

Timing: Long-Term (4+ years)

Potential Implementation Steps:
• Review existing behavioral health resources and develop a comprehensive list of available services
• Develop cost estimates and identify local and state funding sources to support expansion of the BRSS
• Develop comprehensive outreach strategy to advertise the BRSS as a central navigational resource, including through review existing outreach campaigns related to 988 and the ASO call center to determine which messaging is most effective
• Hire staff to respond to hotline calls and support navigation of behavioral health resources
• Collect and report on data on utilization and member satisfaction with expanded BRSS platform

State Example: Massachusetts

In 2023, Massachusetts launched a Behavioral Health Help Line to connect individuals and families to the full range of mental health and SUD treatment services offered in Massachusetts, including outpatient, inpatient, and crisis care.[20] Any Massachusetts resident can call the hotline for real-time support, an initial clinical assessment, and connections to resources. The hotline is staffed by trained clinicians and certified peer support specialists and is available in more than 200 languages. It operates 24 hours a day, 365 days per year by phone, text, or online chat. Unlike 988, it can help people find and make appointments for community-based services and has greater capacity to conduct clinical assessments.

Massachusetts collects data on utilization of the hotline, including demographic information of callers, and publishes it to an online dashboard.[21] The dashboard includes information about call volume by county and age, wait times, call duration length times, communication methods, risk level of incoming calls, and handoff dispositions. Between January and June 2024, the hotline handled over 22,000 calls with 15 percent coming from individuals between the ages of 0 and 25. In most instances, the helpline generated warm handoffs to outpatient mental health appointments or urgent care (60 percent), 16 percent were sent to mobile crisis intervention services, 3 percent to emergency services, and 18 percent to other.

Strategy: Further establish robust cross-agency collaboration

Maryland families often interact with multiple state and local systems, including the Maryland Department of Health (including BHA, Medicaid and Healthcare Financing, Public Health Services, and the Developmental Disabilities Administration (the DDA), the Maryland State Department of Education, the Maryland Department of Human Services, and the Maryland Department of Juvenile Services). It is critical to ensure these systems work together so youth and families receive coordinated, streamlined care.

Current State

Currently, there is communication and planning across Maryland's child-serving agencies. Representatives from the Department of Health, Department of Human Services, and Department of Juvenile Services meet weekly to discuss options for children and youth with behavioral health needs who are boarding in hospitals or emergency departments. In addition, there are a wide variety of advisory councils, workgroups, and other commissions that include cross-agency representatives, as well as providers, advocates, and other stakeholders. In January 2024, Governor Moore re-established the Governor's Office for Children and the associated Children's Cabinet.[22] Other convening groups for cross-agency collaboration include the Consortium on Coordinated Community Supports, which was charged with expanding access to comprehensive behavioral health services for Maryland students, and the Commission on Behavioral Health Care Treatment and Access and the Behavioral Health Advisory Council, which focus on recommending behavioral health care services across Maryland's continuum of care.[23]

While each of these commissions and the Children's Cabinet bring together cross-agency partners, families continue to report major challenges navigating across the rules and policies of the PBHS, the child welfare system, and the educational system.

> *"If the ultimate goal is to keep children at home and out of residential treatment then I do believe that all systems need to work together."*
>
> Survey Respondent

> *"After my daughter was in inpatient nine times, I tried to get her back into school afterwards, but the school said they couldn't handle her and she needed more services. I pulled her out of school to get services, but then I got threatened with a CPS investigation because she wasn't in school enough."*
>
> Focus Group Participant

> *"Families interact with a variety of systems when dealing with behavioral health challenges... We need better collaboration between systems and families should get needed services no matter what 'door' families enter. This requires an active Governor's Office for Children that manages these issues."*
>
> Workgroup Member

Recommendations

To better support children, youth, and families engaged in multiple systems, there is an opportunity for Maryland to identify and formalize a structure for cross-agency collaboration, coordination, and decision-making. As a first step, Maryland could review all existing workgroups and commissions to identify where cross-agency work is underway and where state investments in cross-agency collaborations are most effective.

To ensure it is effectively promoting cross-agency work, the entity could:

- Include key decisionmakers from each of Maryland's key child-serving agencies who are active participants and share responsibility for adopting change; and
- Operate with a clear agenda and governance structure with expectations for results on specific issues and action on recommendations such as those identified in this Roadmap.

One key cross-agency issue raised by Maryland stakeholders that could be addressed through a more robust cross-agency workgroup is continuing to review challenges with the Voluntary Placement Agreement (VPA) process and identifying strategies to improve access to out-of-home placements when clinically appropriate (see Box 2). The workgroup could also work on addressing other issues that span multiple systems, such as school-based behavioral health services or implementation of evidence-based practices for children and youth with behavioral health needs who are involved in the juvenile justice system.

Complexity: Moderate

Resource Intensity: Moderate

Timing: Mid-Term (2–4 years)

Box 2. Maryland's VPA Process[24]

A VPA is an agreement between a local Department of Social Services and the parent or legal guardian of a child who is voluntarily placed in the physical custody of the local department to receive treatment for a developmental disability or mental illness that the child is not able to receive at home. VPAs are often used when a young person needs residential treatment, but the local school system's Individualized Education Program (IEP) team has not agreed to the need for a non-public school placement. A VPA allows the state to cover the cost of education provided in the residential setting, an expense that cannot be paid using Medicaid funds. Parents can be required to make child support payments to the state to offset some of the expense of the residential treatment.

Maryland stakeholders shared that the VPA process requires an intensive review and sweeping changes to minimize the burden on children, youth, and families who may require short-term out-of-home behavioral health care. Moreover, parents in the focus groups reported it can feel stigmatizing to be required to voluntarily place a child in the custody of the state, even when it is to secure help with treatment costs.

Maryland is actively working across state agencies to review current challenges with the VPA process and improve access to care for children and youth with mental health conditions, including considering options for a single point of entry and the removal of administrative barriers.

> *"No parent should be forced to consider placing their child in Voluntary Placement to gain access to the necessary resources and funding for treatment."*
>
> Workgroup Member

Potential Implementation Steps
• Review existing forums that bring together agency representatives and identify central platform that can be charged by the Governor with cross-agency work and decision-making
• Establish a governance structure, agenda and timeline for action
• Set up a reporting structure on cross-agency efforts

Goal 2 | Focused Upstream

The PBHS includes robust prevention and early intervention programs to identify issues early and avert the onset of more serious behavioral health conditions.

Strategy: Leverage Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to support early intervention

Intervening early to provide support to a child or youth can mitigate the long-term negative impacts of a behavioral health condition. In recent years, federal policymakers have emphasized how states can leverage the federal Medicaid benefit standard for individuals under 21 known as EPSDT to ensure upstream support is available and avoid the worsening of behavioral health needs.[25] Most recently, in September 2024, the Centers for Medicare and Medicaid Services (CMS) issued guidance on EPSDT requirements. The guidance highlights opportunities available to states to use EPSDT to screen and identify behavioral health issues early and to ensure access to medically necessary care.

Current State

BHA has made some significant and notable investments in prevention and early intervention and is currently supporting a wide range of programs in every region of the state. These programs include early screenings, school-based programs, and supports for adolescents and transition-age youth. Maryland's Medicaid agency oversees EPSDT in partnership with BHA; together, they work to ensure that children, youth, and family members are screened and assessed for mental health and SUD concerns. Maryland's MCOs have a strong track record of ensuring that such screenings and assessments are carried out. In Maryland, Qlarant conducts EPSDT reviews of each HealthChoice MCO that is part of Maryland's HealthChoice program. Nine MCOs in Maryland scored well above the compliance threshold when evaluated to assess the timely screening of Health and Developmental History, including behavioral health related screenings.[26]

Still, families report barriers to accessing treatment early once a behavioral health need has been identified. Data on Maryland teens with depression indicate that the majority (approximately 60 percent in 2022) are not receiving services, suggesting that high screening rates alone are not enough.[27]

> *"Today when we visit our doctor for a well visit, we are given a mental health screening but even when indicating issues that are present it doesn't go anywhere, the doctor reviews the form and moves on to the medical reason we are at the office."*
>
> Survey Respondent

> *"When my son started showing signs of an issue, we asked his doctor, but the doctor just downplayed it. "He's young...just give it time," he said. I felt like he was not really hearing what was going on. Just being heard is the big thing."*
>
> Focus Group Participant

Recommendations

BHA can continue to work with the Medicaid agency to encourage timely follow-up after screenings and assessments. They also could explore whether a diagnosis should continue to always be required as a condition of receiving behavioral health services, especially in light of the federal September 2024 guidance that notes that "States should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria."[28]

There is extensive research showing that early intervention programs save costs in the long term, particularly for children and young adults.[29] One cost-benefit analysis estimated that every dollar invested in mental health prevention yields between $1.80 and $3.30 in health care, education, criminal justice, and labor market expenditures.[30] In Maryland, however, it may take an extended period of time to adopt the system changes needed for the change due to the division of responsibility for behavioral health services across MCOs, the ASO, and the residual fee-for-service program.

Complexity: Moderate

Resource Intensity: Moderate

Timing: Mid-Term (2–4 years)

Potential Implementation Steps
• Continue working with Medicaid agency to encourage timely follow-up after screenings and assessments
• Review data from other states, such as California, Colorado, and Massachusetts to assess impact and feasibility of providing behavioral health services before receiving a diagnosis
• Explore additional opportunities to implement new prevention and early intervention programs or policies under EPSDT
• Collect and report on data on utilization, spending, and member of experience of care following implementation of any new programs or policies under EPSDT

State Example: Colorado

Since July 1, 2018, Colorado has reimbursed short-term behavioral health services—defined as up to six visits per year—provided by a licensed behavioral provider operating in a primary care setting.[31] The goal of the policy is to provide additional access to behavioral health services for short-term episodes of care of low-acuity conditions. Notably, individuals do not have to have one of the behavioral health diagnoses otherwise required for an individual to receive behavioral health services from Colorado's "Regional Accountable Entities" or RAEs, which are charged with providing care coordination and serve as the capitated behavioral health managed care plans for members of Colorado's Medicaid program (providers offering care in primary care settings, however, still must use the most appropriate diagnosis that supports medical necessity). By not requiring a specified behavioral health diagnosis, the policy creates the possibility of providing care to children and youth—as well as adults—that could prevent the acquisition of a more significant behavioral health condition and the need to receive services from Colorado's more specialized behavioral health delivery system.

Strategy: Continue to expand crisis services to mitigate emergency department boarding and inpatient stays

Without widely available and accessible community-based services and crisis options, young people experiencing behavioral health crises may enter the emergency department, where they may remain waiting for days or weeks before finding an appropriate treatment slot. Those with more complex behavioral health needs—for example, youth with a behavioral health need and I/DD, autism, or fetal alcohol syndrome—are at heightened risk of "boarding" for extended periods, putting them at higher risk of adverse outcomes.[32]

Current State

Maryland is actively designing and implementing a full continuum of crisis services for children, youth, and families to ameliorate crises in community-based settings and mitigate the need for emergency department services and more intensive and costly care options. These efforts include:

- **Integrating 988 into the crisis system.** Maryland has done extensive work to stand up and fund 988, passing a bill in April of 2024 to permanently fund the hotline with a 25-cent-a-month fee on residents' cell phones. The state also has integrated 988 with other resources, such as 211 and the Maryland Youth Crisis Hotline, and developed materials to educate the public about how to use 988, including for special populations such as individuals with developmental disabilities.[33]
- **Expanded mobile crisis and crisis stabilization services.** Maryland has systematically built out mobile crisis services and crisis stabilization centers through new regulations and funding opportunities. Effective May 2024, Maryland updated its requirements for mobile crisis programs, which must provide interventions 24 hours a day, 365 days a year to children and adults whose behavior is consistent with a mental health crisis, an SUD crisis, or a combined crisis. New regulations also established behavioral health crisis stabilization centers, requiring them to provide an alternative to emergency departments for behavioral health crisis care, emergency petition assessment, and avoidable inpatient or carceral engagement.[34] To expand capacity to provide these and other behavioral health crisis services, the state distributed $13.5 million in grants to 19 jurisdictions across the state in March of 2024.
- **Improving quality and coordination of crisis care.** In July 2024, Maryland finalized changes to the Maryland Code specifying how a robust array of crisis services should be coordinated within each LBHA.[35,36] In late 2024, BHA also contracted with a vendor to support training and technical assistance for mobile crisis teams.
- **Building out child and youth-specific crisis services.** During focus groups, family members and caregivers shared mixed experiences with mobile crisis services. Some families found mobile crisis teams were effective in de-escalating situations with their child. Others shared that mobile crisis teams would refuse to come out or would simply not show up. BHA is actively addressing access and performance concerns through the continuation of Mobile Response and Stabilization Services (MRSS) in a subset of jurisdictions, which is a model of crisis services tailored to children and youth (see Box 4). In the fall of 2021, BHA released a strategic vision for implementing comprehensive MRSS for children, youth, young adults, and families.[37] In addition, Maryland now requires that all mobile crisis teams are trained on the MRSS model. However, MRSS is not currently widely available across the state.

> *"If services like mobile crisis are being offered then they should be adequately staffed to have someone available to dispatch when needed."*
>
> Survey Respondent

> *"I called the mobile crisis team when my son was really struggling and being aggressive toward me and asked them to come out. The crisis worker told me to take him to the emergency department. I explained that I couldn't get him there but didn't want to call the police because I was scared they might hurt him. They just kept saying that they couldn't send anyone out."*
>
> Focus Group Participant

Box 4. MRSS

MRSS is an evidence-based crisis service tailored to the unique needs of children, youth, and families. Unlike traditional crisis screening, triage, and referral services, MRSS requires rapid deployment of a mobile crisis team composed of specialized staff trained in child and adolescent needs. Services include mobile crisis response—available 24 hours a day, 365 days per year—a 72-hour period of initial services and supports, and ongoing stabilization services for up to six to eight weeks, including, but not limited to, connections to follow-up services and supports and any other needed treatment services. MRSS programs have consistently demonstrated improved outcomes for children, youth, and families at a lower cost than emergency care and inpatient admissions.[38]

Recommendations

To achieve BHA's vision to expand MRSS statewide, BHA can continue exploring how to integrate the full scope of the MRSS model into existing mobile crisis services. States such as New Jersey have been able to implement the full MRSS model using Medicaid's EPSDT benefit, allowing them to combine state sources of funding with federal Medicaid funds. Other states, such as California and Massachusetts, now require commercial plans regulated by the state to cover crisis services.[39]

To extend MRSS statewide, Maryland would need to identify state funds to cover the non-federal share of Medicaid-covered MRSS services and to pay for services to additional Maryland children and youth with other sources of health care coverage. However, any initial state investment in expanding MRSS could result in long-term cost savings. One analysis of Washington State's Children's Crisis Outreach Response System showed that in a three-year period, the crisis system was able to divert 91 to 94 percent of hospital admissions, saving between $3.8 million and $7.5 million in hospital costs and an additional $2.8 million in out-of-home placement costs.[40]

As MRSS becomes more widely available, BHA may also focus on ensuring youth and families are aware of the service and know how to access it. BHA could continue to work to integrate MRSS services with 988 and the online behavioral health provider bed registry and referral system, so that 988 operators are able to dispatch MRSS teams when needed and secure referrals to available behavioral health providers. In addition, BHA could work with local school districts, the Department of Human Services, and local law enforcement to ensure these key partners are aware of MRSS and know how to deploy teams when needed. It also will be important to coordinate MRSS closely with the intensive care coordination and in-home services available in the1915(i) program.

Complexity: Moderate-High

Resource Intensity: Moderate-High

Timing: Long-Term (4+ years)

Potential Implementation Steps
• Work with 988 administrator to ensure hotline has capacity to connect individuals to MRSS when needed
• Develop outreach and communications materials to ensure children, youth, and families are aware of MRSS services
• Develop cost estimates and identify funding sources for state dollars needed to implement changes, including the potential for Medicaid coverage and commercial reimbursement
• Review current Medicaid state plan on crisis services to determine if additional changes would be needed to secure Medicaid reimbursement for the full MRSS model
• Develop proposed policy details including service definition for MRSS, reimbursement rates, quality oversight, and coordination with other high-intensity benefits
• Pursue Medicaid program changes and issue guidance formalizing policy changes
• Collect and report on data on utilization, spending, and member of experience of care following participation in MRSS
• Collect data on inpatient and emergency department utilization among children and youth with complex needs to assess outcomes of enhanced crisis services

Goal 3 | Efficient & Sustainable

A diverse workforce, an accountability structure, and appropriate financing are in place to ensure the behavioral health system can function effectively on the ground in a sustainable way.

Strategy: Invest in the behavioral health workforce

Successfully delivering a comprehensive continuum of behavioral health services for children, youth, and families relies on a robust and diverse behavioral health workforce. Nationally, even as the need for behavioral health services continues to rise, 122 million individuals live in a mental health professional shortage area.[41] Workforce challenges are particularly acute among practitioners that serve children and youth. In Maryland, it is estimated that over 80 percent of community behavioral health programs serving children have staff vacancies.[42]

Current State

Like other states, Maryland is facing shortages in both licensed and non-licensed behavioral health professionals. In a survey conducted by BHA of behavioral health treatment providers across Maryland, only 21 percent of respondents felt they had an adequate number of psychologists to provide quality of care, 31 percent reported they had an adequate number of case managers, care coordinators, counselors, or peer support specialists, and 43 percent felt they had an adequate number of physicians.[43]

In the face of workforce shortages, BHA has remained committed to investing in training and support to build a robust network of trauma-informed, culturally responsive providers. BHA supports BHIPP, a key resource for pediatric primary care providers in Maryland that offers trainings, workforce development supports, education, technical assistance, and warmline services to allow providers to better meet the behavioral health needs of children and youth. To support workforce development, BHIPP partners with Salisbury University to offer internships to masters-level students working towards licensure in a mental health field. BHA also partners closely with the University of Maryland Baltimore National Center for School Mental Health, which acts as a centralized home for comprehensive training for behavioral health providers in Maryland. In addition, BHA has supported the University of Maryland/Sheppard Pratt Psychiatry Residency Program to strengthen the pipeline of psychiatrists to support Maryland youth and families. Finally, Maryland has established multiple workgroups at the state level, including, but not limited to, the Underrepresented Behavioral Health Workforce Workgroup and a Workgroup for Social Work Requirement for Licensure that are focused on decreasing barriers for underrepresented populations to engage in the behavioral health workforce.

In focus groups, families highlighted workforce shortages have resulted in long waiting lists to see providers or obtain evaluations. High staff turnover contributes to the long wait lists, but has also resulted in inadequately trained staff to do the work.

> *"It can be very confusing. Sometimes I would get different answers to the same question from staff at the same agency."*
>
> Survey Respondent

Recommendations

To ensure Maryland's behavioral health workforce can respond to the growing demand for mental health and SUD services, it will be critical to continue investing in workforce development. This may include both short-term strategies to train and strengthen the existing workforce and long-term strategies to invest in education, recruitment, and retention for new behavioral health professionals.

Specifically, Maryland could consider investing in:

- **Center of Excellence for Youth Behavioral Health.** Maryland could build upon work to train behavioral health providers by establishing a centralized Center of Excellence for child, youth, and family behavioral health. The Center of Excellence could be a centralized home for:
  - Practical trainings for providers of all levels, including pediatricians, school-based health care providers, and primary and specialty behavioral health care providers;
  - Training, technical assistance, and fidelity monitoring supports for key evidence-based practices for children and youth;
  - Learning communities for behavioral health providers across different regions of the state; and
  - Resources for families and community members to support knowledge sharing and ensure Maryland families and communities are aware of services and supports available through the PBHS.

While some portion of the cost of a Center of Excellence may be eligible for federal Medicaid administrative dollars, Maryland would still need to identify state funds to cover the non-federal share of such costs, as well as additional funds to cover the full costs for which Medicaid administrative dollars are not available.

- **Integrated care models.** One strategy to maximize the existing workforce is to ensure that primary care providers, school-based practitioners, and other frontline health care workers are equipped to assess and treat basic behavioral health needs. There is evidence that integrated primary and behavioral health care in pediatric settings can lead to improved outcomes and cost savings for health systems.[44] As of April 2024, Maryland covers the Collaborative Care Model, which promotes team-based integration of behavioral health into primary care.[45] Maryland also covers the Healthy Steps model for young children. Maryland could further invest in and expand these two integrated care models by developing additional training and support for integrated care providers. Maryland could also consider supporting additional integrated care models like TEAM UP, a fully integrated care model for children and youth up to age 21.
- **Long-term workforce investments.** In the long-term, Maryland could consider state and federally funded investments in training, recruiting, and retaining a robust behavioral health workforce. Across the country, states have used Medicaid Section 1115 waivers to secure federal Medicaid matching funds for investments in the behavioral health and primary care workforce. Specific programs vary by state but may include scholarship and loan repayment programs for behavioral health professionals, funding for recruitment and retention of behavioral health professionals that serve the Medicaid population, and partnerships with community and state colleges and universities, including, but not limited to, historically black colleges and universities, to educate and train new and existing behavioral health and primary care practitioners to better support Medicaid members with behavioral health needs.

- **Other strategies.** A needs assessment developed by Trailhead Strategies for the Maryland Health Care Commission, in partnership with the Maryland Department of Health, the Maryland Department of Labor, and the Maryland Higher Education Commission, detailed the current state of the behavioral health workforce in Maryland to inform the design of Maryland's Behavioral Health Workforce Investment Fund.[46] The report is based on quantitative and qualitative findings from local stakeholders and recommends key initiatives Maryland can pursue to address the workforce shortage, including:
  - Offer competitive compensation that provides a livable wage;
  - Increase awareness of behavioral health careers through partnership with local schools;
  - Expand opportunities for paid education and training;
  - Promote timely and effective licensing processes; and
  - Invest in job quality for behavioral health professionals to improve retention rates.

Complexity: High

Resource Intensity: High

Timing: Long-Term (4+ years)

Potential Implementation Steps
• Review existing scope of behavioral health trainings and supports for providers and identify key gaps
• Identify appropriate mechanisms and associated costs to address gaps in training supports for providers, including through a Center of Excellence or through targeted trainings
• Partner with training organization(s) to develop and implement key trainings for behavioral health providers
• Develop cost estimates for state share of a Medicaid-funded workforce initiative
• Collect and review data on ongoing basis from families and providers regarding delivery of behavioral health services to identify gaps in training

State Example: New York

In January 2024, CMS approved a Section 1115 demonstration request from New York for initiatives to invest in the behavioral health workforce, totaling $694 million over a three-year period. The program includes two primary workforce investments:

- A loan repayment program for psychiatrists, primary care physicians, dentists, nurse practitioners and pediatric clinical nurse specialists; and
- A "Career Pathways Training" program to strengthen the health care workforce pipeline in the long-term.

Through the workforce initiative, New York intends to train and recruit additional behavioral health professionals to serve Medicaid-enrolled and uninsured individuals across the state.

Strategy: Develop a financing plan to maximize the efficient use of federal and state funds

Strengthening Maryland's behavioral health system will require new resources, making it essential that Maryland has a financing strategy for maximizing the efficient use of its available funding.

Current State

For state fiscal year 2025, BHA oversees a budget of $727.6 million, with $109 million coming from the federal government and $612.3 million coming from the state funds. The remaining $6.3 million comes from reimbursable funds received from other state agencies that oversee their own budgets and direct some resources to youth behavioral health for services provided through BHA. The Department of Education, for example, is leading investments in school-based behavioral health services as part of the Blueprint for Maryland's Future, a $3.8 billion dollar initiative focused on prioritizing equity in Maryland's school systems. As of February 2024, the Consortium had awarded over $110 million in grants to expand behavioral health care access to students throughout Maryland.

Recommendations

BHA should develop a financing strategy to maximize the efficient use of available funding sources for child and youth behavioral health initiatives, ideally in partnership with other state agencies. The financing strategy should detail funding by state agency to identify areas of duplication and opportunities for using limited dollars more efficiently. In some instances, it may be possible to eliminate redundant initiatives or to blend or braid funds together to increase their impact. Some potential federal funding sources for the initiatives described in this Roadmap are described below; however, each of the federal funding sources has its own rules and requirements (e.g., matching requirements, restrictions on allowable uses of funds). Therefore, it will be critical for BHA to identify current available funding sources and develop a strategic financing plan to achieve the goals and strategies set forth in this Roadmap. In cases where federal funding sources are already fully leveraged, Maryland may need to explore whether state funds could be added or re-directed to cover the costs of specific strategies.

Complexity: Moderate

Resource Intensity: Moderate

Timing: Mid-Term (2–4 years)

Potential Implementation Steps
• Review existing uses of federal grant dollars, Medicaid and Children's Health Insurance Program (CHIP) and opioid settlement funds for youth behavioral health and identify funding sources that have not yet been fully leveraged
• Develop detailed financing strategy to implement strategies described in this Roadmap
• Revise financing plan on an ongoing basis as additional grant opportunities become available and additional funds are "spoken for" for youth behavioral health

Federal Grant Sources:

Due to the changing priorities of the federal administration, some of these programs may be subject to further changes.

- **SAMHSA's Children's Mental Health Initiative (CMHI).** CMHI assists states, localities, and tribes in developing a comprehensive system of care for children, youth and young adults who have or are at risk for serious emotional disturbance.[47] This is a competitive grant opportunity, which can provide up to $3 million per state and $1 million per locality to develop a system of care with sustainable financing, cross-agency collaboration, robust and coordinated policy and infrastructure, and implementation of evidence-based and evidence-informed services and supports. Prince George's County has already received a $1 million grant from this funding opportunity, effective March 2024.[48]
- **Title V Maternal and Child Health Services Block Grant.** These block grant dollars are distributed to states to allow them to address the health services needs of mothers, infants, and children, which includes children with special health care needs and families. Dollars can be used to conduct training and technical assistance for providers on integrating behavioral health into pediatric primary, expand workforce capacity, and support screening and follow up across primary care, early childhood care and education, school, home, or other community-based settings.
- **Other Health Resources and Services Administration (HRSA) Funds.** Other relevant HRSA initiatives include the Pediatric Mental Health Care Access program, which distributes grants to universities, providers, and others to promote behavioral health integration into pediatric primary care. It has funded several initiatives already in Maryland, including the BHIPP Training, Tele-mental Health, and Technical Assistance program. HRSA also supports workforce development programs, including for behavioral health professionals, though these are aimed primarily at individual practitioners.
- **SAMHSA's Community Mental Health Services Block Grant (MHBG).** MHBG funding is for comprehensive community mental health services for children and adults with significant behavioral health conditions that are not otherwise covered. While there are a number of federal restrictions on how it can be used, MHBG generally is considered a relatively flexible funding source that can be used for pilot programs and infrastructure and to launch and scale new initiatives.
- **Title IV-E Prevention Program.** This funding source funds time-limited prevention services to help children and youth involved in child welfare remain safely at home with parents instead of being removed and placed into foster care. BHA and Maryland's child welfare agency already work in collaboration, but there may be opportunities to systematically review if there are even more efficient ways to braid together behavioral health and child welfare funding.
- **The Substance Use Prevention, Treatment, and Recovery Services Block Grant** (SUPTRS BG or SUBG, for short). States can use SUBG for SUD treatment and prevention planning, implementation, and evaluation. Children and youth can be served with these dollars, and at least 20 percent of the funds must be used for primary prevention of SUDs.

Medicaid and CHIP Funding

Medicaid and CHIP can help sustain initiatives over time that provide services to eligible children and youth. They offer states the ability to access federal funding that generally covers 50 percent of Medicaid expenditures and 65 percent of CHIP expenditures. Maryland has already made expansive use of these two programs to cover a relatively robust continuum of behavioral health services for children and youth, but there may be additional opportunities to use these programs, depending on the availability of state and local dollars to cover the non-federal share for new behavioral health services.

In addition, Medicaid administrative funds can be used to finance the cost of training providers to deliver a Medicaid-covered benefit or helping to ensure that they deliver care in a manner consistent with evidence-based standards. These administrative funds also are available at a 50/50 federal matching rate.

Opioid Settlement Funds

Maryland's Office of Opioid Response is charged with overseeing distribution of dollars from the state's restitution fund. As of state fiscal year 2024, the restitution fund has received funds from seven different prescription opioid-related legal actions, some of which impose stricter rules on allowable uses of the funds than others. At least a portion of money received from the various legal settlements can be directed by the Office of Opioid Response, which has prioritized investments in youth prevention, family support, and upstream initiatives.[49] Notably, states often can use opioid settlement dollars as the non-federal share of Medicaid and CHIP expenditures related to prevention and treatment for young people and other populations, creating a potential opportunity to leverage these dollars to bring in an equal amount or more of federal funding.

Goal 4 | Comprehensive & Equitable

A full continuum of services is available to address the needs of Maryland's children, youth, and families. The services reflect the unique circumstances and specialized needs of children and youth at heightened risk for behavioral health challenges (e.g., those who are LGBTQIA+, have I/DD, are involved in foster care, or are part of military families).

Strategy: Continue to strengthen intensive in-home and community-based services for children and youth with the most complex needs

For children and youth with the most significant and complex behavioral health needs, access to in-home and community-based supports can help them remain at home and avoid residential treatment. A robust continuum of intensive in-home and community-based services includes intensive care coordination to support care planning and coordination of services for children with complex needs, supplemented with intensive in-home services, respite care for parents and caretakers, peer support services for youth and families, and other services, supports, and funding to support strengths-building and community inclusion.[50]

Current State

In Maryland, children and youth with complex needs have access to intensive care coordination through the tiered TCM model and to intensive in-home services, respite, family peer support services, and experiential and expressive services through the 1915(i) program. However, BHA recognizes that its TCM model and 1915(i) program currently are not working as effectively as they could be and has made strengthening the 1915(i) program a top priority.

Both data and reports from stakeholders confirm gaps in the existing 1915(i) program. Currently, children and youth with the most complex needs have access to the Level III TCM and automatically qualify for the 1915(i) program. However, utilization of Level III TCM and the 1915(i) program are low, especially relative to residential treatment. In fiscal year 2022, nearly nine times as many children received residential treatment (278 young people) as 1915(i) services (34 young people). Children and youth who need 1915(i) services undergo an extensive eligibility evaluation process by multiple state and local entities, including some combination of the LBHA, ASO, BHA, and the state's Medicaid program. Families reported that they are unclear how to "enter" the system and noted that it often took multiple hospitalizations before they could get their child considered for the 1915(i) program. Once enrolled, many families reported that the care coordination they received was not helpful, in part because the staff assigned to families turned over at a high rate and lacked experience and information on resources.

To address these challenges, BHA is actively making changes to the 1915(i) program based on a comprehensive evaluation that was undertaken by the Department through extensive stakeholder outreach and engagement conducted in Spring 2024. As reflected in a draft 1915(i) State Plan Amendment (SPA)[51] that the state submitted to CMS in February 2025, BHA is revising the eligibility process to lower the barrier to entry to 1915(i) services. This will help ensure that the program is accessible to the estimated 1,800 children and families who need that level of support. BHA is also opening 1915(i) services to children who are in TCM Level I and TCM Level II, not just those in TCM Level III. As described above, 1915(i) changes will also include coverage of youth peer support services in addition to family peer support services. Pending CMS approval, the state anticipates beginning implementation by the fourth quarter of 2025. Finally, the new ASO will also be required to appoint a dedicated liaison person for services available as part of the 1915(i) program to manage enrollment and re-enrollment of participants; analyze discontinuations of enrollment in 1915(i); and make recommendations to BHA and Maryland Medicaid based on the ASO's evaluation and findings.[52]

> *"I have never heard of 1915(i) even though my son has been in and out of the emergency department and psych hospitals since he was nine."*
>
> Focus Group Participant

Recommendations

As BHA implements these changes and addresses barriers to 1915(i) services, it will be critical to ensure families are educated about the availability of the program and that the delivery of TCM and the 1915(i) program is aligned with national best practices and the evidence base.

BHA should work with the ASO to:

- Distribute publicly available and easily accessible information for families and service providers on how to access 1915(i) services and what the requirements are to be eligible for in-home and other intensive community-based services;
- Provide information to community-based organizations, providers, and Care Coordination Organizations that serve youth and families with complex needs to ensure they know how to deliver and/or refer youth and families to assessments and services;
- Review provider networks for intensive in-home services and other 1915(i) services to ensure that there is a robust set of providers available to support children and youth who are eligible for services; and
- Collect data on utilization and member satisfaction with 1915(i) services to evaluate if the program changes were successful in increasing access to intensive in-home and community-based services.

In the longer term, BHA could consider further changes to streamline and standardize the provision of intensive care coordination and establish high-fidelity wraparound or other evidence-based in-home and community-based services and supports. BHA could also establish a standardized assessment process that can be used to assess the needs and strengths of individual young people and consistently integrate those needs and strengths into treatment planning and service delivery.[53]

Complexity: Moderate-High **Resource Intensity**: Moderate-High **Timing**: Mid-Term (2–4 years)

Potential Implementation Steps
• Review the ASO's current plans related to 1915(i) and identify opportunities to educate consumers and providers on updates
• Leverage the ASO to review and identify provider networks for intensive in-home services and other 1915(i) services to ensure there is sufficient workforce to support a growing population accessing 1915(i) services
• Collect data on utilization, spending, and member satisfaction with 1915(i) services to evaluate if program changes have successfully reduced access barriers and/or impacted total cost of care for children and youth
• Collect data on inpatient and emergency department utilization among children and youth with complex needs to assess outcomes of 1915(i) program changes

Strategy: Develop pilot initiatives for special populations

In Maryland and across the country, behavioral health challenges are particularly acute among certain groups of young people, including, but not limited to, those living with I/DD, who are LGBTQIA+, involved in foster care, and from military families. The reasons each of these populations are at higher risk of behavioral health issues vary, but each group warrants continued focus and tailored interventions.

Current State

Maryland is actively making investments into behavioral health initiatives tailored towards the unique needs of special populations, including, but not limited to, individuals with neurodevelopmental disabilities such as I/DD, young people who are LGBTQIA+, children and youth involved in foster care, and members of military families.

Recommendations

BHA has much to build on as it continues to address the needs of special populations. As described in more detail below, it could establish tailored peer support programs to support young people who are part of special populations, including, but not limited to, those who are LGBTQIA+, live with I/DD, involved in foster care or are from military families. Maryland could also extend its engagement with the Trevor Project and consider adding training by Maryland-specific organizations who know the unique issues and needs of young LGBTQIA+ people in Maryland. For military families, BHA can work with the Military Family Policy and Programs division to develop training for behavioral providers on the importance of screening for a military background, military culture, experiences of military families, and military service-related behavioral health challenges and risk factors, such as those offered through Star Behavioral Health Providers.[54] BHA can also expand its work with specialized providers and Project ECHO to provide coordinated support to educational and behavioral health professionals around Maryland in how to address emerging behavioral issues early.

Complexity: Moderate

Resource Intensity: High

Timing: Long-Term (4+ years)

Potential Implementation Steps
• Review current trainings available to behavioral health providers to assess opportunities to integrate further content specific to special populations, including, but not limited to, children and youth who are LGBTQIA+, involved in foster care, part of military families, and/or living with neurodevelopmental disabilities
• Partner with training organization to develop training modules for behavioral health providers specific to populations with complex needs (e.g., Division of Military Family Policy and Programs, Blue Star Family Foundation for military families, TransMaryland for LGBTQIA+ youth, Kennedy Krieger for youth with neurodevelopmental disabilities)
• Collect data on health and wellbeing outcomes among populations with complex needs to evaluate if tailored programs are addressing disparities

Neurodevelopmental Disabilities

The DDA is one of two state agencies charged with providing services and supports to people with intellectual and developmental disabilities. Though it serves as one of the primary partners in this area, it works in collaboration with other state agencies on a local and national level. For example, DDA operates three federally-approved Medicaid home- and community-based services waiver programs that provide employment services, family and peer mentoring supports, and family caregiver training and empowerment services to eligible individuals with I/DD.

Families and clinicians who work with young people with neurodevelopmental disabilities report that it remains extraordinarily difficult to secure services for children and youth with I/DD and behavioral health issues. Hospital leaders note that they are the young people most likely to end up boarding in emergency departments for weeks or even months because of a dearth of available post-hospital treatment facilities. The Kennedy Krieger Institute, for example, has an 18-month to two-year waiting list for placement in its inpatient neurobehavioral unit. There are efforts to move interventions upstream for young people with neurodevelopmental challenges, including a BHA-funded Project ECHO initiative, but stakeholders report that more coordination is needed across the agencies and systems charged with serving these young people if they are to be effective.

> *"A lot of people just keep telling us that my son's meds were a problem, but he had physical health issues and we needed a referral to neurology. They kept trying to tell us it was the meds, but it wasn't."*
>
> Focus Group Participant

Children and Youth in Foster Care

Around 3,800 children and young adults in Maryland are in foster care.[55] Children and youth involved in the foster care system can experience a number of factors that contribute to behavioral health issues, including experiencing complex or ongoing childhood trauma, managing unexpected and uncertain transitions, enduring family disruptions, and facing inconsistencies in access to mental health services.[56] Some children and youth in foster care also experience the over-prescription of psychotropic medications due to lack of coordination among providers during critical transition periods.[57]

BHA has efforts underway to support the unique behavioral health needs for children and youth in foster care. For example, Maryland supports Taking Flight, a young adult peer support program for individuals with behavioral health needs. The program works to reduce stigma and connects young adults to peers with similar experience, including with the foster care system. Additional work is still needed to ensure children and youth involved in foster care have access to behavioral health supports, including for foster care youth who are aging out of the system.

> *"A challenge impacting therapy for youth in foster care is stability; when placement changes, therapist may as well especially if the child is in a 'treatment foster home' and moves programs."*
>
> Workgroup Member

LGBTQIA+ Young People

LGBTQIA+ children and youth are at heightened risk of behavioral health issues due to the stigma they face, bullying, and a higher risk of rejection by families. More than two in five LGBTQIA+ young people (approximately 43 percent) seriously considered suicide in 2022. Since the November 2024 election, LGBTQIA+ youth have increased their calls to crisis resources, such as the Trevor Project and TransLifeline, reflecting anxiety and fear over the impact of the election on their lives.

Maryland has made substantial investments to address the high rates of suicide among young LGBTQIA+ people. In 2023, it set up a partnership with the Trevor Project to provide LGBTQIA+ focused training for the department's Behavioral Health Administration staff, members of the Governor's Commission for Suicide Prevention, and health care professionals across Maryland. More broadly, Maryland has established itself as a sanctuary state for trans people of all ages. In January of 2024, it implemented the Trans Health Equity Act to expand coverage of gender affirming care in Medicaid and, effective October 1 of 2024, it added gender-affirming care to its list of legally protected health care.

The day-to-day experience of families with LGBTQIA+ young people suggests that more still needs to be done. Young people still encounter behavioral health providers who mis-gender them or question whether they are really LGBTQIA+. If they need to leave their families due to conflict over their sexuality or gender identity, they can find themselves without housing, food, or access to health care.

> *"The last time I took my daughter to the emergency department, we had to wait four days for a bed. They said it was because they couldn't find a spot for a trans girl where the facility would put her in a unit with other girls. The whole time I kept trying to get the emergency department staff to use her right pronouns, but they kept mis-gendering her and it made everything so much worse."*
>
> Focus Group Participant

Military Families

Maryland is home to a diverse veteran and active-duty service population, including around 360,000 veterans and 100,000 active duty service members, Reservists, National Guard members, and dependents.[58] Young people in these families face unique stressors that can impact their mental health, including living with a caretaker coping with post-traumatic stress disorder or a traumatic brain injury, facing parental deployment, and managing frequent moves. Research shows that children in military families are at substantially higher risk for negative psychological, social, and behavioral health outcomes than their civilian counterparts, especially as they enter their teenage years.[59]

Currently, BHA supports Maryland's Commitment to Veterans program, which provides referral services, peer support and crisis funding to Maryland service members, veterans, and families. The Military Family Policy and Programs division of the Department of Veterans and Military Families also operates a range of initiatives to improve services for all members of military families. The Veterans Crisis Line, which can be reached by dialing 988 and hitting 1, is available to Maryland service members, veterans, and those who support them.

Military families report that it remains difficult to find services for their children, especially from providers who are trained on the unique experiences of military families. They may not screen for military involvement of a family member nor understand the special importance placed on confidentiality and privacy among military family members. On a practical level, military families are not sure how to navigate the coordination of services across the siloed systems of TRICARE and the PBHS, especially if they are newly stationed in Maryland.

> *"A real struggle for families seeking services is finding providers that understand the unique challenges military families face…like the secondary trauma and the frequent moves"*
>
> Military Spouse

Goal 5 | Youth- and Family-Centered

BHA and its partner agencies maintain a dedicated focus on what children, youth, and families need in terms of support and services and respect their lived experience, diversity, and values in individual treatment decisions and policymaking.

Strategy: Systematically engage youth and families in policy design

Engaging young people and families in the design process to improve behavioral health systems is a key element of a culturally informed, equity-centered youth behavioral health system. As the Lancet Commission on Youth Mental Health highlighted in its seminal analysis of youth mental health, the active engagement of young people is vital to designing systems that are youth-friendly and stigma-free.[60] SAMHSA has also long promoted youth and family participation and CMS has, more recently, elevated the importance of engaging members with lived experience in policy design.[61] In May 2024, CMS issued the Medicaid Access Rule that establishes requirements for engaging consumers in advisory committees.[62] By July 9, 2025, in addition to its existing Medicaid Advisory Council, Maryland must establish a Beneficiary Advisory Council, which is a forum solely for Medicaid members that provides them with a "comfortable, supporting, and trusting environment" to exchange information. Members of this Beneficiary Advisory Council must make up at least 25 percent of the larger Medicaid Advisory Council.

Current State

BHA has made significant investments aimed at centering the lived experience of families and young people into its policy work, including through Taking Flight, Maryland's chapter of Youth MOVE National, and On Our Own of Maryland, a project focused on transition-aged youth. It also makes a practice of setting up focus groups of family members when tackling discrete policy-making issues as it has for this Roadmap and its recent work on intensive in-home services and supports (as discussed in more detail above). Some existing forums, such as the Maryland Behavioral Health Advisory Council and the Commission on Behavioral Health Treatment and Access, also include community members and family representatives.

However, families participating in focus groups shared that they find limited forums in which their voices are heard. Family members asked for more opportunities to share their experiences and inform the policymaking process in a systematic way. A caregiver from the Behavioral Health Advisory Council recommended committees and commissions use more "lay language" so that family and community members can more effectively participate in discussions. To the extent they participate in forums, there may be only one youth or family member present who then ends up representing the sole consumer voice amidst clinicians and policy experts.

> *"Since I don't speak English, I feel people have tried to change the story and I don't get the opportunity to speak. People speak over me because of my limited English."*
>
> Focus Group Participant

Recommendations

BHA could bring youth and families more systematically into the policymaking process. Rather than bringing one or two youth and family representatives into policymaking discussions through a variety of committees and commissions, BHA could identify a single forum that could be used to hear from youth and families on an ongoing basis. This could be a standalone youth- or family-focused council; the existing Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs Workgroup within the Commission on Behavioral Health Treatment and Access; or part of a larger beneficiary advisory council, such as the Beneficiary Advisory Council described above.

After identifying a youth- and family-centered forum, BHA could work with family-focused partner organizations or directly with youth and family members who will participate in the forum to ensure meetings are designed and facilitated in such a way that youth and family voices are elevated and the space is supportive.

Specifically, BHA could consider:

- Opportunities to engage partner organizations, additional state agencies, and/or an expert facilitator to guide sessions;
- Trusted, family-led organizations to partner with to support outreach efforts and identify participants with lived experience;
- Identifying programs with direct access to families utilizing the PBHS that can be built into regular check-ins for meaningful discussions;
- The cadence for engaging youth and families to ensure that feedback is captured;
- If youth and families are being integrated into existing councils rather than in a distinct forum, ensuring there is sufficient representation;
- Outreach strategies and facilitation tools to better engage populations that experience disproportionately negative behavioral health outcomes, including but not limited to non-English speakers, individuals living with I/DD, and those who are LGBTQIA+; and
- Mechanisms for reporting back to youth and families to explain how their feedback is being integrated into policy and program design.

Complexity: Low

Resource Intensity: Low-Moderate

Timing: Short-Term (1–2 years)

Potential Implementation Steps
• Conduct a review of existing or planned advisory councils that engage Maryland consumers, including youth and family members, in the policymaking process
• Develop proposal for better leveraging existing council(s) to engage youth and families, including: – Identify forum(s) that can be used on an ongoing basis to systematically engage youth and families – Develop schedule for convening advisory council(s) – Identify expert partner organization to support outreach to youth and families who may participate in meetings and provide facilitation support
• Identify potential members and provide them with training and resources on their role
• Begin facilitating regular meetings of advisory council(s)

State Example: Oregon

In 2019, Oregon established the Governor's System of Care Advisory Council to advise on ways to improve outcomes for youth and children with behavioral health and multi-system needs.[63] The Advisory Council includes youth and family representatives, tribal members, representatives from youth and child serving-agencies, providers, and advocates. Members serve for a four-year period, and the council typically meets once a month to support the strategic planning and implementation of Oregon's System of Care.

A core value of the Advisory Council is centering the voices of family and youth. The council includes youth between the ages of 14 and 26 who have lived experience with the system and family members. Qualified youth and family representatives receive stipends for participating in Advisory Council activities.

Strategy: Explore opportunities to expand access to youth and family peer support services

A growing evidence base indicates that family and youth peer support can be a highly effective way to support young people with behavioral health needs and their family members.[64] SAMHSA has long promoted the importance of family peer support and is making new investments in youth peer support.[65]

Peers help combat stigma and isolation by allowing a young person or family to talk to someone who has "been there," offer hope that there is a path to recovery, and provide practical support in navigating the behavioral health system.

Current State

Currently, BHA makes family peer support services available free of charge to families in Maryland. In fiscal year 2024, close to 5,000 families across all 24 Maryland jurisdictions received family peer support services.[66] Between 2021 and 2024, use of family peer support services more than doubled. BHA is also supporting establishment of a Family Peer Support Academy, which will provide standardized training for new family peer specialists and ongoing professional development support and may ultimately develop a state-level family peer certification. This state-level certification would complement the national certification offered by the National Federation of Families that Maryland's family peer support specialists are currently required to hold.[67] In addition, Maryland is ensuring peers are part of crisis response. Mobile crisis services in Maryland typically include a licensed behavioral health clinician and a peer, and training for peers is a key component of statewide mobile crisis trainings.

In focus groups, families reported that access to family peer support services is a major bright spot. Family members who did not have access to family peer support services stressed that it would have been extremely helpful, while those who did have family peer support reported that they wished they had it beginning years earlier. In addition, there is currently limited access to youth peers in Maryland. Some Maryland counties have used local funds to implement youth or young adult peer support programs, but it is not universally available throughout the state.

> *"My family peer support specialist helped me get my voice back and figure out how to stand on my own two feet. He helped me figure out how to keep fighting for my daughter."*
>
> Focus Group Participant

> *"A specific recommendation that I would make when it comes to the system would be to have more direct assistance for the caregiver. For instance, a navigator that would be able to give more insight into how an emergency department visit will go or what inpatient hospitalization entails."*
>
> Survey Respondent

> *"Our families need the availability of services that serve their youth but the entire family as well."*
>
> Survey Respondent

Recommendations

BHA could explore opportunities to expand coverage of and access to peer support services for Maryland youth and families, building upon its existing initiative. Specifically, BHA could work to:

- Develop a network of youth peer support specialists, in addition to family peers, in partnership with youth peer organizations;
- Identify additional opportunities to connect youth and families with a peer support specialist, including:
  - Linking families with a peer while a child is in an emergency department, inpatient hospital setting, or mobile crisis situation; and
  - Connecting families with a peer when a behavioral health need is identified during an annual wellness visit or through the IEP process;
- Continue to expand state-level training for family peers as part of the Family Peer Support Academy;
- Consider establishing pilot programs to provide young people and families who are part of special populations (e.g., those who are LGBTQIA+, have I/DD, are involved in foster care, or are from military families) with tailored peer support; and
- Explore expansion of Medicaid coverage of youth and family peer support specialists to leverage additional federal funds.

While expanding peer support programs may have upfront state costs, in the long term, a more expansive peer support network can fill workforce gaps, improve access to early care, and reduce costs spent on emergency department visits, hospitalizations, and residential stays.[68] In one analysis, individuals that received peer support services experienced improved outcomes at only 15 percent of the cost of "treatment as usual," compared to those without peer support.[69] In addition, there may be an opportunity for BHA to convert some existing state investments in family peer support into Medicaid-covered services, freeing up a portion of those resources for further expansion. Currently, family peer services are reimbursable under Maryland Medicaid for children and youth enrolled in the 1915(i) program. Maryland could pursue a SPA that establishes youth and family peer support as services that are covered more broadly, pending the availability of state dollars to cover the non-federal share of any such expansion. Nineteen states have taken this step to cover family and/or youth peer support services through a SPA.[70]

Complexity: Moderate

Resource Intensity: Moderate

Timing: Mid-Term (2–4 years)

Potential Implementation Steps
• Review data to determine the number of children and youth that may receive youth peer support services, develop cost estimates and identify funding sources
• Develop cost estimates and identify local and state funding sources to support contracting with partner organization(s) to identify, train and deploy youth peers
• Evaluate whether to pursue an SPA to cover family and youth peers under Medicaid outside of the 1915(i) program
• Work with the ASO to evaluate the network adequacy of family and youth peers and address gaps
• Collect and report on data on utilization, spending and member satisfaction with youth and family peer support services

Conclusion

Addressing the behavioral health needs of Maryland children, youth, and families requires a coordinated effort by the BHA and its partner agencies that serve youth and families with mental health conditions and SUDs. This Roadmap provides a set of goals and strategies to support the BHA in identifying and prioritizing areas for continued investment and improvement. It recognizes that there is an urgent need to strengthen the PBHS to better support Maryland children, youth, and families with behavioral health needs, while acknowledging that extensive reform cannot happen overnight.

The Roadmap is intended to serve as a long-term, living document to guide the BHA and its partner agencies in addressing the biggest barriers and gaps in the current PBHS. It leverages insights and lived experiences from approximately 160 youth, family members, advocates, providers, and other stakeholders, as well as data on the "current state" of behavioral health in Maryland and best practices from other states. In focus groups, interviews, and targeted outreach, youth and family members shared that, while some parts of the PBHS are currently working well, there is significant room for improvement to ensure that services are family-centered, easy to navigate and access when needed, and that the system is person-centered and culturally responsive.

The BHA is committed to continue hearing from youth and families and using this Roadmap to effectuate a behavioral health system for youth and families that is youth- and family-centered; coordinated and accessible, comprehensive and equitable, focused upstream, and efficient and sustainable. As a next step, the BHA and its partner agencies will seek to partner on a more detailed implementation plan that prioritizes the strategies proposed in this Roadmap and identifies a timeline for pursuing each key change.

Appendix 1

MCF and Manatt facilitated six focus groups with families with lived experience and spoke with representatives from state agencies, provider organizations, and advocacy and consumer groups to inform the recommendations presented in the Roadmap.

Focus Groups

- Western Region: Garrett, Allegany, Washington, Carroll, and Frederick (7 participants)
- North Central Region: Baltimore City, Baltimore, and Harford (6 participants)
- Spanish Speaking Community: Statewide (6 participants)
- Eastern Shore Region: Cecil, Kent, Queen Anne's, Dorchester, Talbot, Caroline, Wicomico, and Worcester (5 participants)
- Mid Central Region: Montgomery, Howard, Anne Arundel, and Prince George's (4 participants)
- Southern Central Region: Charles, St. Mary's, and Calvert (3 participants)

Interviews & Other Contributors

- Commission on Behavioral Health Care Treatment and Access & Behavioral Health Advisory Council
- Kennedy Krieger Institute
- Maryland Behavioral Health Authority
- Maryland BHIPP
- Maryland Children's Behavioral Health Coalition
- Maryland Department of Health
- Maryland Department of Human Services
- Maryland Department of Veterans & Military Families
- Maryland Hospital Association
- Maryland State Department of Education
- Maryland Pro Bono Resource Center
- Mental Health Association of Maryland
- NAMI Maryland
- Public Policy Partners
- Sarah's House
- Trans Maryland

Appendix 2

Roadmap for Change for the Maryland Behavioral Health Care System: Focus Groups Findings and Conclusions

Introduction

To strengthen Maryland's behavioral health system for children, youth, and families, BHA is developing a Roadmap that offers a vision for change for Maryland's behavioral health system. The Roadmap is being developed in partnership by MCF and Manatt Health. The Roadmap will include a set of proposed policy changes and action steps to strengthen the state's behavioral health system for children, youth, and families, and will include:

- Findings from interviews and focus groups;
- A policy and regulatory assessment of the "current state" and development of recommendations; and
- A set of actionable steps to improve behavioral health for Maryland's children, youth, and families

This report focuses specifically on findings from the focus groups. Throughout the report, participants in the focus groups are referred to interchangeably as "participants," "families," or "parents and caregivers."

Focus Group Process

MCF conducted six focus groups across the state with parents and caregivers of children with mental health challenges during June and July. These focus groups were conducted either virtually or in person and facilitated by MCF's Deputy Executive Director, Karen Duffy, using a standardized list of questions asked in each group (list included at end of this report). If time permitted, follow-up questions were asked. Haley Rizkallah, Manager of Grants and Community Partnerships, and Ashley Tauler, Policy & Advocacy Manager, took notes.

Focus Group	Counties Included	Number of Participants
1 – Western	Garrett, Allegany, Washington, Carroll, Frederick	7
2 – North Central	Baltimore City, Baltimore, and Harford	6
3 – Spanish Speaking Community	Statewide	6
4 – Eastern Shore	Cecil, Kent, Queen Anne's, Dorchester, Talbot, Caroline, Wicomico, Worcester	5
5 – Mid Central	Montgomery, Howard, Anne Arundel, Prince George's	4
6 – Southern Central	Charles, St. Mary's, Calvert	3
Total		**31**

In addition to these groups, MCF also conducted an internal discussion group with our family peer support staff and asked them to share their experiences both as parents and caregivers and as professionals working with families currently involved in the system. Eight staff provided feedback on the same questions asked in the focus groups.

Surveys

After each focus group, participants received a follow up email that included a link to a survey that included the questions asked in the focus group. Participants were invited to share any additional feedback they did not have an opportunity to offer in the focus group, information they may not have felt comfortable sharing openly in the group, or anything they may have remembered after the group ended.

Registered participants who did not attend the focus group received a similar email inviting them to complete a survey of the same questions. Additionally, the survey was sent to members of MCF's family leadership program alumni group to solicit their feedback.

Survey	Number of Respondents
Survey to Focus Group Participants	12
Survey to Focus Group Registrants who did not attend	1
Survey to Family Leadership Alumni	2
Total	**15**

Group Composition

The participants in the focus groups, staff discussion, and surveys included biological parents, adoptive parents, and formal and informal kinship caregivers. They each had experience in one or more sectors of the behavioral health care system, including:

- Mobile crisis services
- Inpatient hospitalizations
- Partial hospitalizations
- Intensive outpatient programs
- Intensive in-home services
- Residential Treatment Centers
- Emergency Departments
- TCM
- Psychiatric Rehabilitation Programs
- VPAs

In addition, most families had multi-system involvement with:

- Local Department of Social Services/Child Welfare
- Juvenile Justice
- Maryland State Department of Education/local school system

The participants represented families who accessed services using either Medical Assistance or private insurance. Several participants cared for children who are members of the LGBTQIA+ community and/or are people of color. Some families are active or retired military.

Priority Area 1: System Navigation

In this section, families were asked to share their experiences accessing and navigation the various systems, services, and programs their child needed to support their behavioral health needs. Many families utilized a wide spectrum of services along the continuum of care.

System Navigation Challenges

Most families accessed the behavioral health care system for their child **through their own efforts to research resources and services**. They reported that this method left them feeling isolated and confused. There was a lot of "**trial and error**" with families finding what appeared to be a viable resource, only to discover that their child does not qualify for services. Sometimes, staff at these organizations where the family's attempts were unsuccessful provided them with direction, guidance, or referrals to other resources. Other times, the family had to start over again, alone, at square one. As one mother stated, "All the trial and error left me feeling very alone."

Families pointed out that their lack of knowledge and understanding of their child's challenges made identifying resources using relevant keywords difficult. In essence, they did not have the vocabulary that would have made their searches more efficient. This was particularly relevant among our Spanish-speaking participants.

Families shared that they also relied on information from their pediatrician, child's school, local health departments, emergency departments, or local Department of Social Services. Several mentioned Child Find and Infants and Toddlers programs.

One mother said, "I was so overwhelmed I didn't know where to start." Families reported that **finding resources is an overwhelming process**, that they often do not know where to start, and they often do not know the words to describe what they are even looking for or what is happening to their child. A participant living in the Lower Shore region reported that they live in a "**resource desert**." One mother stated looking for resources "feels like you have to hunt for crumbs." In addition, some helpful **resources are hours away** from where the family lives, making access nearly impossible, especially for parents and caregivers with other children to care for or with jobs that do not provide the required flexibility.

The participants that were aware of 211 did not believe this was a useful resource either because the search engine capabilities were insufficient, the information was unreliable, or because they did not know what to search for specifically.

Families that utilized 988 had mixed feelings about the usefulness of the service. Few saw 988 as a place to find resources either because they had a poor experience or because they believe it was only for crises.

Families pointed to **long waiting lists** as the biggest obstacle to accessing services once they found them and determined their child qualified. Once they were able to see a provider, **getting a diagnosis** was a difficult process, particularly if testing or evaluations needed to be done, as these also often have long waiting lists.

Almost all participants reported that they **did not feel heard or believed by providers** when they explained the challenges and behaviors they were seeing in their child. Parents/caregivers felt like the burden of proof was on them to demonstrate that their child needed services. They expressed frustration that they could not get providers to perform tests or evaluations to confirm that there were challenges to be addressed. They were told by various pediatricians to be "patient," not to "overreact," or to refrain from "comparing their child's development to other children"—even their own siblings. Parents and caregivers expressed frustration that this dismissal of their concerns contributed to delays in getting their children the services they needed.

Participants also mentioned that **telling their story repeatedly** was frustrating and often traumatizing to them and the child. Even when families provided information previously at one facility, they were asked to repeat it with each new provider they saw at that same facility. Families expressed frustration that **communication between providers** is lacking or non-existent and they were left feeling like the go-between or messenger tasked with making sense of it all.

Families found that providers and service organizations made **referrals for services that were not a fit** for the family or that they could not offer any resources at all. They reported feeling that, when they did receive a useful resource, it was "by accident" or "random." As one caregiver said, "Sometimes we only learn about resources because someone is having a good day and remembers to tell you about a resource when you explain your problem to them." One family member reported that her child started having difficulty in early elementary school. She has had several hospitalizations and utilized various services since then. She is now a first-year student in high school and the family has only just learned of the Local Care Team. The mother questioned why it took so many years for someone to tell her about this valuable resource or why she had not come across it in her own research.

System Navigation Recommendations

Many families referenced creating a **centralized repository of resources** and then making sure that information to access that repository is widely distributed and available. This service should include easy to navigate tools using keywords that parents would use, especially as they are just beginning and might not know exactly what they are looking for. Some families recommended an app and others advocated for a physical "one-stop shop" location in each jurisdiction. Participants universally agreed that any centralized repository needs to focus on local/regional resources given that traveling to other parts of the state or into neighboring states is not always a viable option.

Information on available resources should be made available in all the places where families are. This includes schools, pediatrician's offices, churches, daycare providers, libraries, gyms, and coffee shops. Blanketing places where families visit most frequently was repeatedly recommended as a way to ensure the information reaches the families who need it most.

By far, families believed that having a **family peer support specialist** or family navigator is necessary to decrease isolation and minimize or eliminate the "trial and error" approach to finding resources. Because many of the participants were receiving or had received **family peer support** in the past, each said that having a family peer support specialist made a tremendous difference in their journey. Even if they continued to struggle to access resources, the emotional support provided by someone who has been in the same situation was invaluable for these families. Family peer support specialists validated the family's concerns about their child combating the perception that no one is listening to them and that they are alone. They recommended establishing an **automatic referral to**

family peer support at various points of entry into the behavioral health system such as emergency departments, hospitals, 988/211, pediatricians, and schools.

Families believe that providers should make better use of **electronic health records systems** to decrease the need to tell their story repeatedly. They want to see mechanisms that **promote cross-agency collaboration and communication** about their child's care. They would also like to see **providers receive more education about community resources** so that, when they make a referral, it's appropriate and useful to the family.

Priority Area 2: Prevention & Early Intervention

In this section, parents and caregivers were asked to discuss the process they engaged in when they first realized their child might have behavioral health challenges. Specifically, we wanted to learn more about how the families knew they needed help and what, if any, prevention or early intervention strategies were used that minimized the need for additional services or would have if they had been implemented in a timely manner.

Prevention & Early Intervention Challenges

Families reiterated many of the challenges they faced in systems navigation when discussing the emergence of their child's behavioral health challenges. They referenced **lack of resources, uncertainty about where to turn for help, conflicting information from providers, long waiting lists to see providers or access diagnostic services which delayed getting treatment for their child, and feelings of isolation**, particularly when they **felt they were not being heard** by their providers or others they reached out to for support.

Several families also referenced getting **multiple diagnoses that never really fit** their child's behaviors or challenges. This led families down pathways that were dead ends, or which really did not help the child's symptoms or behaviors improve. It often took **several years for the families to get the "right" diagnosis**, which then led to appropriate treatment interventions. Many children had multiple interactions with high-cost services including mobile crisis and hospitalizations before they received a diagnosis that led to the right intervention strategies. However, these high-cost services often exacerbated symptoms and caused trauma for both the child and their family.

Prevention & Early Intervention Recommendations

Families would like providers, particularly pediatricians, to be more educated about what to look for in a child to **promote early identification**. Ideally, these providers would also have knowledge and access to more resources (see Priority Area 1: System Navigation challenges and recommendations) so that families do not have to spend time researching and trying to access services on their own that might not even be what their child ultimately needs. Better education and access to resources was also suggested for school personnel.

A large focus of the discussions in this area focused on the need to **reduce wait lists** for services. One mother said, "You lose a lot of time, and the child suffers waiting for that support."

Families expressed the need for **more early intervention strategies in schools and the community** to avoid the challenges associated with emergency department visits and hospitalizations which were discussed at length and documented below in Priority Area 3: Key Behavioral Health Services.

Our Spanish-speaking focus group participants stressed the need for **more language assistance**. Often, they are not familiar with terms providers are using and their own friends or family members

are not able to interpret for them fully. Professional interpreters readily available would be extremely useful. These families also expressed a tremendous need for cultural competency training.

We heard from other families who experienced implicit bias or direct institutional racism. One grandmother shared that she has custody of her two grandchildren. The grandson is biracial and the grandmother feels her road to accessing the services he needed was much tougher and resulted in longer delays to get the services he needed, during which time his behaviors worsened to the point of being unmanageable in the home. Conversely, her granddaughter is white and the grandmother was offered services and support unprompted by the school. The disparity between how her two grandchildren are treated in the behavioral health community is vastly different.

Priority Area 3: Key Behavioral Health Services

Finally, in this section, participants were asked to consider the wide range of services their child had received, what worked or did not work, and what would have made their experiences better. We asked them to identify the "pain points" and the "bright spots" in their interactions along the continuum of care.

Key Behavioral Health Services Challenges

In each focus group, this portion of the discussion drew the most concerning commentary. Every participant's child had some level of interaction with high-cost services and community- based treatment, and the general themes uncovered in the first two priority areas were repeated and amplified here.

Emergency Departments

Families reported that **emergency department staff would not listen to them** about their child's challenges and past treatments, including which medications worked and which did not. **Families felt dismissed** by emergency department doctors who took a "**cookie cutter**" **approach** to treating their child. **The focus was on managing the crisis at hand, but not always with the intent to arrive at a long-term, viable solution**. Families felt like the goal was simply to move the child out of the emergency department, not determine what the next step beyond that should be.

Another frustration parents and caregivers have experienced with emergency departments is the **extended stays** when the child needs to be admitted to the hospital, but there are no beds available at an appropriate facility. This issue was discussed at length with participants in the Northern Central focus group which included Baltimore City and Baltimore and Harford County parents and caregivers. Participants described being told they would have to **physically stay with the child** until they could be transferred to the hospital and that leaving would cause the child to go to the bottom of the waiting list for a bed. Families pointed to the challenges this caused them including the need to take care of other children and the missed days of work. This is particularly impactful for single parents.

Families also reported **not feeling included in any decision-making** about how to proceed once the child is seen by the emergency doctor. One mother reported that, when she was told that her child would be transferred to an inpatient unit, she disagreed with the decision and wanted time to discuss further. She was told that if she did not sign the papers, the hospital would be forced to make a report to child welfare. She felt she signed papers under duress.

They also expressed concern that **no treatment or intervention is provided to a child** while they wait in an emergency department for a bed to open at a facility. In the interim, the child's symptoms worsen, they are traumatized and marginalized, they are missing out on their education, and generally being "warehoused."

Hospitalization

Families expressed considerable dissatisfaction with psychiatric units for children, youth, and adolescents. They reported that the **hospital staff rarely communicate** with them and when they do, they are talked "at." Parents and caregivers **do not feel included in the decision-making process** and are rarely included in conversations about discharge. **Planning for post-discharge treatment and services is extremely lacking** and some parents and caregivers reported that their child knew before they did that they were being released because no conversation had been held with the family. One family reported that their 14-year-old child was permitted to sign his own discharge papers. He then called his mother to tell her he was being discharged and he was waiting in the lobby of the hospital when the mother picked him up. There was no consultation with the family before bringing the child home and it was two weeks before she had any conversation with the hospital staff, and then only with a nurse on the unit. The mother had to arrange for all post-discharge services without any understanding of what services her child might need and had to obtain a prescription for her child's medication from a community provider. While this might be a rare and isolated circumstance, all participants whose children had been hospitalized reported some variation of lack of collaboration or coordination with the family prior to discharge, and no follow-up or guidance after follow-up. Many reported feeling like there was no long-term plan for their child post-discharge. They felt the intent of the hospitalization was simply to "stabilize" their child, then return them to the community without any support or plan to sustain any progress that might have been made. Parents and caregivers were left feeling like it was only a matter of time before the pattern of "ED-hospitalization-discharge without a plan" repeated itself.

Further, when families are included in conversations about inpatient treatment strategies, they are **"pressured" into making decisions and discouraged from asking questions or taking time to think through their options**. For example, hospital staff prescribe medications that families want to know more about, but they are not given the opportunity to educate themselves, nor does the provider take time to answer questions they may have. Families also believed there were no other useful services provided in the hospital other than stabilizing the child through medication. They reported no real therapy occurred either individually or in groups, and little to no family therapy was done to discuss long-term planning or address issues related to family dynamics. Families also felt like their child just got further and further behind in their education with each hospitalization.

There was universal agreement in the belief that **hospitals only want to move children in and out as quickly as possible**, with no consideration of their past or what will happen in their future. The sense is that the hospital's job is to stabilize the child using medications so that they can put them back into the community without further follow up or guidance for the family about next steps.

Community-based Services

Families believe that community-based services are difficult to find, access, and pay for if their insurance does not cover them. Several mentioned their belief that many services are not made available to their children "until they've been in the hospital three or four times." The belief that **the system is set up only to help children after they have had multiple high-cost services**,

like emergency department visits or inpatient hospitalizations, was pervasive across focus group participants.

Families reported that there simply **are not enough providers to meet the needs** of the children with behavioral health challenges, particularly in specialty areas like applied behavior analysis (ABA) or trauma. Others reported that they do not want their child to receive ABA but that is often the only option made available to them because of insurance limitations. Spanish-speaking participants stated that there are too few Latino or Hispanic providers to meet the needs of this community.

The **staff turnover rate** at community-based organizations is a large concern for every focus group participant. When staff leave, families feel like they have to start over with someone new and there seems to be little to no continuity of care during the transition period. Often, they are assigned to new staff even before that staff person has been fully trained and families feel a burden to provide the staff person with education and training on services and programs.

Families expressed frustration over the **lack of communication between providers** within the same organization or between organizations. Families often play the role of messenger, and they feel stuck in between when there is conflict or different ideas on how to approach a problem. They also reported telling their stories multiple times is traumatizing for both the child and the family.

Again, the issue of **language barriers** from our Spanish-speaking community focus group came to the forefront. One mother said, "Since I don't speak English, I feel people have tried to change the story and I don't get the opportunity to speak. People speak over me because of my limited English." Many Spanish-speaking caregivers also indicated they do not seek services if they are undocumented.

Further, families report **not feeling heard by providers** and that **the burden on proof** is on them to prove their child has a behavioral health challenge. Providers will be dismissive of the parent or caregiver's concerns if they do not observe those behaviors themselves. Parents and caregivers felt providers believe that if they do not see it, it must be a problem with the parent or caregiver, not the child.

Parent/caregiver shaming and blaming was a pervasive theme across all focus groups. It is important to note that many participants reported often **feeling judged and blamed** for their child's challenges. A few parents and caregivers reported that as their child's behavioral health challenges were left untreated, they became increasingly concerned that the school or other entities would **report them to child protective services for abuse and neglect**, even though they were doing their best to get help. One parent reported her inability to secure an appropriate and safe inpatient treatment placement led to reports being made to child protective services, despite the mother's robust attempts to ensure her daughter received the services she needs.

Intensive In-Home Services

Families reported similar concerns with intensive in-home services. **Waiting lists are long, the application process is lengthy and cumbersome, staff turnover is high, and these services seem to be offered only after costly treatments, rather than beforehand to prevent emergency department visits or hospitalizations.** They also reported that authorization periods for services are too short to create any substantive and sustainable changes. In-home ABA services are poor or inconsistent, at best.

There were several participants who were **unfamiliar with the availability of the intensive in-home** services that other participants were discussing. There is a clear lack of awareness of programs like TCM and 1915(i).

Some families felt their lack of knowledge about or inability to access intensive in-home services led to hospitalizations or emergency department visits that otherwise might have been avoided.

Crisis Services/988

Feedback on these services was mixed, with some families having excellent experiences with mobile crisis or 988, and others stating it was not helpful and on occasion traumatizing for the family.

Families appreciated having mobile crisis arrive in the company of law enforcement. They felt the combination of a police officer and someone with a therapeutic approach was helpful in defusing a crisis with their child. They would like to see **more Crisis Intervention Team-trained officers**, however. They also believed this should be **one of the points of entry where family peer support is available**. Many said having a family peer support specialist to support them during the crisis would have helped. At minimum, being connected to family peer support in the emergency department or the next day would have made a difference in their ability to manage the crisis.

Families expressed concerns that often their child will calm down when the mobile crisis team arrives and then escalate again after their departure. **Because mobile crisis staff do not observe the behaviors, no action is taken**. This was another example families pointed to when they expressed feelings of not being heard or believed, and feeling blamed or judged when they indicated they wanted the child removed and taken to the hospital. They are left feeling helpless to address their child's immediate need for treatment and concerned for their safety and the safety of others in the home.

Other parents and caregivers reported that utilizing mobile crisis or 988 was not useful at all. Several reported that mobile crisis would **refuse to come out or would simply not show up**. One parent reported calling their local jurisdiction's mobile crisis hotline when her son was being violent. She asked that mobile crisis come to the home and the crisis worker told her she would have to take the child to the emergency department. When the mother indicated that this was not safe for her to do, the crisis worker indicated that they could not send anyone out. Reluctant and fearful to call 911 due to the child's behavior, the mother was left waiting for her child's anger to abate on its own.

One parent reported being told not to call 988 anymore because "she wasn't suicidal." Other parents and caregivers had similar experiences with being told that they should only call 988 if there was a crisis but these families are under the impression they can call 988 to seek support and resources for themselves and their child.

The consensus on mobile crisis services and 988 is that the **quality of the services received is entirely dependent on where the family lives and who answers the call**.

Key Behavioral Health Services Recommendations

Emergency Departments

Families would like there to be a solution to the challenges presented by the requirement that they must physically stay with their child in the emergency department until a bed is found. The impact on the rest of the family and on the family's financial wellbeing is significant.

They would also like to engage in meaningful discussions about their child's treatment options and have providers take time to educate them and let them have time to consider all options.

They would like to have family peer support available in the emergency department. This is often a frightening and emotional time for parents and caregivers, and they would appreciate having someone at their side who has been through it before and can help them make informed decisions.

They also want to see more treatment options while the child is boarded in the emergency department.

Hospitalization

Families want to feel like a hospitalization will do more than stabilize their child on medications before they are discharged. They want to see **active, meaningful therapy** while hospitalized that is driven by the child's needs.

They want hospital staff, particularly doctors, to **spend time with them explaining what is happening with their child, educating them on medications and treatment options, or, at minimum, giving them time to do their own research to make informed decisions**.

Families want to be **more involved in discharge planning**. They want to bring their child home with **a list of concrete steps** that need to be taken post-discharge and want the ability to **consult with hospital staff if they run into obstacles** implementing the post-discharge steps. They want to know before their child does that the child is being discharged.

Community-based Services

Parents and caregivers want to decrease obstacles and increase access to community-based services so that they can avoid traumatic, high-cost services like emergency departments and hospitalizations.

They believe it's important to **decrease issues related to staff turnover and workforce shortages** within community provider settings.

Families believe more awareness of available services, eligibility requirements, and how to access these services will help decrease the need for high-cost services.

They would like community-providers to undergo **regular sensitivity training** and **cultural competency training** to improve their ability to listen to families without judgment and eliminate the shame and blame parents and caregivers feel after interacting with community providers. They want providers to listen to them and trust their judgment as parents and caregivers who are the **experts on their own child**.

They want mechanisms in place that **promote communication and collaboration across providers and facilities** so that the need to retell their story is eliminated.

Intensive In-Home Services

Families who have accessed these services want a **decrease in staff turnover** and they want to make it easier to access these services. Families who had not used these services believed their lack of knowledge about the services is indicative of how resources are hard to find and that many providers do not even know about them so they cannot make referrals.

They would like to **see more consistent services** provided across in-home service providers and better training for those that are delivery the services.

Parents and caregivers would like to see **these services be used to keep the child in the community before a hospitalization occurs**. Though they may prevent future hospitalizations, more education and awareness may eliminate the need for any hospitalization.

Crisis Services/988

Parents and caregivers want to see **more consistent training among staff** who answer crisis or 988 calls so that they are treated the same way each time they call. They **want mobile crisis to respond** when they call for help. They would also **like to be heard** when they express concern that the child may be calm during the crisis team's visit but that they believe the situation will escalate again after their departure. If the family requests the child be taken to the emergency department, they want to be heard.

School System Challenges

Though challenges families highlighted with the school system fall outside the scope of behavioral health system, it is still important to share their feedback in this report, given that these two systems are inextricably intertwined when discussing children with behavioral health challenges.

Parents and caregivers who participated in our focus groups expressed tremendous concern with how the school system supports their child's needs. While there were a few bright spots, most of the discussion centered on how their children are not being well served. Listed below are general themes that surfaced throughout all six focus groups.

Lack of Collaboration: from accessing special education support to managing classroom behaviors, parents and caregivers reported poor collaboration and communication between school personnel and the family or community providers. Examples include:

- Schools refuse to accept diagnoses and evaluations from the child's community provider, insisting they must do their own. This delays the development and implementation of IEPs and 504s.
- When they conduct their own testing, schools often reach different conclusions than the child's community providers resulting in a refusal to allow the child to access special education services.

Inadequate Strategies to Address Behavioral Health Challenges: school systems lack or have failed to adopt strategies for helping children with challenges be successful in school. Parents and caregivers in the focus groups provided the following examples:

- If the school does not personally observe the behaviors, they will not act or support the parent's request for additional support (mirroring the families' feelings that community providers who do not observe the child's behaviors also do not take action, leaving parents and caregivers feeling frustrated and unheard and the child without the needed services).
- Too often, the school's response to a child's behavior that results from their behavioral health challenge is to suspend the child when the child needs services and support. When the child returns to school, they still are not provided with special education services, so the cycle repeats itself. The consequences are punitive, not solutions oriented.
- Families feel like a "nuisance" or feel judged and blamed for the child's behavior. They feel as if they have to "fight for everything."

Recommendations

Families recommended the following:

- Increased collaboration between the school and community providers so that work is not duplicated and access to in-school services is more efficient.
- Better education of school personnel on community resources.
- Embed family peer support services in the school system on IEP teams to help families navigate and to provide an advocate for parents and caregivers, particularly when they are just beginning the process.
- Decrease obstacles and "hoops to jump through" to access special education services. "Don't make it so hard to get support for the child when they spend a majority of the day in school."

Conclusions

The feedback from parents and caregivers across Maryland yields some consistent themes and universal challenges they face in accessing and navigating the children's behavioral health care system in Maryland.

Families feel that they are on their own.

- Resources are lacking or inadequate to meet the child's needs.
- There's no roadmap, starting point, or central location to access resources.
- Providers are not well-informed about available resources and often point families in the wrong direction if they provide direction at all.
- Families feel isolated, blamed, judged, and not heard or believed when they reach out for help.
- Families do not feel included in the decision-making process regarding their child's care at several points along the continuum. As a result, they must do their own research to educate themselves. They have to fight to be included and heard. They sometimes face punitive measures (i.e., referral to child welfare) if they disagree with a provider.
- Families who face cultural or linguistic barriers are particularly impacted by the lack of resources, guidance, and support.

Potential Solutions

- Centralized but local one-stop shop or app where families can search using keywords familiar to them, particularly in the beginning when they may not know what words to use or even what they're looking for.
- Provide access to family peer support at all points of entry to the behavioral health care system and at high-cost or emotionally overwhelming points of service when parents and caregivers may not be able to make informed decisions.
- Regular continuing education for providers across the continuum on community services and programs, eligibility requirements, and referral procedures.
- Increase availability of bilingual staff.

Communication & Collaboration Among Service Providers and Systems is Lacking.

- Parents and caregivers report that the lack of communication among service providers supporting their child creates pain points in providing timely and appropriate services.
- Families must tell their story repeatedly as they move from one provider to the next, even within the same organizations, practices, or facilities. This is traumatizing for parents, caregivers, and children.

Potential Solutions

- Promote, require, or incentivize the consistent use of electronic health records systems to encourage cross-agency or cross-system communication and collaboration.
- Strengthen mechanisms for communication and continued follow-up as families move from one point on the care continuum to another (i.e., from hospitalization to return to home).

Behavioral Health Services Are Inadequate to Meet the Needs of Maryland Children.

- Parents and caregivers feel there are not enough of the types of services their child needs, or too few practitioners are qualified to provide the required services (i.e., ABA, trauma).
- Workforce shortages have resulted in long waiting lists to see providers or obtain evaluations. They have also caused increased stress among behavioral health care workers, leading to burnout and their own behavioral health challenges.
- High staff turnover has contributed to long wait lists and has resulted in inadequately trained staff to do the work.
- High-cost, often traumatizing services, like emergency departments and inpatient hospitalization, are the default service providers since families cannot access reliable and consistent community services to meet their child's needs due to workforce shortages, long waiting lists, or lack of awareness of existing services and resources.

Potential Solutions

- Incentivize and provide opportunities for behavioral health professionals to engage in additional training to expand their skills and knowledge.
- Identify and address underlying factors related to high turnover rates (i.e., pay, nature of the work, jobs used as stepping stones).
- Ensure that behavioral health care staff have access to support and resources they need to address burnout, vicarious trauma, and other impacts stemming from their work.
- Utilize family peer support specialists to fill the gaps left by workforce shortages in other areas and to provide services and supports families need but cannot get from behavioral health providers.

Focus Group Questions

Our first series of questions will focus on your experience navigating the behavioral health care system. We'll have about 20 minutes to hear from each of you on two key questions. If there is time left in this segment, we may ask additional questions.

1. Who or what helped you navigate the system to find the services, programs, and resources your child needed?
2. What tools or assistance would have made navigating the system easier for you?

Our second series of questions will focus on your experience with prevention and early intervention supports your child might have received. We'll have about 20 minutes to hear from each of you on two key questions. If there is time left in this segment, we may ask additional questions.

1. How did you know that your child needed behavioral health supports?
2. What prevention or early intervention support did your child receive when the signs of their behavioral health challenges first appeared?
3. What tools or resources would have made it easier for your family to access the support your child needed?

Finally, our last series of questions will focus on your experience with the actual services your child received. We'll have about 20 minutes to hear from each of you on two key questions. If there is time left in this segment, we may ask additional questions.

1. Which services worked well and which didn't? Consider services like crisis response, inpatient hospitalization, emergency departments, residential treatment, intensive in- home treatments, or other community-based supports.
2. What obstacles did you face accessing these services?
3. How involved did you feel with your child's plan of care?

Appendix 3

Youth/Young Adult Perspectives on Maryland's Children's Behavioral Health System

Survey and Town Hall Results

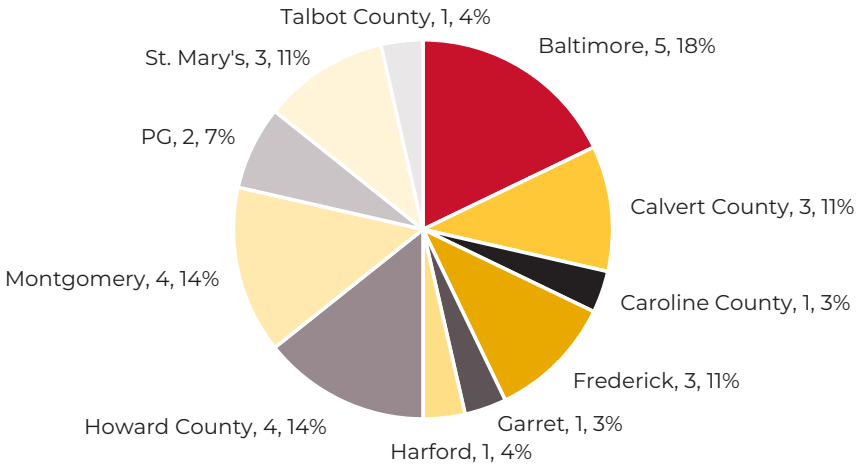
Total number of active participants:

- Survey—15
- Town Hall—13

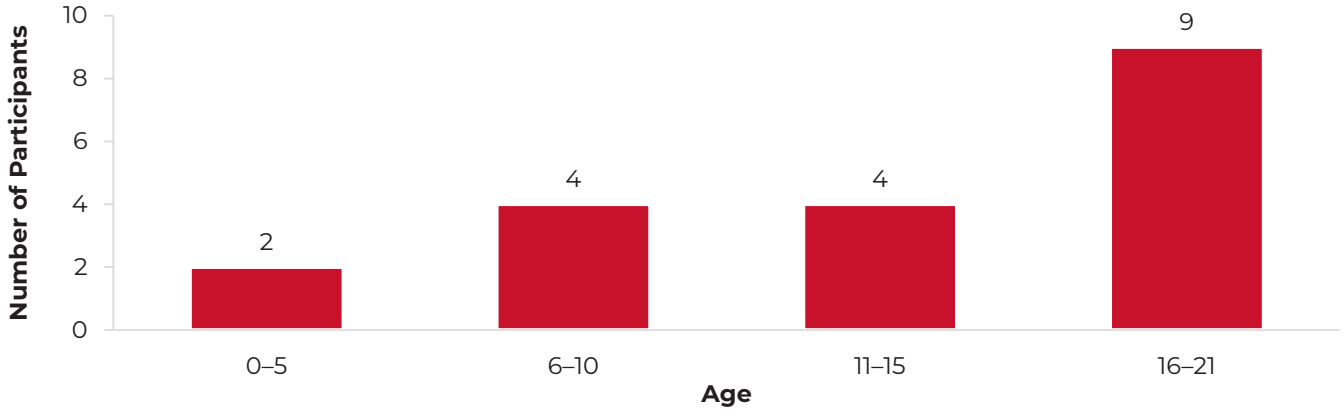
Some town hall participants also completed the survey. To avoid duplication, their responses were excluded from the total survey participant count.

Demographics

Jurisdiction



How old were you when you first encountered the behavioral health system*?



*Survey results

Overview

The focus group was asked the same questions as other statewide focus groups and received a follow-up survey. Survey participants received an abridged version of the focus group questions, but the main topics remained the same. Overall, participants identified parents, teachers, counselors, and friends as key figures who encouraged them to seek support. Only one participant reported accessing early intervention support, crediting their parents' prior experience with behavioral health services for knowing how to navigate the system. While some participants shared positive experiences, these varied depending on their location and the availability of resources in their area. Participants repeatedly highlighted gaps in access to services, emphasizing the need for more streamlined processes. Key concerns included high costs, long waitlists, the need for peer support, and a lack of clear information about where to find help.

Noteworthy quotes

1. **What gaps in the behavioral health system need to be addressed? Consider gaps in access, navigation tools, service delivery, early identification, prevention measures, etc.**

   "Limited availability to services, especially in rural areas"

   "Many communities, especially in rural areas or underserved populations, lack sufficient behavioral health services. Youth, Black, POC individuals, LGBTQIA+ communities, and people with disabilities often face barriers like cost, stigma, transportation, and a lack of culturally competent care. Difficulties transitioning from child to adult services: Youth experience gaps in services when transitioning from child-serving to adult-serving systems. Additionally, Behavioral health systems are complicated to navigate, making it hard for people to know where to start or what services they qualify for. Increases Youth Peer Support and Leadership Opportunities: Youth peer support is a vital resource. Expanding these programs to be more accessible and preventative can help build resilience and empower young people to take charge of their well-being."

   "Limited availability of affordable and timely mental health services, especially in rural or underserved areas. 2. Integration with Primary Care: Lack of coordination between behavioral health and primary health care, leading to fragmented treatment plans and poor patient outcomes. 3. Workforce Shortages: Insufficient numbers of trained mental health professionals, particularly for specialized populations such as children, LGBTQIA+ individuals, or those with severe mental illness."

   "There are issues with access to care, workforce shortages, integration of services, equity in service delivery, prevention and early intervention."

   "We need more ways to make the system more accessible to all."

   "We do not need police to address crisis situations as they are insensitive, authoritative, and bring with them more danger."

   "BIPOC youth and young adults have a hard time accessing health care because of finances, stigma, etc. Moreover, those who are disabled have a hard time getting care and even accessing care physically because of transportation, disability access ramps, etc. **When I was hospitalized, I got "good luck" and was sent on my way with no follow-up, no appointments, no resources, nothing**. After getting treatment for anything, it is crucial that people know where to go from there, in order to keep up with treatment recommendations, aftercare, medication, etc."

"Early Identification - Especially with things like psychosis and bipolar disorder (can be with psychotic features), BPD, etc., early identification is something that will go a long way. Usually, people think "oh they're just a kid they have an active imagination or are going through emotional ups and downs…" Yes, they are, and they do, but some extra care and effort needs to go into paying attention to details, noticing warning signs, testing, etc."

"I have noticed there is a significant access gap prohibiting people from acquiring their much-needed help when it comes to having the means of transportation to travel and receive their help."

"I think there is a gap in not knowing when to seek professional help. Some individuals may be scared or nervous to reach out for help and may not know that they in fact do need professional behavioral health care. Also making it known that behavioral health care is normal, some individuals may also feel uncomfortable getting help because I personally feel like it's not advertised enough to be normalized like other health care specialties."

"Preventative mental health measures should be addressed with more ways for people to engage in their communities…"

"Barriers like stigma, lack of insurance coverage, and long waitlists harmed by delaying or preventing me from seeking necessary mental health support."

"Inpatient hospitalization didn't work well for me. I feel irritated with the environment."

2. **If you could make specific recommendations on areas where the system could be improved, what would you suggest? Consider changes needed to services like mobile crisis, emergency department visits, inpatient hospitalization, intensive in-home services, etc.**

"Expand Telehealth services and increase funds for public behavioral health services."

"Expansion, availability, and integration with local services."

"Intensive in-home services should be available."

"Mobile Crisis Services: Shift more to trauma-informed mental health-led approaches. Ensure they are staffed with mental health professionals, peer support specialists, and culturally competent providers. Also, establish stronger connections between crisis teams and community resources to provide follow-up care. Emergency Department Visits: Create dedicated care team units within emergency departments to provide specialized, compassionate and trauma-informed care, this would include staffing peer specialists. Preventative Services: Implement universal school-based mental health programs to identify and address challenges early."

"Emergency departments need more tools to be able to identify a mental health crisis."

"Safety planning for everyone, regardless of diagnoses. A comprehensive follow-up packet with resources, emergency contacts, tips, information about diagnoses, etc. More treatment facilities and peer support in rural areas."

"Schools, that's where a child spends majority of their life for the first 12+ years so I feel like if proper care was given then it would help tremendously."

"Early Crisis Intervention, parent and caregiver education is critical and doesn't seem to be available"

"The system could be improved within the ER visits as they are not taken as serious/ you aren't taken seriously. Inpatient hospitalizations also need improving as there are many people who have said it was the worst experience they have ever had."

"Tools like online screening tools, telehealth services, and multilingual support can facilitate access to support."

"Some sort of guideline would have made it easier."

3. **Is there anything else you would like included in your feedback that wasn't covered elsewhere?**

   "Incorporating peer support, people that have navigated and survived similar experiences can give valuable insights to others."

   "There should be more investment in preventative care. Also, there is extensive and pervasive racial & gender discrimination in health care."

Appendix 4

Glossary of Acronyms

Acronym	Definition
ASO	Administrative Services Organization
BHA	The Behavioral Health Administration
BHIPP	Behavioral Health Integration in Pediatric Primary Care
BRSS	Bed Registry and Referral and Care Traffic Control System
CHIP	Children's Health Insurance Program
CMHI	Children's Mental Health Initiative
CMS	Centers for Medicare and Medicaid Services
CSAs	Core Service Agencies
DDA	The Developmental Disabilities Administration
ECHO	Early Childhood Development and Mental Health Project Extension for Community Healthcare Outcomes
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HRSA	Health Resources and Services Administration
I/DD	Intellectual and/or Developmental Disabilities
IEP	Individualized Education Program
LBHAs	Local Behavioral Health Authorities
Level III TCM	Highest Tier of Targeted Case Management Services
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
MCOs	Managed Care Organizations
MCF	Maryland Coalition of Families
MHBG	Community Mental Health Services Block Grant
MRSS	Mobile Response and Stabilization Services
PBHS	Public Behavioral Health System
RAEs	Regional Accountable Entities
SAMHSA	Substance Abuse and Mental Health Services Administration
SPA	State Plan Amendment
SUDs	Substance Use Disorders
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
TCM	Targeted Case Management
VPA	Voluntary Placement Agreement

References

1 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Nov 17, 2024; Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland. General Assembly of Maryland Department of Legislative Services. (2022, January). https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/HB1121,2020Ch29(2021)_2022.pdf; *Maryland Department of Health releases new Maryland Action Plan to prevent suicide in schools*. Maryland Department of Health Newsroom. (2024, September 4). https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-releases-new-Maryland-Action-Plan-to-prevent-suicide-in-schools-.aspx#:~:text=Suicide%20is%20the%20third%20leading,of%20death%20for%20all%20ages.

2 Including discussions with members of Maryland's Behavioral Health Advisory Council and Commission on Behavioral Health Treatment and Access, and representatives from Maryland's LBHAs.

3 *Analysis of the FY 2025 Maryland Executive Budget*. Maryland General Assembly. (2024). https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2024fy-budget-docs-operating-M00L-MDH-Behavioral-Health-Administration.pdf.

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5 *Youth Ranking 2024*. Mental Health America. (n.d.-b). https://mhanational.org/issues/2024/mental-health-america-youth-data.

6 *Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) 2022-2023*. Maryland Department of Health. (n.d.). https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx.

7 *Youth Ranking 2023*. Mental Health America. (n.d.). https://mhanational.org/issues/2023/mental-health-america-youth-data#two.

8 2022 National Survey on LGBTQ Youth Mental Health Maryland. The Trevor Project. (n.d.). https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Maryland.pdf.

9 *Youth Ranking 2023*. Mental Health America. (n.d.). https://mhanational.org/issues/2023/mental-health-america-youth-data#two.

10 A list of the specific mental health and SUD services covered by the PBHS is available here.

11 Maryland's 1915(i) SPA covers intensive in-home services, community-based respite care, out-of-home respite care, family peer support, and expressive and experiential behavioral health services for members that meet eligibility criteria.

12 Re: Report required by Health-General Article § 15-1103 and Ch. 378/379 of the Acts of 2023–2023 Annual Report on Enrollment in the 1915(i) Model and Child and Adolescent Case Management Services (MSAR #14577). Maryland Department of Health. (2024b, September 12). https://health.maryland.gov/mmcp/Documents/JCRs/2023/1915(i)enrollmentJCRfinal12-23.pdf.

13 Cushing AM, Nash KA, Foster AA, Zima BT, West AE, Michelson KA, Hoffmann JA. Pediatric Inpatient Psychiatric Capacity in the US, 2017 to 2020. JAMA Pediatr. 2024 Oct 1;178(10):1080-1082. doi: 10.1001/jamapediatrics.2024.2888. PMID: 39158901; PMCID: PMC11334005.

14 *Request For Proposals (RFP) Administrative Services Organization For Maryland's Public Behavioral Health System RFP NUMBER MDH-OCMP-23-19761*. Maryland Department of Health. (2023, January 10). https://health.maryland.gov/procumnt/Documents/MDH%20BHASO%20RFP%20MDH-OCMP-23-10761.pdf.

15 Focus group findings indicate that families remain confused about whether they should call 988 only when in crisis or if it can use the helpline as a resource at other times. At least one parent was told to "stop calling" because her child was not actively suicidal.

16 TTI BED Registry Project: Maryland. National Association of State Mental Health Program Directors. (n.d.). https://www.nasmhpd.org/sites/default/files/Maryland_BedRegistry.pdf; Maryland Behavioral Health Crisis System Workgroup 2021-2022 Summary. Maryland Department of Health. (n.d.-a). https://health.maryland.gov/bha/Documents/Maryland%20Crisis%20System%20Workgroup%20Summary_072622.pdf.

17 Contact information for Maryland's Local Care Teams can be found online: LCT-Directory.pdf.

18 Youth Mental Health Corps. https://www.youthmentalhealthcorps.org/.

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