



CHANGING
Maryland
FOR THE BETTER

Commission to Study **Mental and
Behavioral Health** in Maryland

2019

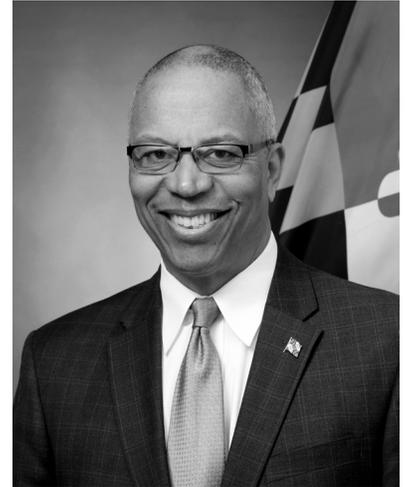
REPORT

Lt. Governor Boyd K. Rutherford, Chair

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December 31, 2019

The Honorable Lawrence J. Hogan
Governor, State of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan,

Since your establishment of the Commission to Study Mental and Behavioral Health in Maryland earlier this year, we have been hard at work studying the state's mental health delivery system and engaging a wide variety of stakeholders in order to determine how we can best support individuals living with mental health disorders and improve mental health services. The Commission has so far hosted six meetings in regions across the state, bringing together families, advocates, practitioners, and others on the front lines of these issues who have offered valuable insight and lived experiences which have greatly informed our understanding of these complex and critical issues.

In addition to studying access to mental health services, the Commission has also focused on the link between mental health and substance use disorders. This is in line with our administration's continued efforts to implement a holistic, multi-pronged approach to combat Maryland's ongoing opioid epidemic. The relationship between co-occurring mental health and substance use disorders is well known and widely accepted among experts in these areas. Therefore, I believe it is imperative that we incorporate a heavier focus on mental health into our substance use prevention, treatment, and recovery efforts.

The Commission is comprised of representatives from each branch of state government, representatives from the state departments of Health, Public Safety and Correctional Services, and Human Services, as well as the Maryland State Police, the Maryland Insurance Administration, the Opioid Operational Command Center, and six members of the public with experience related to mental health. Additionally, we have established four subcommittees to target the areas of Crisis Services, Finance & Funding, Public Safety & Judicial System, and Youth & Families.

Enclosed is our 2019 Report, which outlines the work of the Commission for the past year and includes recommendations for ways to improve Maryland's mental health delivery system. Thank you for your continued leadership and support. The Commission looks forward to continuing our important work in the new year.

Sincerely,

Boyd K. Rutherford
Lieutenant Governor, State of Maryland
Chair, Commission to Study Mental & Behavioral Health in Maryland

BACKGROUND

Throughout its first term in office, the Hogan-Rutherford Administration prioritized efforts to address Maryland's significant but previously overlooked heroin and opioid epidemic. Since January of 2015, the Administration has pursued a holistic, comprehensive response to this public health emergency through a multi-pronged approach encompassing education and prevention, treatment and recovery, and law enforcement efforts.

Just one month into office, Governor Larry Hogan issued Executive Order 01.01.2015.12, formally creating the Maryland Heroin and Opioid Emergency Task Force. The governor tasked Lt. Governor Boyd Rutherford with leading the task force. Over the course of the next four years, the lieutenant governor would lead the administration's ongoing efforts to combat the epidemic. The Administration has since taken numerous steps to invest critical funding, improve collaboration and communication among government agencies at the local, state, and federal levels, raise public awareness of the issue, and break down the stigma surrounding the disease of addiction. Such efforts include but are not limited to the creation of the Opioid Operational Command Center

and the Inter-Agency Heroin and Opioid Coordinating Council, as well as numerous pieces of legislation and the issuance of an official State of Emergency.

It has been through this work that Lt. Governor Rutherford recognized the vital need for the state's approach to expand further and explore the mental and behavioral health needs of the citizens of Maryland, particularly those suffering from substance use disorder. Just as there is a stigma attached to substance use disorder, issues related to mental and behavioral health are equally stigmatized, if not more so. Additionally, it is widely accepted by advocates and medical professionals on both sides that there is a strong correlation between and often co-occurrence of mental health and substance use disorders.

To that end, it was decided that the state should further study the relationship between mental health and substance use disorders, as well as identify potential ways to improve our mental health services delivery system. On January 10, 2019, Governor Hogan issued Executive Order 01.01.2019.02, formally creating the Commission to Study Mental and Behavioral Health in Maryland (Commission).

INTRODUCTION

Over the past year, the Commission has conducted public meetings in every region in the state¹ to engage stakeholders and gather their feedback as it relates to mental health, substance use, and delivery of care.

The Commission has learned that across the country, there has been a historical separated diagnosis and treatment of mental illness from physical illness. This has unintentionally caused two separate and not always equal systems of care. This not only affects the quality of treatment for individuals but raises the cost of care for all individuals. It is more critical than ever to take a serious look at how the state provides care and services to individuals and their families. In addition to a higher likelihood of substance use disorder, individuals with undiagnosed mental health disorders are more likely to experience homelessness, joblessness, negative interactions with the judicial system, and become victims of crime and/or suicide.

Pursuant to the Executive Order, the Commission is required to submit recommendations to Governor Hogan for policy, regulations, and/or legislation to improve the continuum of mental health services, as well as, but not limited to, the following: (1) improving the statewide, comprehensive crisis response system; and (2) ensuring parity of resources to meet mental health needs. The Commission has held six regional meetings throughout the state, with plans to continue meeting throughout 2020. We have heard testimony from persons suffering from disorders, family members and care givers, educators, faith leaders, researchers, elected officials, law enforcement agencies, treatment professionals, advocates, and other stakeholders. The regional meetings have been held in Annapolis, Baltimore City, Largo, Germantown, Hagerstown, and Wye Mills.

This 2019 report reflects the Commission's work over the past year, the work of individual subcommittees, and recommendations moving forward.

Commission members include:

- Lieutenant Governor Boyd K. Rutherford, Chair
- Senator Adelaide Eckardt, District 37, Caroline, Dorchester, Talbot, and Wicomico Counties
- Senator Katie Fry Hester, District 9, Carroll and Howard Counties
- Delegate Robbyn Lewis, District 46, Baltimore City
- Richard Abbott, Representative of the Chief Judge of the Court of Appeals
- Dennis Schrader, Chief Operating Officer and Medicaid Director, Department of Health
- Dr. Lisa Burgess, Acting Deputy Secretary Behavioral Health Administration
- Major Roland Butler, Maryland State Police
- Dr. Randy Nero, Department of Public Safety and Correctional Services
- Dr. Randi Walters, Department of Human Services
- Al Redmer, Commissioner, Maryland Insurance Administration
- Steve Schuh, Director, Maryland Opioid Operational Command Center
- Christian Miele, Deputy Secretary, Department of Disabilities
- Dr. Deborah Nelson, Maryland State Department of Education
- Barbara Allen, Public Member
- Patricia Miedusiewski, Public Member
- Dr. Bhaskara Rao Tripuraneni, Public Member
- Cari Cho, Public Member
- Serina Eckwood, Public Member

¹ Meeting Locations: (1) Anne Arundel County; (2) Baltimore City; (3) Prince George's County; (4) Montgomery County; (5) Washington County; and (6) Queen Anne County.

SUBCOMMITTEES

Based on the areas of concern that have been raised through the Administration's tenure and feedback from stakeholders, the Commission has created four subcommittees: (1) Youth & Families; (2) Crisis Services; (3) Finance & Funding; and (4) Public Safety/Judicial System. These four subcommittees are focusing on the basic fundamental and policy issues facing each of these subject areas. Each subcommittee is chaired by one or two members of the Commission who solicited the participation of stakeholders interested in each subject area.

The following section details the initial focus areas of each subcommittee and the progress thus far.

1. Youth & Families

Co-chairs: Dr. Randi Walters, Deputy Secretary of Programs, Department of Human Services and Christian Miele, Deputy Secretary, Department of Disabilities

Overview

The Youth and Families Subcommittee was created because 1 in 5 children ages 13-18 have or will have a serious mental illness (NAMI, 2016); suicide is the second leading cause of death among adolescents aged 15-19 (CDC, 2017); and, with an increase in school violence in recent years, addressing youth and adolescent behavioral health is more important than ever. Studies have shown that psychosis in young people often does not develop until a person is in early adulthood, making it very difficult for families to assist their adult family member, particularly where the family member does not consent to allowing family members access to their treatment or diagnosis.

Focus Areas

K-12 education: The subcommittee will continue to review current programs in the school systems that provide mental and behavioral health support and services to students and school-aged children. The Subcommittee set out to conduct an inventory of school psychologists and found that as of August 2019, Maryland's Schools psychologist to student ratio is 1:1,250 while the National Association of School Psychologists recommends that the ratio be 1:500-700. The subcommittee will continue to identify best practices in surrounding states as it relates to mental and behavioral health initiatives for youth and

adolescents, including obstacles that make it difficult for families to get services for adult family members who suffer from mental illness.

Caregivers and families: In addition to identifying the services available for youth, the subcommittee will continue to explore the services that are currently available for caregivers and family members of individuals affected by a mental health and/or substance use disorder and how the state can deliver these services to caregivers and/or family members in the most effective manner. The subcommittee has been working to identify barriers to treatment for caregivers and/or family members and what the state is doing and can do to overcome those obstacles.

Mental Health Coordinators: The subcommittee has been looking at the operation and workload of the Mental Health Coordinators across the state, as well as exploring the services available for transition-age youth and how we may be able to expand those services, aggregate data surrounding bullying and youth with mental and behavioral health conditions, and conduct a statewide needs assessment of services available.

Organizing Efforts

The Commission members assigned to the Youth and Families Subcommittee held four meetings throughout the year.

Commission Members: Dr. Deborah Nelson; Dr. Bhaskara Tripuraneni; and Barbara Allen

Participants: Kirsten Robb-McGrath, Department of Disabilities; Ann Geddes, Maryland Coalition of Families; Irnande Altema, Mental Health Association of Maryland; Lauren Grimes, On Our Own of Maryland; Toni Torsch, Daniel C. Torsch Foundation; Courtney Oatts-Hatcher, School Psychologist; Christina Connolly, School Psychologist; Dr. Beverly Sargent, Youth Service Bureau; Allyson Lawson, Psychiatric Nurse; Dr. Liz Park, Youth Service Bureau; Dr. Jackie Stone, Kennedy Krieger Institute; Christine Grace, School Psychologist; Nancy Lever, National Center for School Mental Health; Laura Mueller, WIN Family Services; Dawn O'Cronin, Maryland Center for School Safety; Ivania Morales, National Alliance on Mental Illness for Prince George's County; Jane Walker, Family Run Executive Director Leadership Association;

Jenn Lynn, Upcounty Community Resources, Inc; Joan Smith, Behavioral Health Administration; and Tony Wilson, Woodbourne Center

2. Crisis Services

Co-chairs: Delegate Robbyn Lewis, District 46, Baltimore City and Steve Schuh, Director, Maryland Opioid Operational Command Center (O OCC)

Overview

Maryland understands the relationship between mental health and substance use disorders and continues to evaluate its behavioral health delivery system. A critical component of this system includes crisis services, which are a continuum of services available to individuals experiencing a mental health or substance use emergency. Crisis services aim to stabilize an individual in distress in order to refer them to an appropriate level of treatment to address the underlying causes contributing to their crisis.²

The availability of crisis services in Maryland varies greatly by jurisdiction, and there is some divergence between crisis services available for individuals who have a psychiatric diagnosis versus crisis services available for those with emergencies related to substance use disorder. The Crisis Services Subcommittee continues to study how the statewide crisis system operates in order to explore gaps and to identify opportunities for creating a more comprehensive system of care.

Focus Areas

Given the federal and state commitment to expanding resources to individuals in need of behavioral health services, there are many funding opportunities to support crisis services. This subcommittee continues to partner with the necessary agencies in compiling an inclusive list of all resources allocated toward addressing the crisis services delivery system, specifically those funded through the Statewide Opioid Response (SOR) grant and through the legislature.

Additionally, the Crisis Services Subcommittee has been and will continue to review the gaps and recommendations outlined in the 24/7 Crisis Walk-in and Mobile Crisis Team Services Strategic Plan that was completed by the Behavioral Health Advisory Council (BHAC) in 2017. This subcommittee has also reviewed the Substance Abuse and Mental Health Services: Cost Effectiveness Report. Having a better understanding of the current resources available to address crisis services, along with BHAC's

findings from their strategic plan, has helped members of the Crisis Services Subcommittee strategize how best to leverage work that has already occurred in order to maximize efficiency and reduce redundancy.

Organizing Efforts

The Crisis Services Subcommittee has met eight times. Meetings have included presentations covering the current landscape of crisis services in Maryland, overviews from emergency medical services (EMS) regarding crisis response, and walk-in and mobile crisis services currently underway throughout the state. Following these meetings and presentations, subcommittee members discussed gaps and opportunities to improve Maryland's crisis services.

Commission Members: Dr. Lisa Burgess; Patricia Mieduswiewski; and Serina Eckwood

Participants: Howard Ashkin, Director of Admissions and Community Engagement, Maryland Association of the Treatment of Opioid Dependence; Nancy Rosen-Cohen, Executive Director, National Council on Alcoholism and Drug Dependence; Dan Martin, Senior Director of Public Policy, Mental Health Association of Maryland; Lori Doyle, Public Policy Director, Community Behavioral Health Association of Maryland; Marian Bland, MDH Behavioral Health Administration; Steven Whitefield, MDH Behavioral Health Administration.

3. Finance & Funding

Co-chairs: Al Redmer, Jr., Commissioner, Maryland Insurance Administration (MIA) and Dennis Schrader, Chief Operating Officer and Medicaid Director, Maryland Department of Health (MDH)

Overview

In order to fulfill its mission as it relates to health insurance in both the public and private markets, the Finance and Funding Subcommittee is tasked with assessing how finance and funding in the public and private sectors affect access to behavioral health services. The focus areas of the subcommittee run parallel with the efforts of MDH's System of Care Workgroup.

Maryland's public behavioral health system provides mental health services to over 200,000 individuals and substance use services to over 100,000 individuals annually, the majority of which are covered by Medicaid. Further, Medicaid insures over 20 percent of the State's population. Given the substantial role of both the public

2. Substance Abuse and Mental Health Services Administration (SAMHSA)

behavioral health system and the commercial insurance market in delivering and financing behavioral health services within the State, the subcommittee's focus areas will make an important contribution to the Commission's work.

Focus Areas

Public Mental and Behavioral Health: Assess and develop quality outcome principles. Two bills were introduced during the 2019 session that sought to change the delivery and financing of Medicaid behavioral health services. MDH has convened a System of Care Workgroup to examine and make recommendations on how the State should provide, administer, and finance behavioral health services in conjunction with the Total Cost of Care Model.

The Subcommittee has worked in conjunction with the System of Care Workgroup and corresponding stakeholder discussion groups in the summer and fall of 2019, incorporating subcommittee perspectives into this process. The Workgroup focused on developing a set of design principles to better serve Medicaid participants, develop a system that addresses alignment of Medicaid/ the Behavioral Health Administration, Managed Care Organizations, the administrative service organization, and local system managers. The design principles are organized around five key components: (1) Quality Integrated Care Management; (2) Oversight and Accountability; (3) Cost Management; (4) access to Behavioral Health Services through Provider Administration and Network Adequacy; and (5) Parity. The Workgroup is now developing a framework to propose, organize, and discuss categories of improvements and specific ideas to operationalize the design principles.

Private Mental and Behavioral Health: Review the network adequacy of private insurance and coverage for substance use disorder treatment. Inadequate coverage of behavioral health treatment services in the commercial market (including inadequate networks to provide these services) can cause a financial barrier for individuals who need treatment. The Subcommittee is reviewing and working with MIA to address adequacy issues.

The MIA has completed three Mental Health Parity and Addiction Equity Act surveys. These surveys have involved investigations into the major health insurance providers in the State and have included inquiries into carrier reimbursement rate and credentialing practices, both of which affect network participation. The MIA has received the second annual network adequacy reports that the carriers submitted on July 1, 2019.

Working in partnership with the subcommittee, MIA should continue its in-depth analysis of the network adequacy reports to ensure provider adequacy in regards to behavioral health and substance use disorder. The next steps will be determined once all information has been received from the carriers. The network adequacy regulations should be revisited and revised accordingly.

Organizing Efforts

The Finance and Funding Subcommittee has held seven meetings, recruited stakeholders for participation, and narrowed its focus to two main areas, as outlined directly above. The subcommittee has met monthly and received input on focus areas from its members and participants. In addition to the work of the Finance and Funding subcommittee, MDH has been working concurrently on its Behavioral Health System of Care Workgroup and has been coordinating with the subcommittee.

Commission Members: Senator Adelaide Eckardt, District 37; and Cari Cho

Participants: Nick Albaugh, Director of Licensing & Compliance, Amatus Health; Dr. Robert Ciaverelli, Medical Director for Behavioral Health, CareFirst; Isaiah Coles, Chief Operating Officer, Outreach Recovery; David Stup, Director of Corporate Business Development, Delphi Behavioral Health Group; Steve Daviss, President, Fuse Health Strategies; Mark Luckner, Executive, Maryland Community Health Resources Commission; Daniel Massari, Director of Medicaid Finance, Kaiser Permanente; Patryce Toyne, Chief Medical Officer, MedStar Health Plans

4. Public Safety/Judicial System

Chair: Dr. Randall Nero, Department of Public Safety and Correctional Services

Overview

The public safety sector plays a significant role in the realm of mental and behavioral health for citizens of Maryland. In order to fulfill its mission as it is related to public safety and the judicial system, the Public Safety/Judicial System Subcommittee is tasked with assessing how emergency responders' interact with individuals in crisis and how the judicial system affects access to behavioral health services.

With the deinstitutionalization of patients from the mental health system, individuals suffering from mental health and/or substance use disorders have had increased contact with law enforcement and the judicial and

correctional systems. Therefore, it is critical that these respective systems and the individuals within them have the appropriate strategies and skills to provide effective interventions that are consistent with the behavior(s) and disorder(s) that may have played a role in an individual's circumstances.

Focus Areas

The subcommittee has reviewed policies and procedures of first responders that relate to the identification of, and initial contact with, individuals experiencing a mental and/or behavioral health crisis. This review has also included exploring the most appropriate avenues and options when an individual who is suffering from a mental health and/or substance use disorder, comes into contact with law enforcement.

Additionally, the subcommittee will review how the judicial system handles cases involving individuals suffering from mental health and/or substance use disorders. This includes whether or not courts in Maryland are equipped to provide the most appropriate services to these individuals in conjunction with the resolution of their legal matter.

Individuals who are incarcerated and who suffer from a mental health and/or substance use disorder should be provided with adequate and appropriate care. The subcommittee will further explore use of a Sequential Intercept Model (SIM). This model is used for the mapping of behavioral health services across the State. This is a strategic planning tool to identify and assess available resources and also identify gaps that need to be addressed. In development of this tool, it is best to have stakeholders that cross over multiple systems (i.e. health, justice system, housing, social services, etc.).

The SIM enables the transformation of local and state systems, jail diversion policy, and the documentation

and promotion of evidence-based and best practices in program development. The model focuses on six distinct intercept points: (1) Community Services; (2) Law Enforcement; (3) Initial Detention and Initial Court Hearings; (4) Jails and Courts; (5) Reentry; and (6) Community Corrections. These are used to identify gaps, resources, and opportunities at each intercept for adults with mental and substance use disorders. From here statistical and evidence-based priorities can be designed to improve the system and service of response. With the overlap of multiple state agencies there is potential to incorporate this model into MD THINK and/or part of the Crisis System development.

Organizing Efforts

The subcommittee has held four meetings. The subcommittee has focused on finding solutions to reduce recidivism, as well as solutions to provide necessary training for professionals who interact with individuals who are experiencing a mental health crisis.

Commission Members: Senator Katie Fry Hester, District 9; Richard Abbott; and Major Roland Butler

Participants: Kate Fairenholt, Director, National Alliance on Mental Illness, Evelyn Young, Division of Parole and Probation; Dan Martin, Mental Health Association of Maryland; Brittany Delmore, National Alliance on Mental Illness; the Honorable George Lipman, Maryland District Court Judge; the Honorable Ronald Silkworth, Maryland Circuit Court Judge; Jeffrey Gross, Maryland Insurance Administration; Gary Barton, Office of Problem Solving Courts; Kelley O'Connor, Maryland Judicial Center; Suzanne Pelz, Maryland Mental Health Service; Daniel Atzmon, Governor's Office of Crime Control and Prevention; the Honorable Patti Lewis, Maryland 5th District Court Prince George's County Judge.

UPDATES

Emergency Facility Definition for Emergency Petitions

Currently Maryland law is interpreted to require that someone who is emergency petitioned must receive a medical evaluation in an emergency department of an acute care hospital. As noted in the Commission's Interim Report, Maryland should update the Department of Health's (MDH) "emergency facility" definition.

Emergency petitions are tools that allow medical professionals, law enforcement officers, and others to seek rapid evaluation of a patient in psychiatric crisis, who may be a danger to themselves or others, regarding their need for emergency treatment and possible involuntary hospitalization. Expanding the definition of a facility that can accept such patients would create additional flexibility for first responders to help people in crisis. Emergency petitions need to be reviewed and studied in the context of a crisis services system.

It is imperative that a clinical evaluation takes place by a licensed clinical professional. We need to ensure that facilities have the capability to accept these patients, as well as the appropriate staff and equipment to meet their needs. With this in mind, MDH is assessing by jurisdiction the appropriate facilities that could be incorporated into the emergency facility designation. Once this assessment is completed, MDH can keep a repository of eligible facilities that can be accessed electronically.

Reciprocity Standards for Professional Counselors and Therapists

Across the country, there is a need for qualified and credentialed counselors. As noted in the interim report, one of the Commission's goals is to work with the Board of Professional Counselors and Therapists (Board) to ensure reciprocity standards are inline to recruit qualified professionals to meet the needs of our state. While many believe that reciprocity should work similar to a driver's license, there is a practical requirement that each jurisdiction know exactly who is practicing within their borders and whether they are truly qualified in order to protect the public.

One of the solutions to help fill the need for qualified professionals in this field is to join an interstate compact. Currently, the American Counseling Association (ACA) and the Council of State Governments (CSG) is evaluating and developing an interstate compact for professional counselors. The Advisory Group working on this initiative has met with experts and health professionals in order to develop the framework. Maryland is participating and being represented by the Board's executive director, Kimberly Link. It's anticipated that in early 2020 the compact terms will be finalized and the process for adoption of interested states will begin. Once 10 states join the compact it will become effective.

As a member of the interstate compact, Maryland licensees would be able to practice in any other state that is part of the compact. Individuals that hold a Maryland license would have privileges to practice in the other jurisdictions after completing the appropriate registration. Likewise, individuals with a license in another compact state would be able to register in Maryland and gain privileges to practice here.

In terms of alcohol and drug counselors, there have been a lot of efforts recently to ensure the Board is working with individuals and stakeholders to improve the licensing and credentialing process. Maryland has similar regulations regarding out of state licenses as surrounding states. Due to changes in the Board's administrative processes, there is no longer a backlog of applications for any of the 15 credentials issued by the Board. Applications have been revised and clarified to improve the process and make it easier to navigate. Regulations have been revised and reorganized to be user-friendlier to applicants and licensees. Licenses and certification are issued within 10 days of receipt of the last qualifying document.

The Commission will continue to engage with the Board and review Maryland's standards to improve the effectiveness and efficiency of mental health care services delivered in the state.

RECOMMENDATIONS

Based on testimony from the regional meetings, input from various stakeholders, and work completed by the subcommittees, the following items were identified to pursue. The following recommendations do not encompass all of the work and areas of focus the Commission has and will continue to pursue.

Recommendation One: Design a comprehensive Crisis System

Crisis services are an integral part of the health care system and critical to patients and families in need. The Substance Abuse and Mental Health Administration (SAMHSA) defines crisis-stabilization services as “direct services that assist with deescalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder.”³ While more awareness and resources have been made available the need for crisis services has continued to rise. Stabilization services that can be expanded include mobile crisis teams, stabilization facilities, and expanded same-day access to services within current outpatient treatment facilities.

The state should identify the most critical crisis services that should be available to residents at the county and regional levels. In coordination with MDH, the crisis services subcommittee will complete a gap assessment to determine 1) the areas of most critical need, 2) the services that should be available to all Marylanders, and 3) a plan for implementing mechanisms to create or expand those services. There is not a one-size-fits-all approach for expanding crisis services across the state. Considerations for geographic location, population, and the particular needs of individual jurisdictions for certain crisis services need to be considered in determining minimum crisis-service standards.

The Commission will begin the framework of a Crisis System, in coordination with MDH and the System of Care Workgroup for feasibility. This system will include expanded mobile crisis and crisis services, youth services, evaluate the state’s current emergency petition standards, and assessment of the Certified Community Behavioral Health Clinics model.

Recommendation Two: Continue coordination with the Behavioral Health System of Care Workgroup

The State is evaluating how it should provide, administer, and finance behavioral health in conjunction with the Total Cost of Care Model that increases the coordination and quality of somatic and behavioral health care for Medicaid enrollees. This new model will be cost efficient and promote access to care. A well-functioning behavioral health system should include five key components: (1) Quality Integrated Care Management; (2) Oversight and Accountability; (3) Cost Management; (4) Access to Behavioral Health Services through Provider Administration and Network Adequacy; and (5) Parity.

The Commission will continue to work with the relevant stakeholders and MDH system of care workgroup/community discussion groups to proceed with developing a framework to propose, organize, and discuss categories of improvements and specific ideas to operationalize these design principles. By the summer of 2020, the Commission will finalize specific actions that can be either implemented immediately through existing authority or over a two-year period after the 2021 legislative session.

Recommendation Three: Increase funding for the Second Chance Act Grant

The Second Chance Act is a federal grant program that supports state and local governments to improve the reentry process. One component of the reentry program is for adults with co-occurring substance use and mental disorders. It is designed to improve outcomes for adults with co-occurring disorders returning to communities after a period of incarceration. The Bureau of Justice Assistance (BJA) recognizes that a significant number of individuals who are incarcerated and return to the community have chronic disorders and are in need of treatment in order to successfully complete their supervision, reduce recidivism, and promote public safety. We should work to expand the funding provided by our federal partners to support a broader range of services.

Recommendation Four: Improve the Crisis Hotline

A well-coordinated crisis hotline can serve as an initial access point for someone in crisis. Professionals staffing crisis hotlines serve as important conduits to community resources, providing immediate support and/or facilitated referrals to other levels of care. Maryland’s crisis hotline could improve efficiency and effectiveness

3. SAMHSA: <https://store.samhsa.gov/system/files/sma14-4848.pdf>

by incorporating additional components. The Crisis Now model, which has been implemented in several states, lists two critical components for operating a successful crisis hotline: 1) always know where the individual is located, and 2) ensure that the handoff to the next provider has occurred.

Maryland's current crisis hotline, 211, Press 1, is an easy-to-remember number. BHA and a provider, 2-1-1-Maryland, Inc., work together to manage 211, Press 1 and contract with local vendors that serve as regional crisis call centers. The current system consists of five regional call centers, so a caller who dials 211, Press 1 is often routed to a call center in another county. As the State considers quality improvements to the 211, Press 1 system, it should explore care coordination improvements that link the individual with regional and localized assistance. Additional technical solutions to consider in improving the system may include updating the system to either: (1) Route calls by proximity to local cell towers;⁴ or (2) Use an "air-traffic control" routing model.⁵

Maryland should also take into account the work being done at the federal level regarding crisis hotlines. Recently, the Federal Communications Commission is moving forward with plans to designate a national suicide prevention hotline, "988". The proposal is now open for public comment to initiate the rulemaking process. We should ensure our current system can work in coordination with the federal program.

Recommendation Five: Promote standardized training in behavioral health

Explore standardizing training on behavioral health issues for judiciary, public defenders, State's Attorneys, law enforcement, and corrections for the purpose of enhancing decision making ability related to those with behavioral health needs.

First aid is a term used in reference to emergency aid or treatment given to someone who needs assistance before medical services arrive. EMS personnel are trained to render such aid. Given the number of encounters EMS experience with people in a stage of mental health crisis (including drug and alcohol overdoses), adding a "mental health first aid" training will help de-escalate situations, along with the associated time, expense, and possible adverse consequences.

Recommendation Six: Ensure proper warnings regarding cannabis use

Medical cannabis regulations are approved through the Maryland Medical Cannabis Commission. While there is plenty of anecdotal evidence, there has been a gap in research and empirical evidence to properly advise users of possible side effects, long term effects, and high potency effects of cannabinoids. It is important for psychiatrists and other behavioral health professionals to understand and advise on the possible relationship between cannabis use and mental disorders to ensure the best course of treatment for individuals. Similar to prescriptions, alcohol, tobacco and other warnings that are given to users, Maryland should ensure appropriate warnings regarding cannabis use are provided to users.

Recommendation Seven: Standardize mental and behavioral health programming in schools

Explore standardizing mental and behavioral health programming and curriculum in all Maryland primary and secondary schools (K-12). There should be standard instruction provided by school districts that recognize and educate on the multiple dimensions of health, including mental health. Similar to substance use disorder, there is often a stigma associated with mental health issues. Education is the first critical step to overcoming the stigma and enhancing student understanding, attitudes, and behaviors.

There should be a collaborative effort between state and local governments, as well as interested stakeholders, to further education in this area in order to enhance the health and well-being of students. Additionally, proper health professionals within the school system are necessary to carry out this mission. We should explore strategies to increase school psychologists and social workers throughout the state in order to come closer in line with the nationally recommended ratios.

Recommendation Eight: Improve access to information and services

Improve access to vital information on mental health and substance use disorder websites managed by state government. This can be achieved by implementing design strategies that use clear, concise headings and infographics, which will create more user-friendly and aesthetically pleasing webpages. Identify who is in the best position to maintain such sites with up-to-date information, especially with respect to local resources.

4. Instead of utilizing dispersed vendors, each call to 211, Press 1 could be routed directly to the nearest local crisis hotline as determined by proximity to cell phone towers.

5. Operated using technology and secure web-based interfaces that would allow for an air-traffic- control-like system for tracking and deploying local crisis resources. This type of model has been adopted in several states, including Georgia and Arizona.

CONCLUSION

This 2019 report represents the work of the Commission over this past year. The Commission plans to continue its work over the next two years, including increased focus on substantive solutions to improve Maryland's current mental and behavioral health systems. It is the hope of the Commission that by addressing the critical issue of mental and behavioral health, including its relationship to substance use disorder and the opioid epidemic, that the State will be able to better deliver services to its most vulnerable citizens, improve outcomes, and save lives.

