Baltimore Public Behavioral Health System Gap Analysis

Final Report, December 2019

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Executive Summary

Overview

In April 2017, the City of Baltimore entered into a consent decree with the U.S. Department of Justice (DOJ) to address the DOJ findings related to the Baltimore Police Department's patterns and practices that violate the U.S. Constitution and federal law. One section of the decree dealt specifically with response to behavioral health crises, whereby the City agreed "to conduct an assessment to identify gaps in the behavioral health service system, recommend solutions, and assist with implementation of the recommendations as appropriate." In October 2018, the City, through a competitive procurement process, identified and contracted with HSRI through Behavioral Health System Baltimore (BHSB; the local Behavioral Health Authority) to perform this assessment, which was conducted in collaboration with the Collaborative Planning and Implementation Committee (CPIC)[1] and its Gaps Analysis subcommittee.

The goal of the assessment was to: analyze a sample of police interactions with people with behavioral health disabilities to identify systemic barriers and solutions; and for the Public Behavioral Health System (PBHS) at large, to identify gaps in behavioral health services, problems with the quality or quantity of existing services, and other unmet needs that in turn can lead to preventable criminal justice system involvement. Addressing the issues and recommendations for the PBHS identified within this report will help divert individuals from contact with law enforcement during times of behavioral health crisis, and issues and recommendations identified related to interactions with law enforcement during times of behavioral health crisis aim to help improve the quality and outcomes when contacts with law enforcement do occur.

It is important to note that both qualitative and quantitative data pertaining to youth and services for youth are presented but are incorporated within the main findings. The consent decree also called for a report focused on the needs of youth to avoid contacts with law enforcement. That report is available at: https://www.baltimorepolice.org/transparency/interactions-youth.

[1] CPIC is a working group comprised of individuals and organizations representing a wide range of disciplines and perspectives who seek to improve encounters between law enforcement and people with behavioral health disorders. The vision of CPIC is that Baltimore City will develop a system of care that:

- Treats all people with dignity and respect.
- Prevents people from having unnecessary contact with police.
- Diverts people away from the criminal justice system into services that will meet the needs of the individual and their family.
- De-escalates crisis situations with minimal or no use of force.

(Source: https://www.baltimorepolice.org/transparency/behavioral-health)

Many key stakeholders are already collaborating to address several of the challenges identified here, and this report notes many of the strengths and new initiatives underway within the City. However, we have focused on additional efforts that can be undertaken to help improve the quality of the community-based service system in Baltimore City, thereby helping individuals to avoid contacts with law enforcement during times of behavioral health crisis.

Description of Behavioral Health System Baltimore

BHSB is a nonprofit organization that serves as the local behavioral health authority for Baltimore City. BHSB provides leadership in advancing behavioral health and wellness and helps guide innovative approaches to prevention, early intervention, treatment and recovery. BHSB works to build an efficient and responsive system that comprehensively addresses the needs of individuals, families and communities impacted by mental illness and substance use by expanding the reach and quality of the public behavioral health system, promoting the development of new and innovative services and addressing specific population and system-level needs.

In the role of local behavioral health authority, BHSB collaborates with the State of Maryland Department of Health (MDH) to oversee the continuum of publicly funded behavioral health services in the city. The majority of PBHS services are reimbursed through a statewide Administrative Service Organization (ASO) where providers are paid on a fee-for-service basis for services provided to Medicaid recipients and uninsured persons. BHSB is tasked by the state with a range of activities in managing the PBHS at the local level including compliance activities on their behalf such as site visits to providers and investigating complaints, building and maintaining relationships with local system partners, identifying and pursuing activities to meet gaps within the system of care, general public education about how to access the public behavioral health system, and providing support to providers in delivering services to the people of Baltimore. While BHSB watches over the PBHS at the local level, the state holds the sole authority to regulate the provider network and add services to the benefit package for Medicaid recipients.

Summary of Approach

We used a mixed methods approach to identify public behavioral health system needs, gaps, and recommendations in the City of Baltimore. The project, which was reviewed and approved by the HSRI Institutional Review Board (IRB), consisted of three main elements:

- Gathering existing qualitative and quantitative data from available reports, presentations, and other documents identified by the leadership of BHSB and key informants that were interviewed. HSRI reviewed a total of 38 unique existing documents, presentations, summary reports, and spreadsheets containing information related to public behavioral health services and

supports in the city, Baltimore Police Department (BPD), or other state and local initiatives.

- Conducting semi-structured key informant interviews and focus groups with stakeholders throughout Baltimore and Maryland. Key informants consisted of managers, practitioners, and other key stakeholders. These key informants were all identified through snowball sampling. We began with the CPIC roster and then added additional individuals referred by BHSB and other key informants. A total of 166 individuals participated in key informant interviews or focus groups, including at least 48 public behavioral health service users or family members.
- Analysis of existing ASO data being collected by MDH. Specifically, for the years 2016-2018 we obtained: Medicaid, state-funded and uninsured claims data for behavioral health services for individuals residing within Baltimore City; Psychiatric State Hospital data for Baltimore City residents; and aggregate outcomes data reported for Baltimore City through the OMS DataMart maintained by MDH. We analyzed over 7 million claims from nearly 105,000 unique individuals served. Primary behavioral health services being provided at the managed care organization (MCO) level were not included in this dataset.
- To examine interactions with law enforcement during times of behavioral health crisis, we also obtained data from BPD on numbers of calls for services, numbers of calls related to behavioral health, types of behavioral health calls, Crisis Intervention Team (CIT) training status of responding officers, and summary descriptives of more detailed information that had been collected for a subset of behavioral health calls. In addition to the data from BPD, HSRI also conducted three focus groups at community organizations; these focus groups included 29 individuals who self-identified as having personally had a recent contact with Baltimore police during a time of behavioral health crisis.

Key Findings

Utilization Data

- Over the three years of data examined, the relative proportions of PBHS mental health services remained mostly stable. The exceptions were outpatient mental health services, which were steadily decreasing over time, and Psychiatric Rehabilitation Program (PRP) services, which were steadily increasing.
- The growth in PRP services should be explored further, with closer monitoring and oversight by BHSB to determine what is happening. It might suggest that such programs are proliferating, or existing programs have changed practices to serve more people, potentially at the expense of program quality.

- Community substance use disorder (SUD) services are steadily increasing, perhaps as a result of Medicaid expansion. Interestingly though, and for reasons that are unclear, uninsured individuals compose a higher proportion of those accessing core outpatient SUD services than Medicaid-covered individuals.
- Medication-assisted treatment (MAT) services remain very reliant on methadone. Although other MAT services (e.g., buprenorphine) have nearly doubled in terms of the number served since 2016 in the ASO data, these services appear to be underutilized, though the data available are incomplete.
- Relatively few individuals receiving services are reliant solely on high-cost emergency department or inpatient treatment (2.1%, or 1,433 people). Of those that do, nearly one third are Transitional Aged Youth (TAY) or under the age of 18, suggesting there is either a lack of community-based service options for these individuals or challenges connecting them with existing services. Nearly all individuals receiving services (97.9%) have some connection to community-based services. This does not imply that those services are adequately meeting the needs of these individuals, or that additional services may not be needed.
- Only 16% to 17% of the population served is accessing ED or inpatient services; most (84%) rely solely on community services. This does not imply that the community services are effective, sufficient, or crisis-responsive, but rather that it is a relatively small proportion of individuals who use services overall that access ED or inpatient services.
- Access to key services such as supported employment remains severely restricted (<1%).
- Individuals with co-occurring disorders are likely significantly underserved (17.3% receiving services for both vs. an estimated 30% in need).

Stakeholder Interviews

The key informants interviewed presented a picture of the Baltimore public behavioral health system as a relatively service-rich environment in terms of the numbers of programs and services compared to other areas of the state, with many strengths, but also a system facing many challenges. Many of the key stakeholders are already together at the table collaboratively attempting to address the challenges facing the system (e.g., the CPIC). Some of the gaps and needs identified by system stakeholders already have initiatives underway or in the planning stages to address key challenges; although these were known to the key informants, they stressed the need for more to be done.

HSRI staff entered interview summaries into qualitative analysis software, NVivo, where analysts coded and organized content by topic to facilitate synthesis across sources. The key informant findings presented do not represent a comprehensive inventory of everything that was heard during the interviews. Rather, the findings

present our analysis of the dominant themes across interviews which, combined with our other data sources, then informed our recommendations. We greatly appreciate all the information generously shared by all our key informants.

Looking across all of the interviews and across all services and topics, the following key takeaways were apparent:

- Neighborhoods need 24/7 access to community-based behavioral health services. Community-based, mobile crisis response teams that are not led by the police should be greatly expanded, and these teams need to be supplemented with crisis stabilization, community behavioral health clinics with 24/7 responsibility for crisis care (e.g., Certified Community Behavioral Health Clinics), or peer-run drop-in centers, as well as residential crisis and peer-led respite beds and other round-the-clock options that divert individuals from emergency departments and police contacts by providing alternative disposition options to inpatient care or jail for those still coming into contact with police. Enhancing these types of community-based services will greatly relieve the pressures currently observed on law enforcement and other first responders, emergency departments, and inpatient beds.
- Community education efforts need to be enhanced, with two main areas of focus: anti-stigma efforts targeting both providers and members of the public (and public education about mental health and SUD in general) and campaigns aimed at increasing awareness of service options and the resources for accessing them.
- There needs to be a continued focus on increasing the use of non-methadone MAT services. Also, while stakeholders indicated progress has been made in the adoption of harm reduction approaches, more efforts are needed to educate providers and the community in general about harm reduction.
- Peer services and consumer involvement at all levels (individual service planning through systems planning and oversight) need to be enhanced. Expansion of the formal certification processes (including exploration of exam-based certification that can test competencies) can help ensure a qualified peer workforce, critical for opening additional funding streams and overcoming provider resistance to peer services. There needs to be continued education of providers about Certified Peer Recovery Specialist (CPRS) roles and practices. Peers were widely viewed as bringing added value to Outreach and Navigator roles. Efforts need to be made to ensure there is more peer involvement in systems planning and oversight.
- Workforce development efforts need to continue to target trauma-informed care and enhanced cultural competence (e.g., working with Spanish-speaking or LGBTQIA community members), as well as providing person-centered individualized care.

- The following services also need to be increased: care coordination from the ED or inpatient at discharge, criminal justice reintegration, and community-based case management and systems navigation, including ACT.
- Monitoring and oversight of community-based services needs to be enhanced, with the widest variability in quality reported with PRPs and MAT programs.
- Additional services that need to be expanded include housing with supportive services, evidence-based supported employment programs, and prevention and early intervention efforts (such as Early Childhood Mental Health Consultation, or ECMHC, in the schools and other early childhood education sites).

Law Enforcement Crisis Interaction

The consent decree required the City to analyze a sample of police interactions with people with behavioral health disabilities to identify systemic barriers and solutions (a "root cause analysis"). HSRI attempted but was unable to obtain detailed individual level data about police interactions with people with behavioral health disabilities required for such analysis. This was because the data needed are not widely[2] or consistently[3] collected- and when collected, information is often missing[4] . While BPD is taking steps to collect these data through the development and piloting of a behavioral health reporting form, the piloting of the form with the CRT and in the Central District (the district with the highest percentage of CIT trained officers) means that the behavioral health contacts data that do exist are from the most highly-trained officers on the force and therefore are not likely to be representative of a typical behavioral health contact elsewhere in the city. In order to conduct the root cause analysis as called for in the consent decree, data on behavioral health contacts will need to be widely and consistently collected across the city to allow for a representative analysis, with the individual-level data from the forms made available to researchers so there can be direct follow-up with individuals involved in specific incidents for further exploration of precipitating or contributing factors. Access to such individual level data will also allow for advanced statistical analysis that can quantify the impact of factors such as race, age, gender identity, service utilization, and more on incident outcomes.

HSRI was able to obtain dispatch data as well as aggregate summaries of the behavioral health forms that do exist, and also conducted focus groups with individuals who identified as having had a recent contact with BPD during a time of behavioral health crisis to attempt to learn more about these interactions, despite the limitations of the data and inability to conduct the root cause analysis as initially intended. The dispatch data, behavioral health forms, and focus groups with

[2] BH contact specific information is collected for CRT responses city-wide and for non-CRT behavioral health calls in only one of nine districts

[3] It is estimated that these data are only being collected for a third of the behavioral health contacts that occur

[4] For example, nearly 30% of the forms completed have no information related to training of the responding officer

individuals with lived experience identified a number of key takeaways related to law enforcement interactions with individuals during a time of behavioral health crisis:

- The lack of data available hampered the ability to conduct a detailed root cause analysis, though some data were able to be obtained. Data need to be more widespread and consistently collected on law enforcement contacts with individuals experiencing a behavioral health crisis.
- There needs to be deeper exploration into reasons that CIT-trained officers are not responding at higher rates to what are clear behavioral health calls (e.g., emergency petitions). Even in the district targeted with training efforts, many calls are responded to by non-specialty officers.
- Officer training efforts need to be ongoing. Intensive behavioral crisis training should be occurring with all officers. All officers need exposure to advanced behavioral health training, and training must be sure to include trauma and working with subpopulations such as the LGBTQIA community as well.
- There needs to be access to, awareness of, and further development of community-based alternatives to emergency departments, such as residential crisis beds and other diversion services within the system of care, such as 24/7 mobile crisis for adults and youth that operates as true mobile crisis (e.g., response at the client's location, within an hour of the client's call for service).
- Officers need to interact with individuals in the manner they themselves would like to be treated during a time of distress. This would mean treating all individuals encountered with respect and understanding, and not immediately discounting information shared simply because an individual has a behavioral health disorder.

Despite the best efforts of the system, there will still inevitably be contacts with police at times for individuals experiencing behavioral health crisis—even with a full continuum of community-based crisis services. It is critical that police officers be better prepared for such contacts, so that the individuals in crisis and the officers, family members, and other individuals responding to it are not at risk of further traumatization from the act of seeking help.

Outcomes

The HSRI team examined publicly available aggregate outcome data from the OMS DataMart from 2016, 2017, and 2018 for Baltimore City residents; individual level data could not be obtained within the timeframe of this assessment. It is important to note that the outcome data that were available were not collected from all individuals served, only those being served by certain types of providers, though those providers represent a large proportion of those submitting claims data. Consequently, the data may not represent the effectiveness of the entire system and all the services within; however, they do provide insight into how part of the system is working.

The available data, while limited, hint at a system that is making some progress in some areas, such as increasing independent living[5] while reducing institutional[6] settings and showing some possible gains in decreasing the criminalization of behavioral health disorders[7], but that is struggling to effect consistent change in the ultimate desired outcomes of increasing functioning[8], increasing perceived level of recovery[9], and helping people return to work[10], a key recovery and community integration outcome.

Recommendations

The following tables present a summary of recommendations based on key informant interviews and analysis of qualitative and quantitative data. Please note that ongoing efforts and initiatives may already be addressing some of these recommendations, in which case it is recommended those efforts are continued and expanded. Recommendations are grouped according to the topic area of the recommendation. It should be noted that the main body of the report spells out recommendations in much greater detail. Please also note that the "Suggested Lead Party" is merely our initial suggestion for who might be best positioned to lead efforts related to a particular recommendation; the leading party and others involved would be officially determined during subsequent implementation planning efforts.

Key (in order of appearance): **BHSB**= Behavioral Health System Baltimore; **BHA**= Behavioral Health Administration, Maryland Department of Health; **BPD**= Baltimore Police Department; **CPIC**= Collaborative Planning and Implementation Committee; **PHS**= Non-profit and for-profit Health Systems; **MHA**= Maryland Hospital Association; **UMD**= University of Maryland; **HUD**= U.S. Department of Housing and Urban Development; **HABC**= Housing Authority of Baltimore City; **MOHS**= Mayor's Office of Homeless Services

[5] For 2016-2018, "Independent" living situation increased from 80.6% to 81.1% for those receiving mental health (MH) services, 77.0 to 80.5% for SUD, and from 66.6% to 72.3% for individuals receiving both MH and SUD services.

[6] For 2016-2018, "Institutional" living situation went from 1.1% to 0.7% for MH services, 0.5% to 0.7% for SUD, and from 1.5% to 1.0% for both MH and SUD.

[7] For 2016-2018, arrests in last 6 months decreased from 4.6% to 4.3% for MH services, 7.4% to 4.8% for SUD, and from 6.9% to 4.8% for both MH and SUD services; in jail or prison in last 6 months declined from 3.9% to 3.4% for MH, 7.4% to 4.6% for SUD, and from 6.3% to 4.6% for both MH and SUD services.

[8] A decrease for one population and small increases for two others: For 2016-2018, "Functioning" overall score from 3.02 to 2.96 for MH, 2.41 to 2.44 for SUD, 2.66 to 2.73 for both MH and SUD.

[9] A slight increase for one population and decreases for two: For 2016-2018, "Recovery (MARS-5)" overall score went from 3.37 to 3.43 for MH, 3.93 to 3.85 for SUD, 3.71 to 3.59 for both MH and SUD.

[10] An increase for one population and decreases for two: For 2016-2018, "Currently Employed" rose from 15.9% to 18.4% for MH and went from 20.7% to 19.1% for SUD, 12.4% to 12.2% for both MH and SUD.

Crisis Services

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Follow the recommendations made in the June 2019 Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System (includes 24/7 crisis centers, expansion of mobile crisis teams)	Short and long term	BHSB
Adopt a Crisis Service System Model	Short term	BHSB
Adopt a least restrictive setting/care framework for planning expansion of crisis services	Short term	BHSB
Establish community providers as part of the crisis service continuum	Short and long term	BHSB, BHA
Consider expansion at the mid-level of crisis service intensity	Short and long term	BHSB
Explore implementation of an "Air Traffic Control" system for crisis service management	Short term	BHSB
Improve the quality of law enforcement interactions with individuals experiencing a behavioral health crisis	Short and long term	BPD

Law Enforcement Interactions During Behavioral Health Crisis

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
There needs to be consistent collection of detailed encounter data for all behavioral health contacts by all officers in all districts of the city	Short and long term	BPD
Conduct deeper exploration into the reasons CIT-trained officers are not responding to behavioral health calls at higher rates	Short term	BPD
Make officer training efforts an ongoing process, with all officers receiving advanced behavioral health training	Short and long term	BPD
Ensure that officers are aware of and using existing community-based alternatives to EDs such as residential crisis beds, and other diversion services need to be developed within the system of care	Short and long term	BPD, BHSB
Officers need to interact with individuals in the manner they themselves would like to be treated during a time of distress. This would mean treating all individuals encountered with respect and understanding, and not immediately discounting information shared simply because an individual has a behavioral health disorder	Short and long term	BPD

Data Systems

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Require collection of key outcome measures for all PBHS services	Short term	BHSB, BHA

Expand efforts of law enforcement in the collection of data related to behavioral health crisis	Short and long term	BPD
Leverage any community crisis coordination system to enhance data collection related to community crisis services	Short and long term	BHSB

Implementation and Oversight

RECOMMENDATION AND STEPS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Develop a comprehensive implementation plan	Short term	BHSB, CPIC
A. Form an oversight steering committee to coordinate with key stakeholder groups	Short term	BHSB, CPIC
B. Establish work groups to address common themes identified in this report	Short term	BHSB, CPIC
C. Draw upon research in the field of implementation science	Short term	BHSB, CPIC

Systems Integration

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Promote a “No Wrong Door” approach	Short and long term	BHSB, PHS, MHA
Consider the care coordination model as a framework to guide strategic planning for promoting system integration	Short and long term	BHSB, CPIC
Promote integration of mental health and substance use services and workforce	Short and long term	BHSB, PHS, MHA
Support and coordinate efforts to enhance availability of behavioral health outpatient services in primary care	Short and long term	BHSB, BHA, PHS, MHA
Consider shifting resources from poor-quality programs to more effective services	Short and long term	BHSB, BHA

Workforce

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Address workforce recruitment, retention and competency	Short and long term	BHSB, BHA
A. Explore strategies to attract and retain qualified providers to work in community-based mental health settings	Short term	BHSB, BHA
B. Explore opportunities for funding workforce training presented by the community benefits requirements for nonprofit hospitals	Short term	BHSB, BHA, PHS, MHA

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
C. Ensure that frontline providers have the necessary training, qualifications, supervision, and support to 1) engage and support individuals with complex needs and 2) understand the nature of trauma and provide trauma-informed care, and 3) de-escalate crises so that BPD needs to be called into fewer crisis situations	Short and long term	BHSB, BHA, PHS, MHA
D. Explore additional training and supervision regarding respect for the dignity of consumers	Short and long term	BHSB, BHA
E. Work with local training programs, colleges, and universities to support work in community behavioral health as a career choice	Short and long term	BHSB, BHA, Johns Hopkins, UMD, Etc.

Peer Support

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Support the financial sustainability of peer-run organizations through a variety of funding streams	Short and long term	BHSB, BHA
Work with the state, other funders (e.g., public and private foundations), and local partners, private insurers, and other offices and departments to develop additional funding streams for peer-delivered services	Short and long term	BHSB, BHA, Foundations
Create a strategy to increase public awareness of peer-delivered services	Short term	BHSB, BHA
Support current local and statewide efforts to strengthen the peer support workforce	Short term	BHSB, BHA, PHS, MHA
Support and enhance efforts for formal exam-based certification for peer support	Short term	BHSB, BHA
Reduce ambiguity around peer roles within the system through training to ensure providers and administrators have adequate understanding of the peer role	Short and long term	BHSB, BHA, PHS, MHA
Work with provider communities to expand professional development for peer support workers.	Short and long term	BHSB, BHA, PHS, MHA

Community Education

RECOMMENDATIONS	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Enhance information about how to access behavioral health services	Short and long term	BHSB
Continue with and expand anti-stigma campaign efforts	Short and long term	BHSB

Social Determinants of Health

RECOMMENDATION	STRATEGY TIMEFRAME	SUGGESTED LEAD PARTY/PARTIES
Build on the community health benefit requirements for nonprofit hospitals	Short and long term	BHSB, BHA, MHA
Coordinate with HUD housing programs for people with disabilities	Short and long term	BHSB, BHA, HUD, HABC
Increase the availability of housing vouchers and subsidies	Short and long term	BHSB, BHA, HUD, HABC, MOHS
Enhance efforts related to landlord engagement and education to combat stigma and increase the availability of units	Short and long term	BHSB, BHA, HABC, MOHS
Ensure that Permanent Supportive Housing (PSH) program models are being implemented with fidelity	Short and long term	BHSB, BHA, HABC, MOHS

Background and Approach

Introduction

HSRI was selected through a competitive contracting process to conduct a public needs and gaps analysis of the public behavioral health system in the City of Baltimore. The goal of the analysis was to identify possible areas for improvement in the current system, especially those that might help individuals to avoid contacts with law enforcement during times of behavioral health crisis.

Contextual Information

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority for Baltimore City. BHSB provides leadership in advancing behavioral health and wellness and helps guide innovative approaches to prevention, early intervention, treatment, and recovery. BHSB works to build an efficient and responsive system that comprehensively addresses the needs of individuals, families, and communities impacted by mental illness and substance use by expanding the reach and quality of the public behavioral health system, promoting the development of new and innovative services, and addressing specific population and system-level needs.

In its role as the local behavioral health authority, BHSB collaborates with the State of Maryland Department of Health (MDH) to oversee the continuum of publicly funded behavioral health services in Baltimore City. The majority of public behavioral health system (PBHS) services are reimbursed through a statewide Administrative Service Organization (ASO) where providers are paid on a fee-for-service basis for services provided to Medicaid recipients and uninsured persons. BHSB is tasked by the state with a range of activities in managing the public behavioral health system at the local level including compliance activities on their behalf such as site visits to providers and investigating complaints, building and maintaining relationships with local system partners, identifying and pursuing activities to meet gaps within the system of care, general public education about how to access the public behavioral health system, and providing support to providers in delivering services to the people of Baltimore. While BHSB oversees the system at the local level, the state holds the sole authority to regulate the provider network and add services to the benefit package for Medicaid recipients. In addition to overseeing the larger fee-for-service system, BHSB secures and directly awards public and private funds to support the development of innovative programs and the ongoing operations of behavioral health services not reimbursable by the larger fee-for-service system. In Fiscal Year (FY) 2018, BHSB awarded approximately $58 million in grants, with 332 contracts issued to 191 providers and consultants.

Consent Decree

In April 2017, the City of Baltimore entered into a consent decree with the U.S. Department of Justice (DOJ) to address the DOJ findings related to the Baltimore Police Department's patterns and practices that violate the U.S. Constitution and federal law. The decree's overall requirements address "building community trust, creating a culture of community and problem-oriented policing, prohibiting unlawful stops and arrests, preventing discriminatory policing and excessive force, ensuring public and officer safety, enhancing officer accountability and making needed technological upgrades."[11] One section of the decree dealt specifically with response to behavioral health crises, whereby the City agreed "to conduct an assessment to identify gaps in the behavioral health service system, recommend solutions, and assist with implementation of the recommendations as appropriate."[12] The assessment was to be conducted in collaboration with the Collaborative Planning and Implementation Committee (CPIC), which was formed previously to develop Crisis Intervention Training for the city and was expanded in its membership and functions under the consent decree. The assessment was required to analyze a sample of police interactions with people with behavioral health disabilities in order to identify systemic barriers and solutions, and to identify gaps in behavioral health services, problems with the quality or quantity of existing services, and other unmet needs that in turn can lead to preventable criminal justice system involvement. This report, produced by the Human Services Research Institute in consultation with the Technical Assistance Collaborative, is the result of that agreement.

Collaborative Planning and Implementation Committee

The Collaborative Planning and Implementation Committee (CPIC), as reconstituted under the consent decree, includes representatives from the behavioral health community, criminal justice organizations, health care providers, consumers, family members, advocates, and philanthropists. Original members and co-chairs are the City of Baltimore, acting through the Mayor's Office of Human Services (MOHS), the Baltimore Police Department (BPD) and BHSB. An additional 27 organizations were initially invited to join, but participation has expanded to encompass more than 60 organizations. The CPIC holds monthly meetings that are open to the public (CPIC, Summary of Memorandum of Agreement).

The CPIC is required to review police policies that impact people with behavioral health disorders, establish a system for data collection related to crisis encounters, address Crisis Intervention Team (CIT) training requirements, and conduct a gap analysis including a sample of BPD interactions in behavioral health. The consent decree specified that the data system include information on what precipitated the crisis, what services could have prevented the crisis, how police became involved, how the response to the crisis could be improved, and what could be done to prevent the

[11] U.S. Department of Justice v. Police Department of Baltimore City, Consent Decree, https://consentdecree.baltimorecity.gov

[12] Ibid

crisis in the future. The gaps and needs analysis was to identify gaps including availability of Assertive Community Treatment, permanent supportive housing, targeted case management, crisis services, and substance use disorder services among other community services, as well as to identify problems with the quality and quantity of existing services.

A first-year work plan for the CPIC, corresponding to the Milestones and Deliverables outlined in the consent decree and the First Year Monitoring Plan (MP), identified the tasks for which the CPIC was responsible.[13] These tasks fell under five general goals, each with specified action steps, responsible parties, deliverables, and timelines. The goals are:

1. Complete a Work Plan "with goals, objectives, and appropriate timelines."
2. Complete a Gap Analysis to "identify gaps in the behavioral health service system, recommend solutions, and assist with implementation of the recommendations, as appropriate."
3. Revise BPD policies related to crisis response and dispatch to ensure they are in line with community concerns and language in the consent decree.
4. Develop and implement a Crisis Intervention Plan to ensure that a CIT officer is available to respond to all calls and incidents that appear to involve an individual in crisis.
5. Develop a Crisis Data Form to capture relevant data points as outlined in the consent decree.

The finalized first year work plan was approved by the Department of Justice Monitoring Team on August 1, 2018.[14]

To carry out these tasks the CPIC initially formed three subcommittees: Policy, Data, and Gaps Analysis. A fourth committee, Training and Implementation, was added in 2019.

[13] Collaborative Planning and Implementation Committee, 2018, Behavioral Health Disabilities and Crisis Work Plan.

[14] Collaborative Planning and Implementation Committee, 2018, Notice of Approval of Work Plan for Accomplishing Consent Decree Objectives Regarding Interactions with Individuals with Behavioral Health Disabilities and In Crisis

The following sections summarize some of the key points from the 38 existing documents and reports related to Baltimore's public behavioral health system that the HSRI team reviewed. Summaries are provided for those viewed as most relevant to the gaps and needs analysis.

Reports from Behavioral Health System Baltimore

In March 2017, BHSB produced a report on strategic goals for the period from 2017 to 2020.[15] The plan identified five priority areas:

1. Comprehensive and Quality Public Behavioral Health System
2. Community Structures that Support Prevention, Trauma-Responsive Approaches and Resilience
3. Behavioral Health in All Policies
4. Using Data to Support Practice
5. Organizational Development

For each priority area, the report specified a set of goals, objectives, and measures. The following are the objectives most relevant to this report:

- Objective 1-a: Decrease in use of emergency rooms for mental health and substance use disorder services by establishing a pilot program for stabilization services
- Objective 1-c: Increase diversion from the criminal justice system
- Objective 6-a: Reduce the criminalization of behavioral health disorders by partnering with other systems and stakeholders to change existing policies and practices and implement new ones that divert individuals with behavioral health disorders from the criminal justice system

A follow-up report, produced in February 2019 and revised in March, provided an update on progress toward these goals as well as data on prevalence, utilization and expenditures in FY 2018.[16]

PREVALENCE

The FY2018 report provides prevalence data drawn from the SAMHSA National Survey of Drug Use and Health (NSDUH) 2014-2016, the CDC's Youth Risk Behavior Surveillance System (YRBSS) 2017, the 2016 Maryland Behavioral Risk Factor Surveillance System (BRFSS), and the 2013-2017 American Community Survey 5–Year Estimates from the U.S. Census Bureau. Notably, 17.8% of Baltimore City residents are estimated to have had any mental illness in the past year and 3.5% to have had a serious mental illness. Prevalence of alcohol use disorder in the adult

[15] Behavioral Health System Baltimore, Three Year Strategic Plan: 2017 – 2020.
[16] Behavioral Health System Baltimore (2019). FY 2018 Activities, Behavioral Health Indicators and System Utilization.

population is estimated to be 8.5% and it is 10.7% for illicit drug use in the past year. For youth, the percentage of high school students who seriously considered attempting suicide in Baltimore City was higher (19.2%) than the national rate (17.2%), and likewise with substance use for all but alcohol (56.1% for Baltimore City compared to 60.4% for US); for example, the percentage of high school students who ever used heroin is 7.6% for Baltimore City compared to 1.7% nationally. BHSB gives considerable attention to the prevalence of adverse childhood experiences (ACEs) given the demonstrated relationship to a variety of behavioral health issues. Data on ACEs are collected through the BRFSS, which indicates that the prevalence of three or more ACEs for Baltimore residents is 24%.

Reports on Maryland and Baltimore Crisis Services

Crisis service systems in Maryland and specifically in Baltimore have been the subject of a number of analyses and reports in support of improvement initiatives. The following is a brief summary of these.

In 2002, the Maryland General Assembly passed legislation establishing the Maryland Mental Health Crisis Response System (CRS). The proposed system, however, was contingent on federal funding that failed to materialize; consequently, this ambitious plan was never carried out. In 2015, this legislation was revised to create a Behavioral Health Crisis Response System that would not be dependent on federal funding, and in 2016, the General Assembly required the Maryland Behavioral Health Advisory Council to develop a strategy for establishing a statewide network of 24/7 walk-in and mobile crisis services.[17]

The Advisory Council's report, produced in November 2017, begins with an environmental scan that reviewed national models and the current status of Maryland's crisis service system including the distribution among jurisdictions of types of crisis services and utilization. On the basis of the scan, the Council identified six "key gaps":

- Parity of services across jurisdictions
- Adequate attention to substance use disorders
- Sustainability of programs with existing funding
- Staffing, including certified peers, retention of professional staff, and funding constraints
- Public information about available services
- Coordination across the system

The report identified a number of challenges standing in the way of addressing these gaps:

[17] Maryland Behavioral Health Advisory Council (2017). Strategic Plan: 24/7 Crisis Walk-in and Mobile Crisis Team Services)

- Uncertainty around Medicaid funding
- Barriers to individuals with commercial insurance from accessing crisis services
- Restrictive procedural requirements related to emergency mental health evaluations
- Recruitment and retention of staff
- Need for additional training related to emerging populations
- Need for language translation access and cultural competence
- Challenge of Maryland's geography

Despite these challenges, the report offered a variety of strategies[18] to address the gaps, with options for regional organizational structures to support economies of scale and a summary of needed service enhancements broken down by jurisdiction, along with budget estimates.

Continuity of Care Advisory Panel

Convened by Former Maryland Governor Martin O'Malley, the Continuity of Care Advisory Panel (CCAP) was charged with examining barriers to continuity of care—economic, social, legal, and clinical —and making recommendations to "strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care."[19] The CCAP convened six public hearings in 2013, and established four workgroups, each of which was responsible for addressing one of the four barriers to continuity of care. The report made 25 recommendations to address deficiencies in the following areas: 1) accessibility of mental health records; 2) services to address the needs of individuals with serious mental illness; 3) workforce training; 4) mental health literacy; 5) additional areas for research (workforce shortage, telemedicine, language barriers); 6) delegated decision making; 7) services for court-involved individuals; and 8) involuntary commitment.

Most relevant to this report are the three recommendations under the topic of involuntary commitment:

- Recommendation 23: The Department of Health and Mental Hygiene (DHMH; now known as Maryland Department of Health, or MDH) should promulgate regulations defining dangerousness to promote consistent application of this standard throughout the health care system.
- Recommendation 24: To further ensure consistency, DHMH should develop and implement a training program for health care professionals regarding the

[18] https://bha.health.maryland.gov/Documents/The%202017%20Strategic%20Plan%2024-7%20Crisis%20Walk-in%20and%20Mobile%20Crisis%20Team%20Services.pdf

[19] Continuity of Care Advisory Panel (2014). Report of the Continuity of Care Advisory Panel.

dangerousness standard as it relates to conducting emergency evaluations and treatment of individuals in crisis. Training should also be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.

- Recommendation 25: The Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland. As part of this process, the workgroup should develop a proposal for an outpatient civil commitment program.

The Maryland Crisis Hotline (MCH) Operations Workgroup

The Maryland Crisis Hotline Operations Workgroup was established by the Behavioral Health Administration (BHA) to develop recommendations defining the purpose of the Crisis Hotline, what services it should provide, how it should be structured, and how it should function. The Workgroup met four times in 2017 and produced a Final Report in July 2017, which offered a set of recommendations for the development and operation of the hotline. Recommendations were separated into two categories: those specific to the operations of the MCH and those related to the overall access and availability of services in the system of care. In the operations category several recommendations involved further action by MCH subcommittees: to investigate evidence-based screening tools and to analyze data collection processes. Other operations recommendations concerned functions of the MCH, such as the type of information that would be provided to callers and how the MCH would be publicized. Regarding the system of care, recommendations were related to expansion of mobile crisis teams and walk-in crisis centers across the state.[20]

Baltimore Crisis Response System Plan

In 2018, BHSB produced a report providing a plan to address the gaps within the crisis response system in the city; the document was finalized in 2019.[21] The report is organized according to a conceptual framework that identifies three levels of crisis based on degree of urgency:

1. **Emergency**: Services are accessible immediately, defined as within one hour
2. **Crisis – Urgent**: Services are accessible within 24 hours
3. **Crisis – Non-Urgent**: Services are generally accessible after 24 hours

The report offered a variety of recommendations for enhancement of the Baltimore crisis service system:

- Establish locations other than the EDs that can process emergency petitions

[20] Maryland Crisis Hotline Operations Workgroup (2017). Final Report
[21] Behavioral Health System Baltimore (2019). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System.

- Establish Urgent Behavioral Health Clinics
- Implement Open Access or same-day scheduling in existing outpatient programs
- Provide on-call services for Medicaid-enrolled clients using existing but little-used billing codes for crisis services
- Assess need for expansion of residential crisis units
- Assess need for more inpatient and outpatient withdrawal management, including services for persons with serious mental illness
- Determine need for increased respite services for youth
- Partner with peer organizations to develop peer-run respite programs
- Conduct Sequential Intercept Mapping to assess criminal justice–mental health partnership resources, gaps, and opportunities
- Improve crisis system coordination to track provider availability and individuals' progress
- Develop protocols for high-risk individuals
- Implement high-utilizers program

Emergency Department Overcrowding and Wait Times

Overcrowding and delays in hospital emergency departments (EDs) point to a need to improve the crisis response system, and Maryland has investigated these problems on several fronts. In 2016, the Maryland Hospital Association conducted an analysis of the causes of diversions and excessive wait times for admissions to the state's hospital emergency departments and issued a report with recommendations for improvement.[22] Maryland's wait times (median time between ED arrival and departure for admitted patients) have increased between 2013 and 2015 and are among the highest in the nation. The factors contributing to this problem consist of a complex mix of systemic shortcomings, population-related factors, and consequences of improvement in quality and access:

- **The state's behavioral health crisis**. Behavioral health patients often stay in the ED longer (typically 12 hours vs. 9 hours for non-behavioral health visits). The number of ED visits by individuals with a behavioral health diagnosis rose by 18% between 2013 and 2015, while visits by patients *without* a behavioral health diagnosis fell by more than 5%.
- **The opioid crisis**. This crisis has resulted in increased admissions, and the time in the ED for these patients has been extended by quality of care

[22] Maryland Hospital Association Emergency Department Diversions, Wait Times: Understanding the Causes

improvements such as additional screening, education, and coordination with peer counselors.

- **Medicaid expansion**. Policymakers predicted that Medicaid expansion would reduce ED utilization as beneficiaries sought treatment in primary care; however, studies indicate that those with Medicaid use the ED more than those without coverage.
- **Non-emergent patients seeking care in the ED**.
- **A nationwide nursing shortage**.
- **Care redesign and delivery transformation**. Maryland's All-Payer Model requires the state's hospitals to reduce unnecessary inpatient admissions and readmissions and to use the associated savings to improve the care of individuals outside the hospital. These requirements bring about positive benefits but add to the time it takes to assess, treat, and transfer or discharge patients.

Another report, this one from the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Health Services Cost Review Commission (HSCRC) in December 2017, reviewed the cause and possible approaches to address the overcrowding in Maryland hospital emergency departments.[23] The report identified the following as factors that are exacerbating the problem of overcrowding:

- An increase in behavioral health patients treated at EDs, including overdose patients
- Continuing staff shortages that affect hospital EDs
- Increased patient care requirements in EDs
- Increasing numbers of EMS transports in some EMS jurisdictions coupled with limited options for alternative modes of treatment other than EDs
- A misalignment of hospital reimbursement and EMS reimbursement policies

One issue that received particular attention was the area's Yellow Alert system, which is a protocol for hospitals to divert admissions to other EDs when experiencing overcrowding. The report noted differences of opinion on the utility of this mechanism, with some suggesting it is useful and others that it only exacerbates the problem.

The report identified two strategies to incentivize hospitals to improve ED efficiency: 1) adding an ED performance measure in the Quality-based Reimbursement program; and 2) requesting hospital efficiency improvement action plans from hospitals that have poor ED performance measures.

[23] Maryland Institute for Emergency Medical Services Systems (2017). Joint Chairmen's Report on Emergency Department Overcrowding.

In addition, the report proposed a set of actions by MIEMSS designed to reduce the extent of ED overcrowding:

- Continue to develop new models of EMS care delivery and assess their utility in reducing ambulance transport of low-acuity patients to hospital EDs
- Incorporate/engage hospitals to participate in new care delivery programs under the State's Enhanced Total Cost of Care All-Payer Model, including the possibility of shared savings
- Work with the Maryland Department of Health to identify potential opportunities for changes in the Medicaid program to reimburse EMS for new models of service delivery
- Determine whether the use of Yellow Alerts should be discontinued
- Work with EMS jurisdictions to identify a reasonable standard time for ambulance off-load (the time between the arrival of an ambulance-transported patient and the time that the patient is moved off the EMS stretcher)

Comprehensive Crisis Center

The Comprehensive Crisis Center (CCC) Planning Group was convened in January 2018 by the Behavioral Health Administration for the purpose of developing a plan to establish a 24/7 Comprehensive Crisis Response Center (CCRC) for individual behavioral health needs.[24] The Planning Group membership included representatives of the BHA, BHSB, health care systems, MIEMSS, Medicaid, Maryland Hospital Association, Baltimore City Fire Department, and BPD.

The Planning Group reviewed previous reports and data on ED admissions provided by the Maryland Hospital Association to assess the need for a CCRC. The Group also developed a set of principles and recommendations regarding the population to be served, the type of services to be provided, the preferred location, and a budget. According to Maryland Hospital Association data for 2016, 25,890 individuals in Baltimore City were admitted to EDs with a behavioral health diagnosis. Alcohol and substance use disorders accounted for 44% of the admissions, and psychotic and mood disorders for 30%. The data also indicated that 39% of all ED visits were for non-emergency behavioral health issues.

The Planning Group found that there was no solid data regarding the percent of admissions that were emergency petitions. A goal for the planning group is that the CCRC would be the optimal location for receiving emergency petition admissions; however, that will require changes in policy and regulations.

The Planning Group recommended that the CCRC be located separately from, but near to, a community hospital. Recommendations for staffing included on emphasis on the inclusion of peers. The CCRC would not include extended-stay observational beds, which would be provided by other community programs. The Final Report

[24] Caravan Consulting (2018). Comprehensive Crisis Center Planning Group Recommendations.

included a variety of other recommendations such as protocols for treatment, coordination with community services, and relationships with hospital EDs.

Summary of Our Approach to the Needs & Gaps Analysis

Methods

HSRI used a mixed methods approach to identify public behavioral health system needs and gaps in Baltimore City, and to develop recommendations for improvements. The project, which was reviewed and approved by the HSRI Institutional Review Board (IRB), consisted of three main elements:

- Gathering existing qualitative and quantitative data from available reports, presentations, and other documents identified by BHSB leadership and key informants (see next bullet) interviewed for the study. 38 documents were reviewed.
- Semi-structured key informant interviews and focus groups with stakeholders throughout Baltimore and Maryland. Key informants consisted of administrators and program managers, practitioners, and other key stakeholders including people and families with lived experience with mental illness and substance use. (Appendix G presents a list of the organizations that key informants represented and the roles they held.) Key informants were all identified through snowball sampling. We began with the CPIC roster and then added additional individuals referred by BHSB and other key informants. A total of 166 individuals participated in key informant interviews or focus groups, including at least 48 public behavioral health service users or family members.
- Analysis of existing data collected by MDH. Specifically, we obtained: behavioral health–related claims data for the years 2016-2018 for individuals residing in Baltimore City; State Hospital data for 2016-2018 for Baltimore City residents; and aggregated outcomes data for 2016-2018 reported for Baltimore City through the OMS DataMart maintained by MDH. We analyzed over 7 million claims from nearly 105,000 unique individuals served. Primary behavioral health services being provided at the managed care organization (MCO) level were not included in this dataset.
- To examine interactions with law enforcement during times of behavioral health crisis, we also obtained data from BPD on numbers of calls for services, numbers of calls related to behavioral health, types of behavioral health calls, Crisis Intervention Team (CIT) training status of responding officers, and summary descriptives of more detailed information that had been collected for a subset of behavioral health calls. In addition to the data from BPD, HSRI also conducted three focus groups at community organizations; these focus

groups included 29 individuals who self-identified as having personally had a recent contact with Baltimore police during a time of behavioral health crisis.

HSRI staff entered all qualitative data into qualitative analysis software, NVivo, where analysts coded and organized content by topic to facilitate synthesis across sources. We consider the feedback of service users to be just as important as that of other key stakeholders; consequently, all interview and focus group data were analyzed and summarized together regardless of key informant role. Analyses of claims and other data were conducted with SQL. Summary quantitative data was imported into programs such as Excel, which were then used to create quantitative data displays.

The key informant findings presented do not represent a comprehensive inventory of everything that was heard during the interviews. Rather, the findings present our analysis of the dominant themes across interviews which, combined with our other data sources, informed our recommendations. We greatly appreciate all the information generously shared by all our key informants.

Estimation of Beds or Treatment Slots

"What is the appropriate number of psychiatric inpatient beds required to adequately serve a given population?" or "Is there an empirically-based metric for number of beds requited per 100,000 population?" are questions frequently asked by policy makers, managers, advocates and providers. Similar questions about the required number of ACT teams, outpatient therapy slots, medical management providers, housing units, etc. often arise as well.

In HSRI's work with municipalities, counties, and states conducting needs assessments and gap analyses to support behavioral health system change and improvement, we have found that this question "How many slots are needed?" is less useful than some alternative planning approaches for the following reasons

1) There is no reliable and valid empirical evidence to determine the "right" number of treatment slots, including inpatient beds, ACT teams or other services. What is available instead are wide ranges of recommendations that vary depending on the perspective of the parties offering them.
2) The components of behavioral health service systems are inter-related, though again in ways that are not readily measurable. There is substantial evidence, for example, that ACT teams reduce inpatient utilization (and therefore bed needs) but the evidence for the magnitude of that relationship is highly variable, depending on a number of factors such as previous utilization rates, population characteristics, program fidelity (e.g. to ACT or Mobile Crisis models), etc.
3) Related to #2, every service system is different. The supply of services at each point along the continuum of care typically varies considerably from one system to another. System A may be heavily dependent on involuntary treatment, in which case an increase in crisis services is indicated, whereas other systems may be experience bottlenecks in psychiatric ED visits, in which case more beds may be needed. While the necessary elements of an adequate

continuum of care are well established (notably SAMHSA' "Good and Modern Behavioral Health System" and the ASAM levels of care criteria for substance use treatment), the appropriate capacity of each element in the continuum as yet lacks empirical evidence and, in any case, varies depending on local circumstances.

4) Recommendations about service capacity are influenced by the values of various constituencies. To the extent that ACT teams and peer-run crisis centers may function as substitutes for one another, preferences may legitimately differ depending on perspectives and experience.
5) Because community-based services are preferable to inpatient hospitalizations, are less expensive, and reduce in-patient utilization, it is appropriate to first ensure robust community-based services (e.g. mobile crisis, ACT, supported housing) before evaluating the need for additional psychiatric inpatient beds.

Local stakeholders generally have a good sense of where the need is greatest in a behavioral health system, and these needs are summarized in the Stakeholder Interview findings. The summary includes any suggestions offered by stakeholders as to the capacity needed for any service, (e.g., "It was suggested that there should be at least one mobile crisis team active for each BPD district".) HSRI suggests that the service needs identified within the report be used as a starting point for further discussions with stakeholders during implementation planning, at which point broad ranges rather than precise numbers may be identified and which may then be further refined in subsequent planning efforts based on a variety of considerations. Based on our experience with needs assessment in the public sector, such an approach is more conducive to successful system change than a simple prescription for number of slots in varying treatment modalities.

Data Sources

Below, we further describe our sources of data.

EXISTING DOCUMENTS

BHSB staff and key informants we interviewed identified and sent us a total of 38 unique existing documents, presentations, summary reports, and spreadsheets containing information related to public behavioral health services and supports in the city, BPD, or other state and local initiatives. Appendix C contains a list of these documents.

KEY INFORMANT INTERVIEWS

A kick-off meeting with BHSB was held on October 24, 2018. HSRI IRB approval was obtained on November 14, 2018. In subsequent discussions with the MDH Behavioral Health Administration about the process of getting data use agreements in place post HSRI IRB approval, in late November/early December, it was learned that contrary to initial guidance the project would need to seek IRB approval through MDH before data collection could begin. We submitted a vetted, expedited review to them on December 17, 2018, and learned on January 11, 2019 that the project was exempt from

review. Recruitment of key informants began early the following week, on January 15, and ceased on April 29. Please refer to Appendix E for a copy of the Key Informant Interview Guide used for these semi-structured interviews.

During the interviewing process, the research team attempted to contact and schedule interviews with a total of 163 stakeholders identified as possible key informants. At least three attempts were made to contact each individual. Of those 163, 118 individuals were successfully reached and interviewed—representing a response rate of 72.4%. There were 31 individuals who either did not respond or were unable to schedule a time to participate during the project timeframe; 14 individuals declined to participate. Nearly all key informants were interviewed by phone, though some in-person interviews did occur while we were in Baltimore for service user and family member focus groups.

We also conducted key informant focus groups in person throughout the city, held in February 2019 and April 2019. We held seven focus groups with a total of 48 public behavioral health system service users or family members. Participants were given $15 cash compensation for their time. Focus groups were held at NAMI Metro, H.O.P.E., B'more Clubhouse, Organization of Hope, Disability Rights Maryland, Hearts and Ears, and the On Our Own Charles St. Center.

CLAIMS AND OUTCOME DATA

Given that the majority of PBHS services are reimbursed through a statewide fee-for-service system,[25] we focused on claims data from the Maryland Department of Health for insight into utilization patterns, analyzing behavioral health claims for Baltimore City residents in the years 2016 through 2018. We received 7,119,765 claims records for 104,710 unique individuals whose services were billed through the ASO that is contracted by MDH to manage utilization and claims payment for the PBHS. Claims data for the PBHS includes information on services for Medicaid recipients, state-funded services and services for uninsured individuals. Providers have up to one year to submit a claim for services. Primary behavioral health services being provided at the MCO level were not included in this dataset. We also obtained State Hospital utilization data for Baltimore City residents.

Availability of data was a barrier to the project. Although the process of getting approvals began in mid-November 2018 with the receipt of HSRI IRB approval, the Data Use Agreement was not signed and fully executed until March 18, 2019. Claims data were first received on April 2, 2019 (for state hospital claims), and on July 1, 2019 we received the final claims data files that we were waiting for (related to the Medicaid claims). Individual-level Outcomes Measurement System (OMS) data were also authorized for transfer but were unable to be delivered in time for analysis and inclusion in this report. Consequently, we relied on publicly available OMS DataMart aggregate data reports for summary outcome data.

[25] BHSB, "FY 2018 Activities, Behavioral Health Indicators and System Utilization"

Findings

The following sections summarize what was learned about Baltimore's public behavioral health system from key informants and the data analyzed. First, we describe the organizing framework we used for the assessment of the PBHS, including our description of the current system and findings from the key informant interviews. Next, we summarize the service utilization data that were made available and note trends observed across the past three years. Then we summarize the major themes we heard from the system stakeholders about the various services. There is also a section focused on law enforcement interactions with individuals experiencing a behavioral health crisis; this summarizes dispatch and other data related to these interactions collected by BPD, as well as what was learned about the nature of such interactions and how they can be improved from focus groups held with individuals who had experienced law enforcement responses in times of crisis. Finally, we look for insight into how the system is ultimately functioning by examining client outcomes available from the OMS DataMart for the same period of time as the utilization data reviewed.

It is important to note that this review of the system and services is undertaken to inform systems planning efforts related to the Consent Decree and potentially beyond, with the ultimate goal of better serving individuals through the PBHS, thereby helping to divert individuals from contact with law enforcement.

Please note that both qualitative and quantitative data pertaining to youth and services for youth are presented but are incorporated within the main findings. The consent decree also called for a report focused on the needs of youth to avoid contacts with law enforcement. That report is available at: https://www.baltimorepolice.org/transparency/interactions-youth.

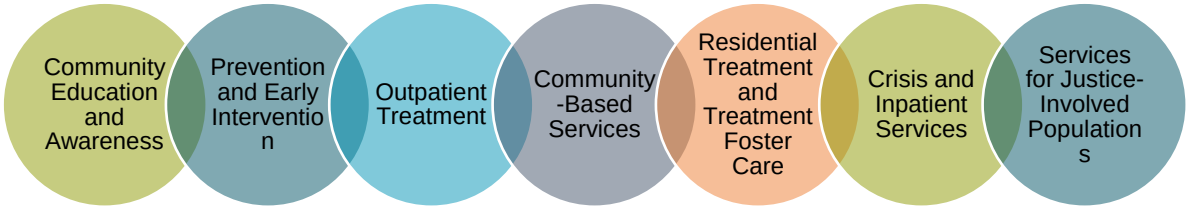
System Framework and Description

When assessing Baltimore's public behavioral health system, we employed a framework (Figure 1) that reflects national best practices for a comprehensive behavioral health service array.[26] The framework consists of a continuum of broad service types, progressing left to right from those generally the least to the most restrictive in nature, as well as from those with more of a broader population focus (e.g., community members) to those focused on more of a discrete, specific population (e.g., criminal justice involved individuals). For the purposes of examining the Baltimore system, we modified the framework slightly in terms of how some services

[26] Substance Abuse and Mental Health Services Administration. (2011). Description of a good and modern addictions and mental health service system [PDF file]. Rockville, MD. Retrieved from https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

were grouped together for discussion. Yet we maintained coverage of all the key service types within this comprehensive array.

Figure 1 **A comprehensive behavioral health service array spans numerous program types and agencies to provide the right mix of services at the right time.**



Such a system provides a variety of service types with different levels of intensity, with an emphasis on "upstream" prevention and diversion—resolving potential crises at the community level to the maximum extent possible in order to minimize involvement of law enforcement and "downstream" utilization of emergency departments and inpatient admissions.

Appendix D provides a detailed description of the current system. The system description we present is not meant to provide an exhaustive catalog of all services available in the city. Instead, it provides a general sense of the services within the Baltimore public behavioral health system in relation to this best practices framework.

This framework is also used to organize the summary of the key informant findings.

Findings from Utilization Data

Service Utilization Patterns

Error! Reference source not found. shows the number of individuals served each year and the number of claims for that year. Because an individual might have received services for more than one year, the total number of unique individuals served is less than the sum of individuals served each year.

Table 1
Individuals served and claims records per year

	FY2016	FY2017	FY2018
Count of records	2,042,691	2,274,511	2,802,563
Count of unique people	64,039	66,645	69,484

Error! Reference source not found. shows the demographic characteristics of the individuals served in the most recent year for which claims data was available, 2018. Of note is the nearly 50/50 split between men and women served; typically, behavioral health systems serve a larger proportion of women than men. For example, NSDUH estimates indicate that in 2018, 14,207,000 women with any mental illness received mental health services compared to only 6,372,000 men.[27] It is unclear why fewer women than usually expected might be accessing publicly funded behavioral health services in Baltimore. It is possible that women in Baltimore are accessing public behavioral health services funded through other means, such as federal, state, city or private grant funding that is not administered by the ASO.

Table 2

Demographic characteristics of Baltimore City PBHS recipients who received behavioral health services in FY 18

	N	%
Total	**69,484**	**100%**
Gender		
Female	34,232	49.3%
Male	35,251	50.7%
Age		
Age 0 to 17	17,362	25.0%
Age 18 to 25	6,798	9.8%
Age 26 to 64	43,442	62.5%
Age 65 or Older	1,882	2.7%
Ethnicity		
Hispanic/Latino	5,453	8.1%
Race		
Black or African American	53,111	77.2%
Asian	774	1.1%
Native American	807	1.2%
Pacific Islander	52	0.1%
White	14,025	20.4%

Notes: Demographic characteristics are based on the latest claim record within the fiscal year. N=2,341 individuals (3.4%) had unknown ethnicity and are excluded from the Ethnicity category; N=715 individuals (1.0%) had unknown race and are excluded from the Race category.

To determine whether there are any possible disparities in access to public behavioral health services, we compared the demographics of those billing the ASO of the PBHS for behavioral health services to the population of Baltimore City in general (shown in **Error! Reference source not found.**). Please note that the age and race/ethnicity categories differ slightly from those displayed in **Error! Reference source not found.** in order to align with the census data that was available. This table indicates that there are fewer females receiving publicly funded behavioral health services than might be expected based on the overall demographic makeup of the city, as well as more African Americans and fewer individuals who identify as White. The finding that individuals identifying as Hispanic/Latino are accessing PBHS services at a rate higher than the proportion of the general population was

[27] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect8pe2018.htm, Table 8.17A

unexpected given what was heard in our key informant interviews, where Spanish-speaking populations were identified as being harder to reach by a number of key informants across multiple service types (see "Community-Based Services").

Table 3

Comparison of the PBHS population receiving behavioral health services and the general population of Baltimore City, FY2018

	Baltimore City PBHS Recipients Receiving BH Services		Baltimore City Residents	
	N	%	N	%
Total	69,484		619,796	
Gender				
Female	34,232	49.3%	328,419	53.0%
Male	35,251	50.7%	291,377	47.0%
Age				
Under 18	17,362	25.0%	129,901	21.0%
18 and over	52,122	75.0%	489,895	79.0%
Race/Ethnicity				
Black or African American	53,111	77.2%	389,222	62.8%
White	14,025	20.4%	187,725	30.3%
Hispanic/Latino	5,453	8.1%	30,729	5.0%
Native American	807	1.2%	1,886	0.3%
Asian	774	1.1%	15,855	2.6%
Native Hawaiian and Other Pacific Islander	52	0.1%	309	0.0%

Sources: Behavioral health claims via MDH, FY2018; ACS 2017 5-year estimates for Baltimore City

Having identified who is being served by PBHS behavioral health services in Baltimore City, we turn our attention to the services being received, as well as any changes in that mix of services over time. **Error! Reference source not found.** shows the number and percentage of individuals with any claim for a particular PBHS service category for the years 2016, 2017, and 2018. Please note that any cells with 10 or fewer individuals served were suppressed to protect privacy. It is also important to note that BHSB directly contracts for an array of "crisis" services; therefore, the numbers here do not accurately reflect true service volume of crisis response in the city. Residential crisis services are the only service category listed within the table largely dependent upon non-Medicaid Fee For Service (FFS) revenues for service provision. Additionally, the Mobile Treatment category code Maryland uses contains both Assertive Community Treatment (ACT) and non-ACT mobile treatment services (see Figure 2 for more information).

Interestingly, **Error! Reference source not found.** shows that the percentage of individuals receiving different types of mental health services, with a few exceptions, essentially held steady from year to year as the overall number of individuals served per year increased (see **Error! Reference source not found.**). Of note for mental health–oriented services, the percentage receiving outpatient treatment declined over the three-year period and the percentage receiving inpatient services remained steady or even declined, while the percentage receiving psychiatric rehabilitation services increased by multiple percentage points each year. This seems to hint that individuals are accessing psychiatric rehabilitation programs instead of traditional outpatient

mental health services or that outpatient mental health providers are referring more of the individuals they serve to PRPs, but that this increased reliance on a different service type is not resulting in more ED or inpatient care exposure. It should be noted that the overall number of individuals seen has increased for mental health services while the proportion has remained flat due to overall system volume increases.

Table 4

Service Utilization by Fiscal Year

	FY2016		FY2017		FY2018	
	N	%	N	%	N	%
Mental Health Services						
Outpatient	49,187	76.8%	49,378	74.1%	50,847	73.2%
Mobile Treatment	1,170	1.8%	1,224	1.8%	1,279	1.8%
Case Management	1,206	1.9%	1,229	1.8%	1,317	1.9%
Supported Employment	498	0.8%	523	0.8%	454	0.7%
Residential Crisis	623	1.0%	660	1.0%	766	1.1%
Emergency Room (MH)	6,924	10.8%	7,132	10.7%	7,223	10.4%
Partial Hospitalization	675	1.1%	662	1.0%	627	0.9%
Inpatient	4,767	7.4%	4,885	7.3%	4,734	6.8%
Psychiatric Rehabilitation	11,126	17.4%	12,897	19.4%	15,495	22.3%
Residential Rehabilitation	1,059	1.7%	1,089	1.6%	1,177	1.7%
Residential Treatment	172	0.3%	137	0.2%	153	0.2%
Respite Care	45	0.1%	40	0.1%	36	0.1%
Baltimore Group (Capitation)	331	0.5%	342	0.5%	330	0.5%
Purchase of Care	*	0.0%	*	0.0%	*	0.0%
Traumatic Brain Injury	*	0.0%	*	0.0%	*	0.0%
PRTF Waiver	*	0.0%	*	0.0%	*	0.0%
SUD Services						
SUD Outpatient	14,118	22.0%	20,799	31.2%	23,110	33.3%
SUD Intensive Outpatient	4,190	6.5%	5,141	7.7%	6,391	9.2%
SUD Partial Hospitalization	1,110	1.7%	1,538	2.3%	1,589	2.3%
SUD Methadone Maintenance and Other MAT	11,800	18.4%	13,695	20.5%	13,899	20.0%
Emergency Room (SUD)	3,038	4.7%	3,480	5.2%	3,935	5.7%
SUD Inpatient	966	1.5%	1,029	1.5%	879	1.3%
SUD OP Detox	917	1.4%	1,261	1.9%	1,355	2.0%
SUD IP Detox	777	1.2%	720	1.1%	625	0.9%
SUD Residential ICFA	122	0.2%	132	0.2%	52	0.1%
SUD Residential All Levels	N/A	N/A	N/A	N/A	3,094	4.5%
SUD Residential Room and Board	N/A	N/A	N/A	N/A	3,060	4.4%
Totals	**64,039**	**100%**	**66,645**	**100%**	**69,484**	**100%**

Source: Behavioral health claims via MDH, FYs 2016-2018

Notes: 1) Service categories are as classified by Maryland Medicaid with the exception that we pulled Emergency Room (ER) claims into their own categories; ER claims were identified by the following service codes: 0450, 0451, 0452, 99284, 99285, 99283, 99282, 99281, 0981, or POSCOD=23. 2) The Mobile Treatment category includes both ACT and non-ACT services; see **Error! Reference source not found.** for a breakout of mobile treatment types. 3) The SUD Methadone Maintenance category includes claims for other medication-assisted treatment (MAT), such as buprenorphine and naltrexone; see **Error! Reference source not found.** for a breakout of methadone vs. other MAT.

It is also interesting to note that the percentage of mobile treatment services that are ACT also showed a steady decline (see **Error! Reference source not found.**). This provides some support for what key informants indicated about difficulties accessing this particular service (see "Assertive Community Treatment" on page 42), as providers may be relying on other mobile treatment options more frequently when ACT services are not accessible (resulting in the proportion of mobile treatment services that are ACT decreasing).

Figure 2
ACT declined as a percentage of mobile treatment over the three-year period

Utilization patterns for services for substance use disorders (SUD) showed a steady increase in the use of services, with the largest increase observed for outpatient SUD treatment, rising from 22.0% of individuals receiving public behavioral health services to 33.3%, with a roughly 64% increase in the total number of individuals receiving that service. ED visits have also increased, by 900, from 2016 to 2018. It is suspected that the observed increase in utilization of all substance use services is partially due to Medicaid expansion (more people have Medicaid) and an enhancement of the Medicaid package in Maryland to cover more SUD services. It is also possible that it is due to the public attention focused on the opioid crisis, which may be encouraging more individuals to seek treatment. There was a small bit of an increase observed in the Methadone Maintenance and Other MAT category.

As Figure 3 indicates, there have been small but steady increases in the percentage of individuals using other MAT (e.g., buprenorphine or naltrexone), but methadone is overwhelmingly relied upon for MAT in Baltimore. It is interesting to note that the raw count of individuals receiving other MAT more than doubled—from 485 in 2016 to 1,037 in 2018—indicating that initiatives to increase access to buprenorphine may be having an effect. Given that only ASO-billed MAT services are reflected and that buprenorphine is provided through grant funding in many non-ASO settings, the full extent of non-methadone MAT use is unclear; however, the data available suggest that this promising treatment option for individuals with opioid use disorders remains underutilized.

Figure 3

Methadone Maintenance remains the most common type of MAT treatment in Baltimore City; "Other MAT" doubled over the period, though from a small base

Note: Methadone Maintenance includes the following service codes: H0020, W9520; Other MAT includes the following service codes: J0574, J0572, J0573, 80348, J0571, J2315, W9521

We also looked at whether services used varied depending upon the type of funding. There were a number of notable differences in MH and SUD service utilization depending on the funding source used, looking at 2018 data. For mental health services, individuals with Medicaid had higher rates of receipt compared to the other funding sources for outpatient treatment (75.6% vs. 36.7% uninsured vs. 31.6% state-funded), emergency room (10.8% vs. 1.4% vs. 0.7%), and psychiatric rehabilitation (23.0% vs. 15.7% vs. 3.3%) services. Interestingly, uninsured individuals had higher utilization levels of mobile treatment services (4.8% vs. 1.6% Medicaid vs. 1.3% state-funded). There were no other differences in patterns of mental health services received that stood out. These data appear to suggest that it may be easier to access core mental health services if one has Medicaid, or conversely, that providers of these services may be better at getting individuals connected to Medicaid funding.

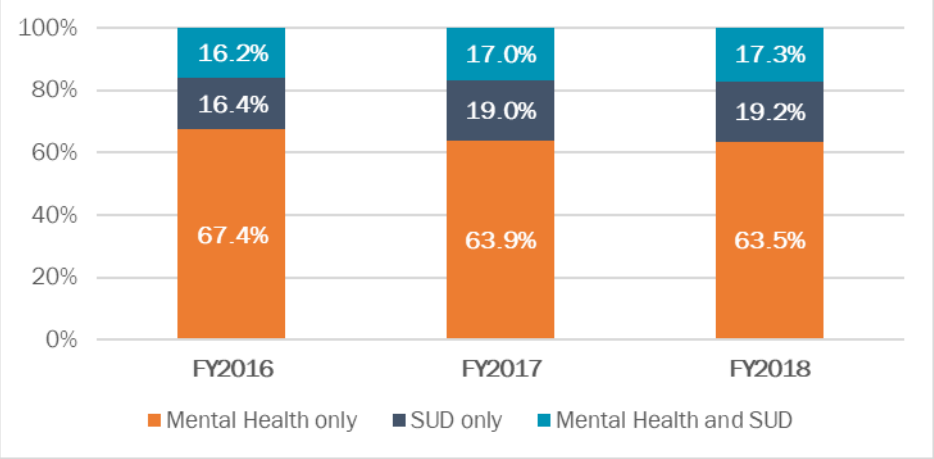
Receipt of services also varied by funding source for SUD services. Individuals with Medicaid funding were more likely to use SUD intensive outpatient (9.3% vs. 5.4% uninsured vs. 1.8% state funded), partial hospitalization (2.4% vs. 0.2% vs. 0.3%), or OP detox (2.0% vs. 0.1% vs. 0.3%). Individuals who were uninsured were more likely than their counterparts with other funding sources to use SUD outpatient treatment (41.5% uninsured vs. 32.4% Medicaid vs. 24.8% state) and methadone or other MAT (35.8% vs. 19.1% vs. 6.6%) services. There were no other differences in patterns of SUD service receipt that stood out. While it is important to keep in mind that the number of individuals with uninsured status is quite small in comparison to the number receiving Medicaid, it might be worthwhile to explore further why a higher proportion of individuals who are uninsured than those with Medicaid are accessing core outpatient SUD services.

To better understand the ways in which PBHS behavioral health services were utilized, we also explored the mix of services individuals were receiving. Figure 4 shows the percentages of individuals receiving mental health services only, SUD services only, or services for both. Though there has been an increase in community-oriented SUD services over the past three years, the majority of individuals (nearly

two thirds) received mental health services only. Likewise, only 16.2% to 17.3% of individuals were receiving both mental health and substance use treatment services. It has been estimated that roughly 30% of individuals with mental health or substance use diagnoses have co-occurring disorders,[28] which suggests there is a large amount of unmet need for this population. Key informants indicated that most co-occurring services are not integrated (concurrently and cohesively treating both MH and SUD). The claims data did not allow for further exploration of this as there is no code to support integrated service delivery and the majority of mental health and SUD services cannot be billed on the same day.

Figure 4

Nearly two thirds of individuals served received mental health services only, but research suggests a large proportion are likely to have a co-occurring disorder

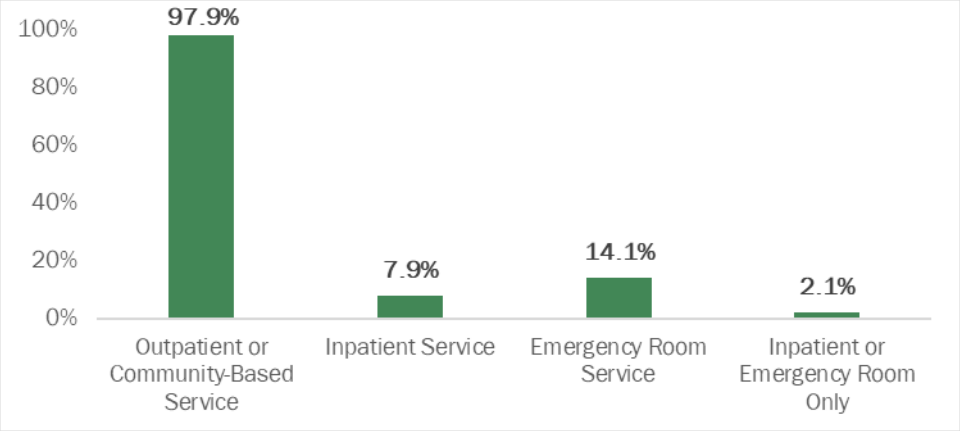


Error! Reference source not found. and **Error! Reference source not found.** further break down service utilization by the types of services received. **Error! Reference source not found.** displays the percentage of individuals with PBHS claims receiving any type of service in FY2018. Service types are: outpatient treatment or other community-based services, inpatient services, emergency department service, and inpatient or emergency room only (implying no connection to community-based services). Of note, nearly all individuals (97.9%) with a PBHS claim received some sort of community-based service (at least one contact). Only 2.1% of individuals (but still 1,433 people) appeared to be reliant solely on inpatient or emergency department services. Individuals relying solely on inpatient or emergency department services tend to be male (53.5%) and Black or African American (75.7%). Notably, 18.6% of individuals reliant solely on inpatient or emergency department services are between the ages of 18 to 25, and 12.9% are under 18, suggesting either a lack of community-based services for youth and TAY or difficulties accessing them. Also of note, 14.1% of individuals had some sort of behavioral health emergency department contact, indicating that there are roughly 10,000 unique individuals in the PBHS using emergency departments to meet their behavioral health care needs at least once during the year.

[28] Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse, JAMA, 264(19), 2511-2518.

Figure 5

Only 2.1% of individuals who received services in FY2018 relied solely on inpatient or emergency room care for their behavioral health care needs



Error! Reference source not found. presents the combination of service types, or "service packages," that individuals have received over the past three years. Of note, the vast majority of individuals with PBHS claims in Baltimore City are receiving community-based services only (holding steady between 83% and 84% over the past three years). This indicates that 16% to 17% of the behavioral health population in Baltimore City being served through the PBHS is responsible for all behavioral health inpatient and emergency department contacts being billed within Baltimore City as Medicaid or State funded. It is important to note that our data do not include Medicare funded services, private insurance, or other funding sources for inpatient care such as the capitation projects, and that inpatient costs for uninsured individuals are also factored into hospitals' enhanced rates.

Outpatient/community services combined with emergency department services was the only service package that showed a clear increasing trend over the past three years. This pattern would be consistent with what key informants had noted about community service providers relying on emergency departments for crisis or after-business-hours care (see "Emergency Departments" on page 60).

Table 5

Service Packages

	FY2016		FY2017		FY2018	
Combination of Services	N	%	N	%	N	%
Inpatient only	477	0.7%	517	0.8%	429	0.6%
Emergency Room only	695	1.1%	681	1.0%	673	1.0%
Outpatient/Community only	53,596	83.7%	55,505	83.3%	58,138	83.7%
Inpatient and ER only	344	0.5%	324	0.5%	331	0.5%
Inpatient and Outpatient/Community only	1,029	1.6%	1,153	1.7%	1,091	1.6%
Outpatient/Community and ER only	4,211	6.6%	4,725	7.1%	5,176	7.4%
Inpatient, Outpatient/Community, and ER	3,687	5.8%	3,740	5.6%	3,646	5.2%
Totals	**64,039**	**100%**	**66,645**	**100%**	**69,484**	**100%**

In addition to the mix of services received, we also calculated total and per-person costs associated with broad types of care for Baltimore City residents. **Error! Reference source not found.** shows the total amount billed by service type in FY2018. **Error! Reference source not found.** shows the per-person cost billed for those amounts.

Figure 6
Total billed costs by service type, FY2018

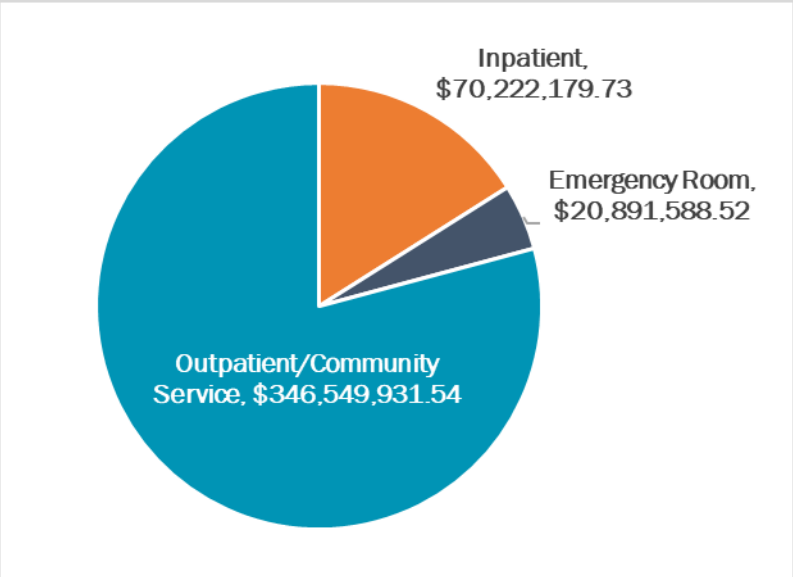
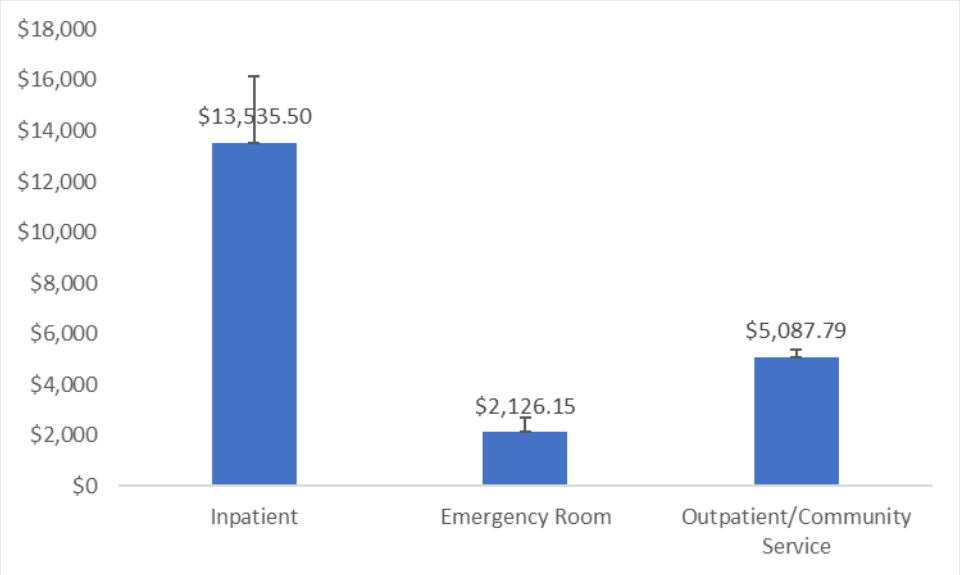


Figure 7
Per person costs by service type, FY2018



Note: The brackets on top of the bars represent the size of the standard deviation in individual costs for each service type.

State Hospital Utilization by Baltimore City Residents

Although the state hospital system was not a key area of focus of this study, there are a small number of Baltimore City residents served within that system. A combined total of 779 unique individuals utilized the state hospital system in 2016, 2017, and 2018. In comparison, over 104,000 unique individuals are represented in PBHS claims for behavioral health services during that time span. In Maryland, the state hospital system is primarily used to serve forensic patients. As expected, **Error! Reference source not found.** indicates that most Baltimore City residents served in the state hospital system are forensic patients.

Table 6

Legal status of Baltimore City residents served in the state hospital system

	N	%
Not Forensic	107	13.7%
Forensic	672	86.3%
TOTAL	779	

Source: Maryland Behavioral Health Administration State Hospital database, FY2016-FY2018

through **Error! Reference source not found.** display the demographic characteristics of those Baltimore City residents being served within the state hospital system. They are predominantly male, young adult to middle-aged, and African American—consistent with the population within the larger criminal justice system.[29]

Table 7

Gender of Baltimore City residents served in the state hospital system

	N	%
Male	617	79.2%
Female	161	20.7%
Unknown	1	0.1%
TOTAL	779	

Source: Maryland Behavioral Health Administration State Hospital database, FY2016-FY2018

[29] https://goccp.maryland.gov/wp-content/uploads/dpscs-restrictive-housing-report-2016.pdf

Table 8

Ages of Baltimore City residents served in the state hospital system

	N	%
Under 12 years old	1	0.1%
12-17 years old	37	4.7%
18-24 years old	81	10.4%
25-34 years old	186	23.9%
35-44 years old	137	17.6%
45-54 years old	146	18.7%
55-64 years old	142	18.2%
65-74 years old	39	5.0%
75 years or older	6	0.8%
Unknown	4	0.5%
TOTAL	**779**	

Source: Maryland Behavioral Health Administration State Hospital database, FY2016-FY2018; Note: Spring Grove Hospital Center operates an adolescent unit, but services for individuals under the age of 12 are contracted for with private providers.

Table 9

Race of Baltimore City residents served in the state hospital system

	N	%
American Indian/Alaska Native	1	0.1%
Asian	4	0.5%
Black/African American	649	83.3%
White	105	13.5%
Other	20	2.6%
TOTAL	**779**	

Source: Maryland Behavioral Health Administration State Hospital database, FY2016-FY2018

Table 10

Ethnicity of Baltimore City residents served in the state hospital system

	N	%
Not Hispanic or Latino	681	87.4%
Hispanic or Latino	15	1.9%
Unknown	83	10.7%
TOTAL	**779**	

Source: Maryland Behavioral Health Administration State Hospital database, FY2016-FY2018

Grant-Funded Services

As noted earlier, public behavioral health system services are largely reimbursed through the state-administered FFS system. However, BHSB does provide additional funding to cover services not reimbursable by Medicaid and to spur the development of innovative programs. Unfortunately, the service data available did not allow for looking at concurrent receipt of Medicaid FFS and grant-funded services. In FY2018,

BHSB awarded approximately $58 million in grants, with 332 contracts issued to 191 providers and consultants.[30]

These grant-funded services include: assertive outreach, court-based assessments, mobile crisis response, methadone home delivery, housing supports, school-based services, wellness and recovery centers, peer support, prevention, overdose education and naloxone distribution outreach, early childhood services, and specialty services tailored to meet the unique needs of special populations such as older adults, people experiencing homelessness, women with children, and individuals involved in the criminal justice system.[31]

While complete utilization data for grant-funded services were not available, the following were noted for 2018 in BHSB's most recent annual report[32]:

- Responded to 42,990 hotline calls.
- Mobile crisis services responded to 2,599 individuals.
    - More than half of those (53%) were to hospital emergency departments for diversion from inpatient admission to community-based care[33]
    - When a mobile crisis team was called to an emergency department for evaluation for diversion, 76% of the individuals were diverted to a community-based service[34]
- Baltimore City residents visited Wellness and Recovery Centers 208,426 times. The Centers provided 14,268 one-on-one peer counseling sessions, over 161,880 group support sessions, and placed 175 persons in jobs. In addition, 1,333 persons were confirmed to have entered a treatment program as a result of a referral from a Wellness and Recovery Center.
- The Expanded School Mental Health (ESMH) program provided prevention and mental health treatment services in 126 out of 177 schools (71%) to 9,707 youth during the school year.
- LifeSkills Training was provided in 35 schools (target 6th graders).
- SUD prevention, early intervention and treatment services were provided in 15 schools and two school-based sites in Baltimore City.
- Early Childhood Mental Health (ECMH) services were provided in 80% (4/5) of Head Start centers, with a total of 924 children served.

In addition, BHSB continued providing overdose education and naloxone distribution during FY 2018. Through targeted street outreach and classroom trainings, BHSB

[30] BHSB, FY 2018 Activities, Behavioral Health Indicators and System Utilization
[31] Ibid
[32] Ibid
[33] Behavioral Health System Baltimore (2019). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System.
[34] Ibid

staff and Bmore POWER members (a group of people with lived experience with SUD that is administratively supported by BHSB) trained 9,112 people to respond to overdoses and distributed 8,779 naloxone kits.

City-Administered Services

The City of Baltimore itself funds or directly provides some service programs and other supports. For example, the Mayor's Office of Human Services operates a street outreach team for homeless individuals and supportive housing through federal homeless service dollars, is planning to develop a rental assistance program, and oversees Head Start and five community action programs. The Baltimore City Health Department provides outreach education and naloxone distribution, mobile needle exchange services with peer support, buprenorphine induction, maternal home visiting, and navigation services for high utilizers of emergency departments. The Mayor's Office of Criminal Justice oversees violence prevention and victim support programs including Safe Streets and ROCA. Unfortunately, we do not have any data available on the utilization of these and other similar programs.

Key Takeaways from Utilization Data

The service utilization data reviewed provide some key insights:

- Over the three years' of data examined, the relative proportions of PBHS mental health services remained relatively stable. The exceptions were outpatient mental health services, which were steadily decreasing over time, and Psychiatric Rehabilitation Program services, which were steadily increasing—and at a fair amount.
- The growth in Psychiatric Rehabilitation Program services should be explored further, with closer monitoring and oversight by BHSB to determine what is happening. It might suggest that such programs are proliferating, or existing programs have changed practices to serve more people, potentially at the expense of program quality.
- Medicaid expansion appears to be having an effect on access to SUD services, with community SUD services steadily increasing. Interestingly, individuals who are uninsured had a higher proportion of individuals accessing core outpatient SUD services than those who had Medicaid for reasons that are unclear.
- MAT services remain very reliant on methadone. Although other MAT services (e.g., buprenorphine) have nearly doubled the number served since 2016 in the ASO data, these services appear to be underutilized, though the data available are incomplete.
- Relatively few individuals receiving services are reliant solely on high-cost ED or inpatient treatment (2.1%, or 1,433 people). Of those that do, nearly one third are TAY or under the age of 18, suggesting that there is either a lack of community-based service options for these individuals or challenges

connecting with existing services. Nearly all individuals receiving services (97.9%) have some connection to community-based services. This does not imply that those services are adequately meeting the needs of those individuals, or that additional services may not be needed.

- Only 16% to 17% of the population served is accessing ED or inpatient services; most (84%) rely solely on community services. This does not imply that the community services are effective, sufficient, or crisis-responsive, but rather that it is a relatively small proportion of individuals who use services that access ED or inpatient services.
- Access to key services such as supported employment remains severely restricted (<1%).
- Individuals with co-occurring disorders are likely significantly underserved.

Findings from Stakeholder Interviews

HSRI staff employed a phenomenological approach to the analysis of the key informant interviews. In such approaches, priority is given to the key informants' descriptions of their experiences (in this case with the PBHS), attempting to understand each individual's perceptions, regardless of whose perception it may have been. Consequently, all interview and focus group data were analyzed and summarized together regardless of the role of the key informant within the system. The dominant themes that emerged for each topic—those emphasized multiple times by various stakeholders—are summarized below. The fact that a theme emerged as dominant does not mean there was complete consensus among stakeholders, or even that it represents the opinions of a majority. While all perceptions were treated equally in determining the dominant themes, we did note if a theme appeared to be influenced or driven by individuals in a particular type of role or inhabiting a particular vantage point within the system.

Community Education

Many stakeholders alluded to a need for more education programs for both providers and the community at large. The calls for more community education centered around two main themes: fighting stigma and increasing awareness of service options within the community.

Concerning stigma, key informants felt that any perceived mental health or substance use disorder would result in an individual having difficulty accessing services and resources within the community, such as housing. For example, sober housing for individuals with SUD might be unwilling to accept people using methadone or some other medication-assisted treatment, and attitudes about drug use have led to resistance to safe consumption sites and other harm-reduction strategies, such as needle exchange programs or even education about drug use. Some noted that stigma was impacting the adoption of and access to peer support services. Individuals with

behavioral health disorders who are LGBTQIA were identified as facing the strongest stigma within the public behavioral health services system and the community at large. There was some optimism that public education campaigns, as well as family psychoeducation, would help counter such beliefs.

The other main theme for community education was the need to educate both providers and the public at large about the services and resources available within their community. The siloed nature of services and hyper-localization of public awareness means that if individuals are aware of services at all, it is often only because of some direct personal contact with a service—and that knowledge does not extend to other options for that same service elsewhere in the city or beyond their immediate neighborhood. This lack of knowledge of available service options leads to an overreliance on 911 and other crisis/emergency systems to access care. Services for youth and transitional age youth were identified as being particularly opaque.

The need for more education and awareness about community service options was not limited to members of the general public. Multiple key informants also commented on a lack of awareness of options, resources, and understanding of processes/requirements by service providers and other professionals. Stakeholders felt that increased use of service registries like 211 or comprehensive resource guides listing things such as eligibility criteria would be helpful for providers, as would education targeting specific resources (e.g., eligibility criteria for Medicaid).

Behavioral Health — Promotion, Prevention, and Early Intervention

For mental health services, stakeholders indicated that there was a need to expand promotion, prevention, and early intervention services throughout Baltimore, across the lifespan. School systems were identified as being in need of more healthy socioemotional development–focused programs as well as mental health consultation and services. Expanded access to early Head Start and more home visitation programs were also identified as needs.

For mental health early identification, the need for more depression screening was highlighted. On the substance misuse side, people identified a need for more widespread opioid overdose preventative activities, such as distribution of Narcan kits and use of fentanyl test strips. Some lamented all of the attention being placed on opioid prevention efforts, feeling that alcohol and other drug prevention efforts are being ignored at the expense of opioids.

Challenges encountered with promotion, prevention, and early intervention services centered around funding, service coordination, and attitudes toward services. In the area of funding, it was noted that many prevention services are grant funded, as many often are not currently billable to Medicaid. While some school-based providers are billing Medicaid FFS for behavioral health interventions in the schools, it was noted that when the prevention services are grant-funded, providers often lose money delivering the service. It was also stressed that prevention programs are also often the first to be cut during times of financial pressure, impacting continuity and sustainability of the programming. Reimbursement for screening activities was

another financing gap identified. In terms of service coordination, people noted that prevention services are often provided outside of the normal service delivery system (e.g., in schools), limiting awareness of and coordination with such services in general by those in the public behavioral health system. More coordination is also needed among the prevention programs and initiatives within the schools; it was noted that there are more resources and attention being paid by the state recently to topics such as mental health resources in schools, but there does not appear to be any coordination or collaboration between those school-based initiatives. It was also noted that there tend to be challenges with information sharing and barriers to collaboration and coordination between schools and the behavioral health system due to HIPAA and other privacy protections. Another factor impacting access to prevention and early intervention services identified is a general culture of mistrust of those in any sort of authority position—be it police or a provider or behavioral health authority, which was thought to have worsened since the civil uprising following the death of Freddie Gray in 2015. Other attitudes impacting access to prevention and promotion services were maintaining an abstinence-based philosophical approach (resisting harm-reduction approaches) and competition between the treatment and prevention communities over what should take priority for limited funding resources.

Immigrants/New Americans were identified as a population largely underserved by behavioral health promotion, prevention, and early intervention efforts. It was mentioned that Baltimore City Public Schools has recently begun early intervention programs with younger students and for immigrant students, and they are in the process of figuring out how to enhance and expand such services. Other populations stressed as important to target included adolescents ages 13-17, young children ages 0-5, parents of youth of all ages, and young African American men who are involved in the juvenile justice, criminal justice, and child welfare systems. It was also suggested that there needed to be more African American individuals in leadership and harm reduction positions.

There was a clear desire for behavioral health promotion, prevention, early intervention, and other youth services to utilize a trauma-informed approach. Many stakeholders noted the challenges faced by youth due to violence in their communities, unaddressed grief and loss, and poverty, making it absolutely critical for the workforce to utilize a trauma-informed approach for these and other services. There also appears to be a need for more thorough workforce training in the area of harm reduction; it was noted that program leadership will often be on board with such an approach and use the language, but many of the folks on the ground still feel the only pathway to recovery is full abstinence.

Community-Based Services

ASSERTIVE COMMUNITY TREATMENT (ACT) AND OTHER HIGH-INTENSITY COMMUNITY-BASED MOBILE TREATMENT AND SUPPORT

Stakeholders indicated that ACT services are valued by the system and effective when they are able to be accessed; the challenge is that many report the service to be in such

demand as to be unavailable.[35] Many spoke of only futile attempts in making referrals to the service, including one individual working with homeless individuals with a 10+ year history of lack of successful referrals.

In addition to overall lack of capacity for ACT services, key informants also identified a number of financing, policy, or regulatory issues impacting the availability of ACT services. Stakeholders noted that the start-up costs for ACT level services are high compared to typical treatment and case management programs (staffing costs—for example, prescribers, case ratios). While reimbursement rates were generally viewed as favorable statewide, it was noted that the reimbursement rate is not enough for city teams to provide wages at a level conducive to attracting individuals and overcoming the deterrent of perceived level of violence and lack of safety in some neighborhoods, making it difficult to fully staff the ACT teams. Others noted that private insurance and even Medicare do not cover this level of service, requiring the state to fill the gap by using state funding to cover this service for uninsured individuals or Medicare recipients.

Program policies can also serve as a barrier to accessing ACT services. It was suggested that the referral process for ACT level of care was cumbersome, with lengthy delays in hearing back, which was attributed to lack of staff dedicated to the referral process. It was also suggested that there was a strict review criteria by the ASO once the service was accessed that can limit the ability to maintain the service, with approval for as little as 3 months of service before pressure to transfer individuals to a lower level of care (the evidence-based model calls for services to be unlimited as needed). State policies have also impacted the availability of ACT services. For example, we heard that a Federally Qualified Health Center (FQHC) had attempted to develop ACT teams to meet the service need for their population but that state policy excluded FQHCs from billing for ACT services.[36]

Youth were one of the populations suggested for targeting by ACT programs; it was felt that the non-traditional nature of services, level of outreach possible, and frequent contacts enabling the development of a therapeutic relationship were beneficial for serving this population. A number of stakeholders also identified older adults as another possible population to target with this service model, as the ability to deliver

[35] Upon review of the draft report, BHSB staff noted that the engagement piece of enrolling in ACT which is not reimbursed by the PBHS hinders getting the people who are difficult to engage into the service—that is, you can't get the service until you sign consent, and most teams can only do so much pre-engagement services.

[36] Upon review of the draft report, BHSB staff noted they have also heard that despite ACT's status as an EBP for working with people experiencing homelessness, most ACT teams are not flexible enough to work with this population, often resulting in dropped referrals or low retention. Providers and referral sources have attributed this to thin financial margins along with financial disincentives for ACT teams to work with: 1) people who need significant time to build trust and engage prior to enrollment, 2) people who are hard to locate and stay in contact with, and 3) people with complex needs who need more frequent contacts than ACT will cover. Anecdotally, other stakeholders have cited the third group ("need more frequent contacts") as a reason why ACT teams aren't serving more ACT-eligible older adults.

services in the individual's home addresses a key barrier to service access for this population.

CASE MANAGEMENT

Many of the key informants reported that there was a definite need for the expansion and enhancement of case management services. It was noted that though there are many options for services available in a community, awareness of service options is often lacking and the system can be very difficult for individuals to navigate alone without assistance. A benefit noted of case management services is that, beyond connecting individuals with behavioral health services, they can also help connect individuals to other services that address social determinants of health.

Stakeholders reported that barriers to access of case management services were largely financial and regulatory in nature.[37] Many noted that this service has been historically underfunded, with current reimbursement rates for Targeted Case Management roughly one third of what would cover program costs. It was noted that grants for a case management service that supplemented reimbursement rates ended 3 to 4 years ago, and this has led to the closing of many case management programs because the reimbursement rate alone is not sufficient to cover costs. For example, one provider organization spoken to indicated that their case management program operates at an annual loss of around $300,000; this drastically limits the pool of organizations able to offer the service. Those that continue to offer this service do so because they feel it is such a critical service. Stakeholders also identified a recent (within the past few years) change in eligibility criteria for case management services as greatly impacting access; one stakeholder noted that the level of acuity a person needs to qualify for general case management services has risen to a point that they would practically be eligible for ACT. It was suggested that more active follow-up by case management programs after referral would also help better reach those needing the service. It should also be noted that targeted case management services are not Medicaid eligible for individuals with a primary SUD.

Youth and older adults were identified as the populations that could be better served by case management the most. For youth, stakeholders reported that there are hardly any case management services; there hadn't been many to begin with, but the low reimbursement rates for targeted case management led to program closings. For older adults, who often need mobile services, it was suggested that case managers needed to be more aware of services and resources for that age range. Stakeholders also mentioned individuals with co-occurring disabilities and individuals with SUD as other populations with a need for enhanced case management services.

[37] Upon review of the draft report, BHSB staff noted that a lot of people have access to some sort of grant-funded "case management" (many different funders in many systems) but there are no quality standards and most services are short-term and limited to a specific need. It was also noted that holistic, client-centered, MH/SUD/Somatic integrated approaches are not common.

HOUSING AND SUPPORTIVE SERVICES

Housing was nearly unanimously endorsed by stakeholders as one of the largest gaps within the system. All types of affordable housing were identified as being in need, but access to evidence-based housing models pairing permanent housing with supportive services was identified as a dire need. Stakeholders noted a limited number of Housing First units available, with some remarking that their organizations and health systems had no access at all to any Housing First programs. Another type of housing program frequently cited as a need were transitional housing units (particular for individuals with SUD), as well as more emergency shelter beds and other short-term options to help people get off the street.[38]

Some of the challenges to accessing housing and supportive services identified by stakeholders included a lack of affordable, habitable housing stock in general, geographical locations, and stigma and prejudice. In terms of location, housing stock and programs that are available are often not located near public transportation, limiting access to the units as well as other critical supportive services. Others noted that recovery housing is often located in drug-infested neighborhoods, providing too much temptation for those seeking sobriety. Stigma against those with mental health or substance use disorders also serves as a major barrier to access; for example, individuals mentioned an unwillingness by landlords to rent to individuals with SUD because they think they will be using on-site and their property will become a shooting gallery; others bar individuals using methadone or other MAT from their programs.

Stakeholders also identified financing, policy, and regulatory barriers to housing. For financing, a lack of funding devoted to housing and creating incentives for the development of housing was noted. Numerous individuals mentioned the stock of abandoned row houses throughout the city and suggested that they be developed. Others highlighted the capitation program, and how increased flexibility around the use of those program funds had enabled some subsidization of housing costs and increased housing and housing stability for the individuals served in that program.

In terms of policy, eligibility requirements were identified as a challenge, noting that many programs are not set up to support individuals with housing needs until they get to an extreme level of care needed, and only then do individuals become eligible for dedicated groups of vouchers (people with mental health disorders experiencing homelessness) and have a chance of accessing the services. Eligibility requirements for many programs require individuals to be chronically homeless. Along the same lines, the process required to document homelessness was viewed as burdensome and an additional barrier for individuals who may not be comfortable staying in shelters, such as those with trauma histories or those who identify as LGBTQIA. It was also noted that the Coordinated Entry System (CES) slowed down the process of finding housing—with the need to enter information to confirm eligibility and waiting times

[38] Upon review, BHSB staff noted that short-term rental assistance and eviction prevention funds might also be useful.

for review—and also limited the pool of potential housing options because housing programs have to be participating in CES in order to be accessed by individuals.[39]

The lack of regulation and oversight of housing programs was also identified as a major gap impacting accessibility to quality housing services. It was noted that residential programs below an assisted living level of care are not licensed or regulated by the state or city, opening the door for predatory group and recovery houses to proliferate. We heard stories of unscrupulous operators targeting the homeless and individuals with SUD, doubling up people in rooms, offering nothing beyond housekeeping support, and pocketing the entirety of individuals' incomes—all while fraudulently claiming medical or other professional credentials. The lack of oversight also means that evidence-based models are not always being followed with fidelity; for example, we heard that many programs claim to be Housing First and have adopted the language and changed how the program is framed, with no actual changes in program practices being made. It was noted that there still needed to be more education and training to stakeholders about the Housing First model in order to increase understanding.

While housing with supportive services was identified as a strong need for individuals throughout the behavioral health system, there were a number of populations singled out as having particular difficulty accessing housing. The populations identified as in need of extra consideration when addressing housing included people with only a mental health or substance use disorder (that is, not co-occurring), people in recovery from SUD (especially for women with children), people transitioning out of jail or criminal justice settings, people with criminal backgrounds (especially some sort of sex offense), people with HIV, survivors of domestic violence, members of the LGBTQIA community, senior citizens, and transition aged-youth.

INTENSIVE OUTPATIENT AND PARTIAL HOSPITAL PROGRAMS

Intensive Outpatient Program (IOP) services were not identified as a pressing need within the behavioral health system by stakeholders, though a couple of individuals did reference a need for more step-down options from inpatient care such as partial hospitalization programs. It was noted that it can sometimes take 2 to 4 weeks to access IOPs, and that stigma can influence access to programs, as sometimes the willingness to seek services at a program might be influenced more by the neighborhood a program is located in than their actual quality of services. It was also suggested that IOP programs as a whole have not been designed with consideration for transgender women but noted there were training efforts underway with at least

[39] Upon review, BHSB staff noted that the purpose of implementing a CES is to create a more standardized, transparent, equitable process for applying for PSH programs in which persons are prioritized based on length of homelessness and severity of health needs. So, while the current iteration of CES may have slowed the process (compared to the prior process of having PSH programs fill their own vacancies), it may, when fully implemented, result in shorter wait times and more equitable outcomes for persons with behavioral health needs, while helping to ensure that the individuals with the greatest needs are able to access housing.

one program to increase the cultural competence of IOP staff in working with this population.

OUTPATIENT MENTAL HEALTH SERVICES

Stakeholders indicated a need for more access to psychiatrists, therapists, and other mental health providers, but individual viewpoints and experiences varied. Some thought there was sufficient access to prescribers and, in ways, an overreliance on medication, with therapy being more difficult to access. Others found the opposite, or cited lack of access to community prescribers as a heavy driver of ED traffic. Many noted that Baltimore is a very service-rich environment (many providers and programs exist within the community) as described above, but that the issue is that many lack awareness of all the service options and programs available, or that the overall capacity is enough and the issue is inefficient access to the available open options. Despite the variation in perceptions, there was consensus that outpatient mental health services are not being delivered in sufficient volume to meet the need demonstrated. It was suggested that some sort of 24-hour outpatient behavioral health clinics are needed, possibly something like the Certified Community Behavioral Health Clinic (CCBHC) model which provides 24-hr crisis coverage. Mosaic Community Services recently began operating a CCHBC, but it is the only one in the city.

Barriers to accessing outpatient mental health services noted included stigma associated with having a mental health condition. In the area of financing for services, it was noted that finding outpatient prescribers that accepted Medicaid could result in wait times of 3 to 4 weeks longer than if other funding for services was available, leaving individuals to turn to EDs to try to obtain medications. Key informants also commented on Baltimore's heavy reliance on grant funding for innovative service programs or non-Medicaid billable treatment; programs tend to close when the grant funding ends, creating a constantly shifting pool of resources that is tough to remain aware of and navigate. Outpatient mental health program policies can also serve as barriers to accessing services. Key informants noted that there is only one mental health program in the city that does not require an ID upon intake for services,[40] and that this severely limits or delays access to services for individuals who might be homeless, in extreme poverty and unable to afford document fees, or otherwise without a valid ID. Others noted that programs sometimes place service requirements on individuals—for example, that if they want to see a psychiatrist, they must also see a therapist on a regular basis—which can serve as a deterrent and keep individuals from accessing needed mental health treatment services. It was also suggested that many programs will often have narrow eligibility criteria—MH only, no SUD; if SUD, at least x months of sobriety, etc.—so that while it may appear that there are many potential providers available to an individual in a particular area, once the eligibility criteria are accounted for there

[40] Upon review, BHSB staff noted they have heard the same feedback about SUD programs.

might be only a couple, suggesting that there is insufficient capacity of integrated treatment options for co-occurring disorders.

There were a number of populations identified for whom outpatient mental health treatment services are struggling to reach and effectively serve. These include youth under age 18, who are not as interested in traditional service models; children involved with the Child Welfare system, due to additional perceived bureaucratic and collaborative challenges of that system; older adults, due to issues with transportation and lack of mobile service models;[41] LGBTQIA individuals, due to issues of sensitivity and cultural competence; veterans; and individuals involved in the criminal justice system. For individuals involved in the criminal justice system, it was noted that while individuals may receive some type of mental health service while incarcerated and will be referred to community-based services prior to/upon discharge, they often do not connect well with services. One pilot program of the past (Second Chance) was effective in countering this by having the community-based provider begin delivering services roughly four months before discharge, providing the opportunity for a therapeutic relationship to be formed that was then continued upon release. This program was grant-funded and ceased with the end of the grant funding.

OUTREACH

Key informants indicated that there was a need for outreach teams for both mental health and SUD focused services that were truly mobile in nature, able to go into the community around the clock to engage with individuals wherever they may be. Having individuals with lived experience of trauma and training in trauma-informed care, rooted in the culture of the neighborhoods they are operating within, in such outreach positions can help lead to better engagement. Persistence in outreach efforts is also necessary; sometimes it can take months of outreach contacts to develop the trusting relationship needed to further engage individuals with services.

In terms of barriers to engagement with and provision of outreach services, stakeholders also identified an inability to bill Medicaid for outreach or to share information between providers about individuals in need of outreach (e.g., ED "frequent fliers") because of HIPAA. Homeless individuals and frequent users of ED services were identified as populations most in need of outreach services. It was also suggested that peer outreach workers attempt to connect with individuals in jails, inpatient settings, and detox units in order to facilitate connections to community-based services upon discharge.

PEER SUPPORT

Some noted that there is a lot of peer support available in Baltimore, whereas others reported that it was difficult to access such services. Overall, peer support services were widely endorsed as being helpful and there was a need felt for an expansion of peer support services throughout the public behavioral health system. A particular focus was a call for more wellness and recovery centers and peer-operated drop-in

[41] Upon review, BHSB staff also noted that reliance on Medicare for coverage of treatment services might impact accessibility of care for older adults as well.

centers, able to operate 24/7 to give people a place to go to get support. Although peer operated drop-in centers currently exist, their hours of operation are limited. It was suggested that more accessibility to such centers would reduce the number of contacts with police by giving people a place to go. Peers were noted for their ability to help other individuals navigate through the system, and are seen as well positioned to help connect with individuals not currently engaged with the behavioral health system and to assist with connections for housing, education, food, and other resources. There was little to no awareness of promising peer support models such as Peer Crisis Respite. Stakeholders noted that there can still be a stigma against peer support services, and it was felt that available peer-delivered services are being ignored by providers.

Stakeholders identified that the major financial barrier for peer services is the lack of their ability to directly bill Medicaid for such services, and stakeholders strongly supported efforts being made to change this. According to key informants, most peer support positions are predominantly grant funded, though others are dependent on community donations, other local funds, footed by the organization, etc.—all funding models impacting the long-term sustainability of such services. Billing for PRP services within a Clubhouse setting can have unintended consequences for access, such as more hesitancy by PRP programs (historically a strong source of referrals) to refer since they are worried about having claims unpaid due to a policy limiting the number of PRP claims within a day (if an individual went to a peer-run program in the morning, and their program in the afternoon, the afternoon claim might be unpaid since there had already been a PRP charge for that day). Medicaid can also limit the flexibility of services provided, so maintaining a balance of funding sources so non-Medicaid reimbursable services can be provided is important.

Key informants indicated that there is a need for more exploration of models of peer support for older adults, including mobile teams. Youth peer support services were also identified as a major gap within the array of services in the current system. Family peer support programs and parent-to-parent peer support programs were also identified.

In terms of the peer support workforce, key informants strongly indicated that there needs to be more certification and credentialing of peers. It was noted that the University of Maryland has been very active in promoting the certification and credentialing of peers, but that more training needs to be made available within the confines of Baltimore City, and funds/scholarships need to be available to support individuals in accessing the trainings. Key informants noted that a number of trainings for peers have taken place across the city, led by different organizations, but it was not thought that they had resulted in any formal certification. Formal certification of peers was viewed as helping to legitimize peer support in the eyes of the traditional BH service providers, as well as improving the quality of peer support services by helping to impose some minimal entry standards for such positions. In addition to formal exam-based certification, key informants recommended the development of peer career pathways—that the role is not just looked at as entry-level only and compensated as such, but that options for promotion exist and for peers to

be compensated at the level of value they provide to programs (on par with clinician roles). The supervision of individuals in peer support roles was mentioned as a general need, with a suggestion that supervision provided by actual certified peer specialists was helpful. It was stressed that it is important that individuals in peer support roles are supported themselves, as the work can be very taxing. It was also noted that there has been some difficulty experienced recruiting recovery specialists to work in hospital SUD settings; some of this was attributed to the intensity of hospital environments and difficulties with hospital hiring practices given SUD histories.

PSYCHIATRIC REHABILITATION PROGRAMS

Some key informants indicated that they had run into difficulty accessing PRPs (that they were few and far between), others indicated that they felt there was an over-proliferation of these programs within the community. It was suggested that it would be helpful to have a listing of all PRP programs in one place in order to increase access to these services. It was also noted that in some cases, health systems have been consolidating some of their PRP programs, resulting in less access to these services in some communities.

There were a number of financially related barriers to PRP programs identified. Key informants noted that there are no PRPs for children without Medicaid, making it impossible to access this service if one does not have Medicaid. While Medicaid does cover PRP services for adults, the reimbursement rates were viewed as being low and it was suggested that some billing policies were limiting access to this type of service. It was indicated that there is a cap of no more than six PRP encounters that can be billed for in a month, and that two or more providers cannot bill for PRP services on the same day. Such policies (or perceptions of such policies) have had a negative impact on the willingness of PRP programs to refer to others for services that they might not have available in-house (e.g., peer support, supported employment) for fear of losing their own billing opportunities, depriving the individuals being served of useful services. A key informant at the state level indicated that there actually isn't a monthly cap on PRP contacts, but there was a minimal requirement. The confusion about PRP billing policies and guidelines indicates that there needs to be more education of the provider community to dispel billing myths and misperceptions that may be impacting access to care.

In the area of program policies, monitoring, and oversight, stakeholders indicated that the quality of PRPs is quite variable. Some have a good grounding in what PRP services should be and are providing quality services; others seem to exist primarily to bill for services, with little attention given to quality or consistency of services, or little apparent understanding of what psychiatric rehabilitation actually is. It was indicated that the larger and more established programs tended to be more effective and helpful, while a lot of the newer, smaller programs seemed to struggle more with the delivery of quality services. Key informants indicated there was a clearly defined need for more active oversight and monitoring of these programs and the services they

provide at the State level, likely through licensing. It was felt that there are not enough quality requirements in place for PRPs.

Children are the only population highlighted by key informants as experiencing difficulty accessing PRP services. PRP services for children were identified as being particularly inconsistent in their approaches and reliability with service delivery. Key informants indicated that the workers not showing up when they are supposed to frustrates parents and makes them less willing to use or continue using the programs.

In relation to PRP workforce issues, key informants indicated that, in general, there needs to be more cultural competence around LGBTQIA issues, as well as a need for training in the delivery of trauma-informed care.

SERVICES FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS

Key informants indicated that there are a large number of substance use disorder services within the city, and that the issues with services tend to be more about quality of services and access to them, more so than a lack of overall capacity. Many noted an influx of new services given the increased funding to combat the opioid epidemic.[42] Despite increasing service options, stakeholders noted numerous barriers related to access. There is still a stigma associated with SUD which acts as a strong deterrent to individuals seeking services, with an interviewee citing that an estimated 10% of people that need or could benefit from services are in treatment.[43] People will frequently access services after an overdose or some sort of EMS or law enforcement contact. There was a strong desire expressed for 24/7 access to services—noting that when individuals have to wait for services, motivation to change behavior can wane and many resume usage before they are able to enroll in a program. Attitudes of city officials and the public can also impact accessibility of services; key informants noted the efforts to expand harm reduction services through the development of safe consumption zones which are not supported by many due to liability concerns. Multiple suggestions were offered as potentially helping counter barriers to access. The real-time capacity project the Baltimore City Health Department is working on is a technological solution that many thought would help increase access. Another is for services to meet people upon discharge from jail or hospital, before they have a chance to get lost within the community. Others called for individuals, such as peers, who can meet individuals in the ED and help connect them to/navigate services quickly. Street outreach was also viewed as effective for increasing access.

There were also some barriers related to financing or billing of SUD services emphasized. One was that you can't provide or bill for addiction services in an outpatient MH clinic. Another challenge identified is that Licensed Professional Counselor (LPC) staff are unable to bill for addictions counseling, even though they

[42] Upon review, BHSB staff noted the addition of Medicaid reimbursement for residential SUD services had also increased access.

[43] This is consistent with estimates of treatment penetration based on the NSDUH, such as Lipari, R.N. and Van Horn, S.L. Trends in substance use disorders among adults aged 18 or older. The CBHSQ Report: June 29, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

have more academic requirements than LADCs. It was also noted that harm reduction services need to be directly billable, and that billable services should not be limited to treatment. In the areas of financing SUD services, key informants noted there is still a reliance on grant funds (e.g., a new program targeting pregnant and at-risk teens who are homeless and currently using substances), and that this affects sustainability; and that rates for reimbursement of services, while initially adequate when first offered 3+ years ago, have not kept pace with inflation (e.g., for withdrawal management services).

Despite the aforementioned barriers, key informants seemed to feel that the most pressing challenges to provision of substance use treatment services were related to issues of service quality and lack of monitoring or regulation. Related to the quality of services, key informants reported that there is often a lack of individualization of services, with everyone treated the same. It was noted that this in turn leads to a lack of connection between the service user and provider, impacting the effectiveness and utilization of services. Stakeholders also expressed that there is a strong need for SUD and mental health services to be integrated, describing services as often siloed, with providers just wanting to deal with SUD and not underlying mental health issues because the SUD is viewed as easier to address. Additionally, the perception was that providers are able to reject individuals on the basis of having a co-occurring disorder;[44] it was felt that both the city and state should leverage their authority to insist on better standards of treatment for individuals with co-occurring disorder.

SUD program policies were also identified as presenting barriers to accessing services. It was noted that a lot of programs can have specific eligibility requirements—for example, not only having a diagnosis of SUD but also some other requirement such as 'last used 5 days ago', 'can only have an opioid use disorder', etc.—which can turn a seemingly broad pool of services into a narrow one quickly. Program policies can also sometimes serve as a deterrent—for example, curfew hours, not being able to have guests. Key informants commented on referral policies as well, noting that the Crisis Stabilization Center requirement that individuals be referred by BCRI or EMS only significantly limits access to that resource.[45] Key informants also called attention to broader program development practices, such as the siting of SUD programs. Such programs are often located in areas where there is a high population need as a means of increasing access, but such decisions can inadvertently affect the ultimate effectiveness of the programs, because that also means that they tend to be located in areas with lots of drugs in the neighborhood, posing challenges to those seeking to maintain sobriety. It was noted that individuals sometimes have to leave the city entirely to achieve recovery, as there are just too many triggers in the neighborhoods around local treatment options.

[44] Upon review, BHSB staff noted that they also frequently hear this is a major issue—that providers are allowed to reject people with complicated needs, such as dialysis, deafness, non-English speaking, or appropriately prescribed marijuana or other pain medication.

[45] Upon review, BHSB noted that this referral requirement was only in place during the very initial phases of implementation and has since changed, with walk-ins and self-referrals now accepted.

There were a number of populations that key informants indicated the addictions service system struggled to reach. Youth with addictions was the most emphasized, with key informants indicating a dearth of community-based, residential, or inpatient services. It was suggested that it can be especially difficult to find inpatient SUD services for female youth due to staffing requirements; often, the census will be too low to justify the staffing expenses, so the units close or aren't even considered as a possible option because it is expected they won't have the staff to take new admissions. Individuals with co-occurring substance use and mental health disorders were also frequently mentioned. Stakeholders indicated that they still hear about people in addictions programs being discharged when the programs realize the individual also has a mental health issue. Others noted that individuals with alcohol use disorders (AUD) often have difficulty accessing services. This was attributed to the current hyper-focus on opioids but also because community SUD providers typically don't have medical backup and are concerned about individuals with AUD going into what can be life-threatening withdrawal. LGBTQIA individuals were also frequently mentioned, with stakeholders citing that there is still a lot of stigma and that many organizations are not LGBTQIA-friendly—especially inpatient SUD units, which were identified as being challenged in housing transgender individuals appropriately. Older adults with SUD were also emphasized, due to the challenges with mobility as well as the cognitive side-effects of long-term substance use. Along the same lines, people with brain injuries were mentioned as hard to serve as it was perceived that their needs typically exceed what behavioral health providers can handle. While not widely mentioned, another population identified as experiencing challenges with SUD services, especially residential ones, were women with children. It was indicated that there simply aren't many programs that accepted women with accompanying children.

Stakeholders sensed that there seemed to be more of an adoption of harm reduction language and practices within the past three to four years among the addictions workforce, but they reported that overall there were still very few providers willing to work with individuals who are actively using drugs, as most are focused on treatment and abstinence. It was also noted that SUD providers are experiencing difficulty finding staff who have been trained in non-punitive approaches to treatment. In terms of staff shortages, it was noted that there seem to be fewer Certified Alcohol and Drug Counselors (CADCs) generally available, or physicians that are familiar with behavioral health, though there have been efforts to get primary care physicians to obtain buprenorphine waivers. Many stakeholders opined that there is a need to improve the level of competence of the SUD workforce in terms of trauma-informed care. Stigma among providers also needs to be combatted; attention was called to the need for the workforce to better serve individuals with dignity and respect, noting that if people don't like how they are received when they come through the door, they won't stick around for services.

MEDICATION-ASSISTED TREATMENT

Key informants commented on a number of aspects related to Medication-Assisted Treatment (MAT) in general, as well as specifically about methadone and

buprenorphine. Stakeholders noted that there is a stigma about the use of MAT both in the public and among behavioral health providers, including some addictions specialists. It was noted that some housing and other service programs will not accept individuals if they are utilizing some sort of MAT, and that the attitude of the general public is that they do not want MAT programs located in their backyards. Others noted that while they supported MAT, it did not address the root causes of issues like programs targeting social determinants of health do, and that simply prescribing a MAT with no additional supports was not very effective.[46]

In the area of financing MAT, it sounded as if the unbundled rate was working well and the planned increase for this summer was keeping reimbursement rates at acceptable levels, but it was also noted that there were some billing policies that negatively impacted access to services, such as a MAT program not being able to bill for counseling if an individual is living in Recovery Housing. With program monitoring and accountability, a lack of quality indicators for MAT programs was lamented because it leaves people with no objective way to tell which programs are the good ones. It was reported that the quality of MAT programs varied widely, and that the lack of quality monitoring of SUD programs has resulted in a proliferation of for-profit "mom and pop" billing mills offering medication only, no other wraparound or supportive services, and paying individuals cash for referrals to the program. Populations identified as experiencing challenges accessing MAT services include youth and women who are pregnant.

- *Methadone:* Key informants indicated that stigma against the use of methadone greatly affected access to a number of other services. Key informants reported that individuals using methadone experienced difficulty accessing sober homes and other recovery housing, transitional housing, general housing programs, and inpatient services. The effectiveness and motives of programs providing only medication were questioned.
- *Buprenorphine:* Key informants referenced a number of efforts in recent years to make buprenorphine more accessible, such as multiple initiatives supporting ED physicians in getting their waivers (including offering financial incentives), encouraging the start of MAT during an ED visit, mobile vans located outside correctional facilities to engage individuals and start prescribing upon release, efforts to prescribe and monitor via telemedicine (with workarounds of federal law), and education to correct misperceptions (e.g., that physicians couldn't refer someone to mental health counseling if they were prescribing for that person). Despite a large number of physicians obtaining the waiver in recent years, stakeholders indicated that a large number of these prescribers were not actually seeing patients, for reasons that are not understood. One population that is not receiving buprenorphine are those that are incarcerated as it is apparently not allowed to be prescribed in

[46] Upon review, BHSB staff noted that based on recent studies, MAT combined with psychosocial therapy has been shown to be more effective than MAT alone or therapy alone, but also MAT alone has been shown to be somewhat effective.

the Baltimore City Jails or prisons; key informants indicated that individuals will be switched over to methadone when entering custody, sometimes to their detriment. A key informant referenced an issue two to three years ago when the Department of Public Safety and Correctional Services (DPSCS) was concerned about pills, including suboxone, being smuggled into prisons and was successful in lobbying to get buprenorphine removed from the Medicaid formulary, making it much more difficult for individuals to access the medication statewide, not just within the criminal justice system.

- *Naltrexone:* The stakeholders interviewed did not specifically address the use of Naltrexone when discussing MAT, with methadone and buprenorphine being the only MAT medications that were directly named.

EMPLOYMENT AND OTHER REHABILITATIVE SERVICES

Stakeholders were in consensus that there need to be more employment services available to individuals being served within the public behavioral health system. Key informants indicated that there was not much available in the way of supported employment services for this population, with many programs more focused on the intellectual and developmental disability (IDD) population. Active usage of substances was identified as a barrier to engaging with employment services, and it was suggested that employment services adopt more of a harm reduction approach rather than excluding individuals if they struggle with current usage or a relapse. Having a criminal record was also reported as a huge barrier to successfully accessing employment programs. Other key informants noted that the Division of Rehabilitation Services (DORS) was not reliable, that they will reach out to individuals about their services but then not keep the appointments that have been scheduled. PRPs may also offer Supported Employment Program services, but it was noted that not all PRPs will do so and the quality of the services varies much like other PRP services. Some employment services are also available through the recovery and wellness centers, though it was acknowledged that they typically follow the Clubhouse model of transitional employment, not the Individualized Placement and Support model (IPS; generally recognized as *the* evidence-based supported employment program), and therefore do not meet the official state definition of Supported Employment. Stakeholders indicated that typically if employment programs do exist, they are not usually following the evidence-based IPS model, with the exception of employment services being offered through the ACT teams.

In terms of policies affecting employment services, it was noted that the definition of what counts as supported employment had recently changed, presumably to align more with the IPS model of services, resulting in a narrower range of services that providers are able to be reimbursed for.

Key informants indicated that individuals with criminal histories and active substance use tend to have difficulty accessing employment services. It was also noted that there are even fewer employment and educational services for individuals under the age of 18 than there are for adults, resulting in a major gap in services.

The major challenge referenced in terms of the workforce was a lack of knowledge of benefit systems, how to access benefits, and how benefits interact with work. There are apparently no Certified Benefit Specialists positions, or at least none that key informants were aware of, to help people navigate through how employment affects benefits and what is permissible and what is not.

Crisis Services

COMMUNITY-BASED CRISIS SERVICES FOR ADULTS

While stakeholders were generally complimentary of the performance of BCRI for the city's adult crisis services (when these services were able to be accessed), they did note issues related to access to crisis services. The mobile crisis team does not operate 24/7 (no overnight availability), leaving law enforcement or emergency departments as the only places to turn when someone is experiencing a behavioral health crisis outside of their operating hours[47]. The geographical area of coverage also greatly limits access, as there are limited teams attempting to cover the entire city. Time is also lost in traveling cross-city to respond, placing further constraints on already limited time available. One individual mentioned that they had personally experienced days of wait time before BCRI was able to see them in their apartment. They noted that often the hotline is the only service readily accessible, but questioned how useful this could be for individuals experiencing acute crisis and that there should be an in-person response. There was a consistent theme of BCRI doing the best they can in their situation, but of being consistently overstretched, limiting their responses to only the most serious of situations and generating frustration about the lack of alternate options.

BCRI services are largely grant funded, though we heard that they do try to bill for services via the ASO when possible. It was mentioned that they are unable to take private insurance, which had personally limited access to crisis services in a time of need for one key informant we spoke with. Others noted that BCRI's level of funding was not adequate, evidenced by there being limited mobile crisis teams to cover the entire city. Key informants also mentioned that BHSB's financing policies[48] can also cause a major strain on organizational resources, such as initial payment not being made until months after the signing of a contract, flat funding of contract amounts, and concerns about shifts to outcomes-based payment given the time-limited nature of most crisis interactions and interventions (too much viewed as out of control of the provider). It was also noted that state and federal block grant funding has not increased in many years.

It was indicated that BCRI can be challenged in serving individuals with violence histories. They do not bar individuals with a history of violence from their services, unless that person has previously had some such incident with them. Stakeholders

[47] Upon review, DOJ noted that the majority of calls during BCRI's normal operating hours came from emergency departments. See "Grant-Funded Services".

[48] Upon review, BHSB noted that it is administrative burdens of overreliance on grant funding rather than policy that impact the items described.

indicated cultural competency, specifically related to the LGBTQIA community, was a glaring area of need for improvement of BCRI services; for example, we heard that BCRI staff had even warned an individual that it was not a safe environment for them. It was suggested that this had not always been the case, but that this particular area had eroded in the face of staff turnover, with the challenges seeming to be more rooted at ground level. We heard that BCRI has been attempting to address this issue, but that it was challenging because some of it is rooted in staff religious beliefs. It was also indicated that the staff competency in trauma-informed care needed to increase.

It was noted that it can be difficult to find staff that want to do work of this nature, that are willing to go into the communities and homes for the level of pay that BCRI is able to offer—especially when competing with the hospital systems. It was noted that having more Spanish-speaking staff at BCRI would also be helpful.

COMMUNUTY-BASED CRISIS SERVICES FOR CHILDREN AND YOUTH

Key informants indicated that access to the child and adolescent crisis services system, BCARS, is even more limited than that of BCRI, even though the data show that BCARS is effective in diverting individuals from expensive inpatient care. There is no mobile crisis response that is able to perform assessments in the community; individuals must come to the BCARS offices for that service, often on the following day, resulting in no mobile or immediate crisis response. It was suggested that a recent loss of some funding had a dramatic impact on BCARS' ability to respond; a reduction in the hours of operation and a closure of the two ED diversion programs (previously referenced in the "Emergency Department" section of this report) were mentioned as some of the most visible impacts of this reduction in funding. It was also noted that there are no drop-in service centers for children and families, with one key informant indicating that it was their perception that discussions and planning for such services have been focused on adults, which also serves to limit access to needed services. Key informants strongly stressed that there need to be 24/7 service options for children and families. According to BCARS, there are usually only 2 to 3 days a year that they are full and unable to accept new referrals, and most individuals access their services through referrals from the schools and emergency departments. In terms of non-BCARS children services, it was suggested that Early Childhood Mental Health Consultation models be implemented widely within the school system.

In terms of policies, it was mentioned that the two-week limit on length of stay was not long enough for some children to be stabilized, suggesting flexibility around authorized length of services might be helpful for some families. BCARS indicated that a challenge identified with the financing of their services is that the Medicaid reimbursement rates are not adequate to support all and must be supplemented with grant funds to cover non-billable services to make the overall service viable. It was noted that an upcoming increase in Medicaid rates would help, but rates would still be below the level needed to fully support services. BCARS does not accept private insurance—one must be either uninsured or insured through Medicaid in order to access services. Key informants did not suggest that BCARS had difficulties serving

any populations; it was noted that they don't have a Spanish-speaking clinician but do use translation line services when needed.

It was noted that there tend to be more social workers in the workforce than other graduate-level clinicians, which had led to some delays in filling a certain type of non-social work position, and that it was difficult to find supervisors, but otherwise there were no types of workforce shortages encountered by BCARS. It was suggested that the previously noted low Medicaid reimbursement rates were influencing employee retention by limiting the salaries that could be offered to a level below those of the school and hospital systems.

CRISIS STABILIZATION CENTERS

Stakeholders indicated that a 24/7 crisis stabilization center for mental health clients was a critical need, suggesting that such a resource would reduce reliance on EDs and provide law enforcement with an alternative option for individuals who might not be candidates for emergency petition but still are in need of some immediate assistance. Some key informants indicated that they had been a part of a group that had done a report for the state (not the city) on the need for a walk-in mental health crisis stabilization center in Baltimore City in the summer of 2018. This work group process was intended to bring consensus in the state around what is needed in a comprehensive crisis center for people with mental illness and to pilot a program in the city that would serve as a regional crisis center. That effort did not result in a center opening due to changes in leadership at the state and due to lack of funding. In addition, this effort lead to the frustration of stakeholders as communication concerning the outcome of the work group was sparse and it was unclear what effort the state was going to take to continue to develop a center of this sort.[49]

For the existing Maryland Crisis Stabilization Center being operated by Tuerk House, key informants felt that the service had promise but noted it was still new. A few were concerned that SUD (and just opioids) had been focused on, as their data they had reviewed indicated there was more of a clear need for a mental health crisis stabilization center, and others noted that key stakeholders, like the hospital systems, had been largely left out of the conversations when the center was being planned. We heard that the crisis stabilization center had a lot of unused capacity; this was attributed to what were seen as overly restrictive referral criteria at the beginning of the project. The center was described as initially only accepting referrals from EMS or BCRI; walk ins are now accepted though there appeared to be limited awareness of this change. It was also suggested that EMS might need additional training on triaging between the ER and crisis stabilization center to increase the flow of referrals, and to be able to better describe the services offered so as to inform individuals about options other than the ED. It was also suggested that having a single site citywide served to limit access, as EMS might not want to transport individuals from one side of the city to the other and instead will rely on the closest service available, often an ED. Another barrier that was noted in terms of access to the service is that it is

[49] Upon review, BHSB staff noted that there has been some state-level policy work on this issue post-2018 (e.g., workgroup that planned the Crisis RFP).

inaccurately perceived by some in the community that the crisis stabilization center requires some sort of insurance or have presumed eligibility in order to be served, and it was suggested that this created barriers to access for individuals who may transient or homeless (e.g., without IDs, mailing addresses to receive materials, etc.). Such perceptions suggest that there remains confusion and misconceptions about what the center is, how it can be accessed, and how it fits into the larger crisis system. There were no other populations identified by key informants as experiencing difficulty accessing the crisis stabilization center services.

RESIDENTIAL CRISIS BEDS

There was broad consensus that there needs to be an increase in the number of crisis respite beds available in the city. It was noted that residential crisis bed availability through BCRI is sporadic—at times they are available, other times they are not. Key informants were not aware of any peer-run respite services available within the city, but suggested that the Living Room model was potentially a useful one for crisis respite services[50]. It was mentioned that only having BCRI offering residential crisis beds severely limited accessibility, because once they are full there is nowhere for people to turn for that resource.

In terms of financing or policy barriers, it was noted that the reimbursement rates for crisis residential services had not changed much within the past several years, and it was suggested that these should be increased to be more in line with the recently adjusted detox bed reimbursement rate. In terms of monitoring, it was suggested that more regular reviews and audits were needed to hold the service accountable, especially in regard to serving vulnerable populations.

Stakeholders noted that there are almost no child and adolescent crisis beds available either in Baltimore City or elsewhere in the state. Individuals with co-morbid medical and behavioral health conditions were also identified as having difficulty accessing/being served in residential crisis settings, due to challenges in supporting the medical needs of those individuals. As noted in the BCRI section, key informants discussed many challenges for effectively serving LGBTQIA individuals.

MOBILE CRISIS AND OTHER CRISIS SERVICES

There was also broad consensus that mobile crisis services need to be greatly expanded. It was suggested that there should be at least one mobile crisis team active for each BPD district, and that combined with a few strategically placed crisis stabilization centers throughout the city and an expansion of residential or respite beds, many law enforcement and emergency department behavioral health contacts could be averted, alleviating current pressures on the system. As noted earlier, access

[50] Living Room programs (model developed by Recovery International) use a recovery model to support stabilization and return to active participation in the community. Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy. The programs employ teams consisting of doctors, nursing staff, and peers with lived experience to engage with the guest. Risk assessment and management, treatment planning, and discharge goals are set, and a peer counselor is assigned to the guest to discuss crisis and coping skills that can be used to reduce distress and empower the individual.

to the mobile crisis services are extremely limited due to the limited number of mobile crisis teams to cover the entire city and lack of 24-hour availability for adults, and no mobile crisis assessment services for children and adolescents except for very limited grant funded mobile crisis services for schools and Department of Social Services. The ability of services to come to individuals wherever they are located in a time of crisis was viewed as being absolutely critical and largely lacking, resulting in an overreliance on police for response instead of the behavioral health professionals who should be responding. It was also suggested that youth mobile crisis services should also respond to the schools, as many youth seen in the ED are being referred by schools. Key informants noted that there can also be long wait times for mobile crisis services; for example, one noted that it was not unusual for someone to call for assistance at 11 am and be told that the team will not be able to make it to see them until after 5 pm.

EMERGENCY DEPARTMENTS

Key informants identified hospital emergency departments located throughout the city of Baltimore as one of the primary means that individuals with behavioral health disorders first access care, the other often being through an initial contact with law enforcement. It was thought that individuals often came to the ED for service because they were not aware of any other service options within the community, indicating that enhancing public awareness of alternate pathways to services could potentially reduce ED volume, as could active assistance in navigating those pathways (such as peer navigators). It was also offered that people sought services at the ED because they know they are always open, suggesting that access to alternative round-the-clock behavioral health services would divert individuals from the ED. It was noted that community providers also utilize the EDs in this manner, directing individuals to the ED for care outside of their own normal operating hours. Multiple key informants noted that people will use the ED for things like getting prescriptions refilled, or to get warm if they are on the streets and it is cold outside.

It was suggested that a perceived lack of inpatient beds by some and pressure to discharge people from those beds as soon as possible, coupled with a lack of connection to community-based services,[51] results in a revolving door through EDs. Key informants with EDs offered estimates that roughly 30% of individuals presenting for a behavioral health issue are in need of some sort of inpatient care[52]. Some stakeholders noted that boarding in the ED, with wait times of 2 to 5 days to find an open inpatient bed, is a major challenge being faced.[53] While some key

[51] 1) Overall, key informants indicated that Baltimore is a relatively bed-rich environment given the multiple strong hospital systems within the city. 2) Upon review of the draft report, BHSB staff noted that there is a lack of low-barrier, nonacute care coordination (or case management) services that can accept a referral and meet with a client within 24-72 hours.

[52] It is anticipated that this percentage would rise if more individuals were receiving adequate treatment in the community, as fewer individuals would be presenting in the ED for non-emergency needs; this would mean those being seen in the ED would be more in need of an emergency and potential inpatient level of care.

[53] Upon review, BHSB staff noted that children and youth are boarded more often and for longer periods of time than adults.

informants attributed this boarding time to a lack of inpatient beds, many others stressed the relatively bed-rich environment of Baltimore and indicated they felt the problem was more of an inefficient use of the beds that were available. Still others noted the lack of connection of individuals with community resources and suggested that better provision of quality community-based resources could help prevent some individuals from experiencing a behavioral health crisis, thereby reducing pressures on both EDs and inpatient beds.

The major barriers faced by EDs identified by stakeholders were largely related to financing. Key informants indicated that Maryland's funding system for hospitals created disincentives for hospitals to develop new programs because they cannot generate any new revenue with those programs; their annual revenues are capped. While there might be incentives for investing in their communities, the benefits of community improvement don't flow back to the hospitals and could possibly even hurt the health system if a community's lesser need then gets factored into funding distribution. Consequently, initiatives such as the crisis stabilization center are viewed as helping relieve pressure on the health systems financially by reducing the number of individuals presenting to the ED to be served (the reimbursement per person effectively goes up); contrary to many communities with fee-for-service systems where increasing patient volume increases organizational revenues.

Also in the area of financing, others mentioned the law that hospitals are required to serve individuals regardless of their ability to pay (EMTALA), and indicated that this can place a major financial strain on ED resources. Others lamented the loss of successful ED-based programs due to difficulty obtaining and sustaining funding; one key informant noted that there was a very successful diversion program that lost funding where children's crisis services staff (BCARS) were housed in some EDs to perform assessments and make warm-handoffs to their other programs.

Key informants indicated that care coordination was also a challenge faced by EDs, with EDs not knowing if an individual was able to successfully connect to a community-based provider, or if they have been recently treated in other facilities. It was noted that the CRISP program (a health information exchange for Maryland and D.C.) enabled some sharing of information, and that EPIC (an EHR program used by a majority of hospitals) also had some capabilities, but it did not sound like CRISP usage was widespread by community-based providers[54], and it was noted that there is a lot of variability among hospitals as to the information entered into EPIC.

The ED environment was also identified as a potential barrier to effective care. Multiple individuals noted that EDs are really not the best physical environment (e.g., noise, activity, surrounded by others in acute distress) for treating individuals with behavioral health disorders, stressing the importance of dedicated ED space for

[54] Upon review, BHSB staff noted that CRISP has not implemented Consent2Share, which would support 42 CFR Part 2 requirements related to protecting the confidentiality of SUD treatment records. Without Consent2Share or another solution, SUD treatment programs are limited in their use of CRISP.

behavioral health patients. Others suggested that psychiatric urgent care centers might provide more timely care and be a more welcoming environment than EDs.

There were a number of populations that stakeholders identified as experiencing challenges in EDs or as being more reliant on EDs for care. It was indicated that individuals who are experiencing homelessness may have difficulty accessing services through an ED. For example, one key informant shared that this had personally occurred to them at multiple EDs when they were attempting to get help, stating that they were told to contact 211. Individuals with intellectual or developmental disabilities or some sort of cognitive disorder and no family to facilitate care were a population identified as being particularly underserved in the community and reliant upon EDs. Another population is youth, who are often referred to the ED because there aren't any other options. Older adults experience the same, and because of the lack of specialty units, they often find themselves being treated within the ED for days, according to stakeholders. Forensic patients were also identified as being difficult to find either inpatient or community resources, as well as those with complex medical co-morbidities. Key informants indicated that cultural and linguistic competency is still a struggle for EDs, citing understaffing of interpreter services and difficulties serving Spanish- and Arab-speaking populations.

In the area of workforce barriers, key informants indicated that EDs in Baltimore are experiencing the same shortages of nursing staff as other areas in the country. The hiring and retention of staff in social work-type positions was also mentioned, thought to be due primarily to low salary levels in relation to the costs of living; we heard that individuals are quick to jump to better paying positions at other area hospitals or decide to leave the field altogether to pursue more lucrative options. The attitudes of ED staff toward the people they are serving was identified as a possible deterrent for services, with individuals indicating that doctors will often think that the individual does not know anything and discounting any information they attempt to share.

ROLE OF LAW ENFORCEMENT

Key informants were quick to point out that in a fully functional system, police officers would not be tasked with responding to behavioral health calls because non–law enforcement mobile crisis and other services would be available around the clock instead, as just the sight of an individual in uniform can be triggering to many individuals within the community, and being put in handcuffs is traumatizing in and of itself. Others questioned whether it was appropriate to use law enforcement as a hammer to get people into services (referring to the LEAD program). There is a disconnect between claiming to be trauma-informed yet then relying on police to coerce individuals into treatment. However, there was a consensus among stakeholders that more should be done to increase the community mental health crisis response to reduce the substantial reliance on police officers as first responders. Key informants pointed out the disparity in how behavioral health and physical health are responded to within the city: If one is experiencing a physical health crisis, an ambulance responds and transports to a

hospital; if a behavioral health crisis is experienced, the police respond and potentially transport to jail.

Even with such concerns, all stakeholders recognized that the system as currently constituted will continue to depend on law enforcement for behavioral health calls, and that even with a robust non–law enforcement mobile crisis response, there will always be some calls coming in that do not appear to have anything to do with behavioral health initially that upon response and the gathering of more information will turn out to be behavioral health–related. Therefore, ongoing efforts to increase the capacity for officers to respond skillfully to individuals experiencing behavioral health crises should continue to be promoted while the infrastructure for alternative crisis responses is being developed and programs implemented.

Key informants indicated that individuals often access services after some sort of law enforcement contact, and reported that in some cases even admit to committing a criminal act solely because it is viewed as a way to more quickly access services. A challenge identified as faced by law enforcement in diverting individuals from jail to crisis services is a lack of knowledge of those services available in the community. It was suggested that some sort of system that would help officers identify where available crisis stabilization beds are would be very useful in countering this barrier. Also identified as being very useful are 24/7 behavioral health urgent care clinics or crisis stabilization centers; such centers give officers a known place where an individual can be dropped off to be assessed and connected with the needed level of care with the officer quickly returning to the streets. Such clinics should take a true behavioral health approach, integrating mental health and substance use treatment, with eligibility and services not limited to just either mental health or substance use (or even only a particular type of substance use, e.g., opioids). From the perspective of law enforcement, ideally within each of the nine police district areas there would be a civilian mobile crisis team or some sort of 24-hour behavioral health urgent care/crisis stabilization center. It was also noted that there needs to be other robust community services as well, so individuals can step down to other services and keep the inpatient and crisis stabilization beds available. Stakeholders also suggested a need to create better awareness of 211, 311, crisis hotlines, and other resources that exist; it was noted that people just reflexively call 911 for everything, whether there is an actual emergency or not.

In the area of policy, it was noted that law enforcement struggles with the idea of policies to divert from a law enforcement response due to fears about being held liable if they are not physically on site in response to a call and some sort of incident happens and injury occurs. A policy was also suggested to stop arrests for prostitution and instead divert all individuals facing such a possible charge to services instead, recognizing the extensive trauma histories of women who engage in prostitution.

Key informants noted that one population that law enforcement struggles to interact with effectively are individuals from the LGBTQIA community, even among the CIT trained officers that theoretically should be more sensitive with their approaches.

Concerning issues related to the workforce, it was indicated that there has been a historical lack of support for officers' mental health, such as debriefing after a difficult call, and it was suggested that there be "mental health first aid" for officers to help each other recognize when they should reach out for help themselves. It was also noted that many police officers don't want to spend so much time in training for behavioral health—they became police officers not therapists and social workers—but that they recognize they are the only round-the-clock option for response and must learn to effectively interact with individuals experiencing a behavioral health crisis. Key informants noted a need for more trauma-informed care training for officers, which it was reported has been well received by those that have been exposed to it and has helped change the way in which they view individuals they encounter. Stakeholders indicated that a lot of officers will just look at someone's race and the neighborhood they live in and treat individuals poorly, and that there needs to be more respect in the way that they interact with people.

Baltimore Police Department Initiatives. The BPD has developed a number of specialty initiatives to better serve individuals that they come into contact with experiencing behavioral health crises in the community. The following is a summary of the major themes that key informants noted about these initiatives.

- *Crisis Intervention Team (CIT) Training:* Key informants noted that the dispatch center has a list of all CIT-trained officers, and that when a behavioral health call comes in, an attempt is made to assign it to an officer who has received the training. It was noted that the tone in which officers interact with people is everything, and that fatigue and overscheduling can play a role in how officers respond. According to key informants, in evaluations of the CIT efforts, officers who received the training indicated it helped them better engage with individuals, develop more empathy, and that they found the skills they learned useful in their life in general, not just for responding to behavioral health calls. It was also noted that the training gave a common language with which officers could communicate about behavioral health. Consistent with such findings, many stakeholders felt that *all* officers should be required to go through the full 40-hour CIT training, but it should be the choice of the officer then as to whether they want to be designated a CIT responder or not. It was suggested that a full CIT training be incorporated into the curriculum at the police academy, and that it also may be beneficial to have other first responders such as EMS complete the training. Although training has been concentrated in the Central district, there are officers across all nine districts that have been trained in CIT/BEST. The training is currently suspended as BPD performs a review of all of their training practices and the DOJ vets the curriculum they are using; this was a point of frustration for some key informants as they see the training as being both in need and effective.
- *Crisis Response Teams (CRT):* Stakeholders expressed a need for co-responder models such as the CRT. Some stakeholders expressed concern about interventions such as the CRT because they see such programs as

reinforcing the idea that the police should be responding to the behavioral health needs of individuals within the community rather than the public behavioral health system itself, though the addition of a clinician to behavioral health–trained police personnel was appreciated if there is going to be some sort of police response at all. CRT officers have done the full CIT training, Mental Health First Aid, more training on trauma and trauma-informed care, and four days of ride-alongs with the BCRI mobile crisis teams. Overall, they have at least 40 to 60 hours of behavioral health training beyond the full 40-hour CIT course. A service some deemed valuable offered by the CRT is follow-up (usually by the clinician[55]) with individuals who have received emergency petitions or recently been discharged from an inpatient unit. Challenges identified included that there is a single CRT to cover the entire city, and the limited hours of operation (11 am – 7 pm) of the program—though the hours of operation were informed by call volume data so the team would be operational during peak demand. Another challenge identified was that the team has no bilingual officers, with a recent grant proposal to expand the pool of CRT officers being unsuccessful. As mentioned previously, there was also the challenge noted of whether it was appropriate for police officers to be responding to behavioral health crises at all. Stakeholders reported strong levels of collaboration between the CRT and community partners and providers.

- *Homeless Outreach Team (HOT):* Most of the individuals, but not all, who commented on the HOT were directly involved in law enforcement roles or worked regularly with law enforcement. It was suggested that the HOT might prove to be a good resource for other community service providers trying to locate individuals who have been referred, as HOT tends to have a lot of knowledge about some of these individuals. It was indicated that the HOT is understaffed, hampering their ability to respond, but that they are in collaboration with the Mayor's Office of Human Services and other outreach teams in the city. Key informants indicated that BPD needs to have more officers who are comfortable working closely with the homeless population, not just those who are part of specialized teams.[56]
- *Law Enforcement Assisted Diversion (LEAD):* Key informants indicated that the LEAD program is doing a good job and helping people access SUD treatment, though stakeholders who were connected to the program stressed that the program was more about engaging with individuals first and foremost, and that connection with treatment is not necessarily an immediate goal. It was suggested that there was interest in expanding the program to

[55] Upon review, BHSB staff noted some find it problematic if the follow-up is not done by the clinician or is performed by the clinician in the presence of the officer, as the involvement of the officer may be viewed as coercive.

[56] Upon review, BHSB staff noted that they have heard that HOT does not consistently collaborate with community service providers, and that some stakeholders feel it would be more appropriate to have service providers conducting all outreach efforts instead of police.

target other populations or target areas, but that administrative oversight and funding challenges had hindered progress.[57] It was indicated that the LEAD program has played an integral role in providing access to both crisis and employment services, as well as educating officers about harm reduction strategies and substance use disorders in general. Some stakeholders were questioning of the program model, expressing confusion about whether the focus was on diversion from the criminal justice system or as a referral program to SUD services, noting that it could not be a true diversion program if the police were still involved. One suggested there appeared to be profiling of individuals by LEAD, such as targeting individuals who may be viewed as a community nuisance, and noted that research shows noncoercive approaches are better. Others noted that LEAD is targeting some of the very populations that have historically been most abused and traumatized by law enforcement and questioned whether the model is appropriate in light of this fact.

Specialty Courts and Service Programs. In addition to the BPD initiatives, key informants discussed a number of other criminal justice system initiatives intended to reduce the criminalization of behavioral health disorders and to connect people with needed services. The following is a summary of the major themes that key informants noted about these initiatives.

- *Drug Courts:* Key informants endorsed drug courts as an effective model for helping people to connect with services in the community and avoiding incarceration, and impressive in their compassion toward the individuals appearing on their docket. It was reported that there has been a decline in referrals to the drug courts compared to prior years—it was suggested this may have been related to falling arrest numbers after the spike in arrests after the death of Freddie Gray. The overall number of circuit court cases declined from 10,000 in 2002 to 2,500 in 2018 according to a key informant directly involved with the circuit court. It was indicated that one population the drug courts are challenged to serve in terms of achieving stabilization are those individuals who also have more significant behavioral health disorders. Criticisms of the drug court model that were noted are that the judicial system is not the appropriate place to treat and manage behavioral health disorders; that treatment is mandated, which has been shown to be not nearly as effective as when individuals decide they are ready for treatment themselves; and that you have judges who are not trained behavioral health clinicians judging mental health and substance use disorders, and dictating treatment plans.
- *Mental Health Courts:* Stakeholders indicated that, in their own personal experience, the Mental Health courts had been quite helpful in helping family members get needed treatment. It was noted by one stakeholder that in their

[57] Upon review, BHSB staff noted that some of the challenges were philosophical as LEAD relies upon contact with police for individuals to access services which the consent decree is ultimately trying to avoid. It has also been suggested that the majority of referrals to LEAD are not for diversion but are instead focused on social contacts.

experience, for the program to be effective, individuals usually needed enough of a criminal offense for the courts to mandate treatment for a year or more. As with drug courts, it was also noted that the criminal justice system is not the ideal setting for the treatment of mental illness; there are concerns about coerciveness of treatment, and the qualifications of judges to be making mental health treatment decisions.[58]

- *Forensic Alternatives Services Team (FAST):* The reliance on grant funding for the FAST program was viewed as an asset, as they aren't limited by insurance considerations in the referrals they receive. It was indicated that the program has been there for 17 years and there have never been discussions of seeking alternate funding; the judges and lawyers like the flexibility in access to the FAST team afforded, and the FAST team enjoys the programmatic flexibility they have in terms of partnering with jails, hospitals, and other providers. The flat grant funding does limit the salary[59] that can be offered for team positions, though, which has affected their ability to recruit seasoned clinicians. It was indicated that FAST's amount of community provider collaboration had declined over the years since the mental health court came online, as the mental health courts have assumed responsibility for some of the care coordination that FAST used to provide before the specialty courts existed. It was noted that since they are clinicians, FAST staff will often have a different perspective than judges or lawyers, and they see their role as advocating in the best interests of their client, not just rubber-stamping what the court desires—and have found that most judges are open to those discussions.

Inpatient Services

Key informants presented a mixed picture when it came to the adequacy of inpatient beds for behavioral health. Many noted the resource-rich environment within the city with the many hospital systems and indicated capacity was sufficient and much better than other areas they had lived or practiced in; others felt that there needed to be an increase in capacity in terms of the numbers of beds available. Some noted that they saw the issues being more due to the inefficient use of beds rather than a lack of beds. Still others indicated it was both: a shortage of beds but also poor and inefficient use of the beds available. It was noted that the issue is not always the number of beds available, but how accessible they may physically be to the individual, as the individual may not be able to travel to where the available beds are. Others noted the mix of individuals on a unit can impact the availability of seemingly open beds; an example was given of a pediatric unit accepting an adolescent with a history of violence toward younger children and consequently not being able to accept any new

[58] Upon review, BHSB staff noted that BHSB has a partnership with the DTC and MHC to place assessors in the courthouses to assist with identifying appropriate service for those who volunteer or decline to participate in a specialty court.

[59] Upon review, BHSB staff noted that the higher cost of doing business with the city compared to a community based provider also affects this.

admits of children under the age of 10 due to safety concerns. That is, it may look like they have unused capacity, but the open beds may not be available to the 8-year-old sitting in their ED. Such issues were also identified as being a major challenge to the creation of bed registries, mentioned as a possible solution to increase ease and speed in finding an open bed. There was agreement among key informants, though, that enhanced community services and crisis alternatives would help ease the current and widely observed demand for inpatient beds.

Key informants noted some policy and practice issues impacting inpatient services. Key informants raised issues about the typical length of stay, reporting that it was not unusual for individuals to be admitted and held for 72 hours and then being discharged back to the community before they are truly stable, which results in the individual finding themselves back in the ED a week later and repeating the process over again. Key informants recognized that such discharge practices are often due to the demand for beds, but that such practices also inflate the demand for beds because the service is not adequately meeting the needs of the individual, maintaining their demand for the bed. Some noted that inpatient units had restrictive policies that didn't seem to have much value; for example, not being able to have access to one's phone was viewed as being counterproductive because it cuts people off from natural supports in the community needed for success.

There were also some financial policies and factors impacting inpatient services. It was suggested that the change to more value-based purchasing systems such as the new total cost of care waiver model currently being explored/transitioned to in the state may inadvertently affect access to inpatient beds for older adults and others viewed as more likely to need readmission, though such potential issues are attempting to be addressed through risk adjustment considerations. Some felt that the current reimbursement levels were not adequate for the complexity of the individuals they find themselves serving.

There were a number of populations identified as experiencing difficulties accessing or being discharged from inpatient beds. Key informants indicated that there was a lack of inpatient substance use disorder beds for youth. Individuals with co-morbid psychiatric and medical problems were reported as having problems accessing services at certain hospitals, or being discharged from an inpatient bed back to the community; for example, an individual may be on an inpatient unit and require dialysis, but they can't discharge to the community because the services that can handle the dialysis won't accept them because of the psychiatric diagnosis, or some psych units may refuse to admit the individual in the first place if they cannot handle the dialysis services. Others noted a lack of specialty units for older adults. Individuals with IDD were also identified as experiencing difficulties accessing inpatient beds. Any type of criminal or forensic history was identified as affecting timeliness of discharge due to difficulty finding community services. It was also suggested that there is a shortage of beds for individuals with serious mental illness who require more long-term extended care, as the state hospital largely only serves forensic patients now.

In terms of the inpatient workforce, it was suggested that there needs to be more education around trauma-informed care. Key informants indicated that there were some hospital systems doing better than others in this area, but that overall across the city being more trauma informed is a need for inpatient services. Stakeholders also expressed a desire for more peer support services being available on inpatient units. It was noted that hospitals have had a hard time recruiting addiction recovery specialists, making it harder to open SUD units.

Discharge and Community Reintegration

Many key informants noted the need for effective discharge planning with follow-up, and for community reintegration programs following incarceration for individuals with behavioral health diagnoses. It was suggested that the lack of successful connection with community-based resources after discharge from inpatient or correctional settings contributed to the volume of ED utilization observed, as individuals turn to the ED for their care. Many noted that discharge planning is happening, referrals are being made, but individuals are not connecting with those services they are referred to. This was thought to be due to a lack of time and funding for follow-up on the part of the discharge side, a lack of outreach to individuals once referrals are received on the community side (again due to issues of time and funding), and lack of follow-through by the individual (possibly because of the lack of an existing relationship with the community provider). It is likely all the other usual reasons for lack of referral connection also apply (transportation, costs, perceived level of need for the service by the individual, etc.).[60] Numerous stakeholders also mentioned that they thought discharges were happening too soon, before individuals had a chance to fully stabilize, resulting in a revolving door between ED, inpatient, and community.

Stakeholders identified a few promising approaches that had demonstrated the ability to foster successful connections to services. One program described, Second Chance, did provide in-reach to the prisons. Beginning four months prior to a person's release, the community mental health provider would begin meeting in the prison with the individual and provide services in that setting, with the result being a 100% attendance rate at the first appointment in the community after discharge. This success was attributed to the ability to develop a therapeutic relationship with the individual prior to their release. As we heard often happens in Baltimore, though, this very effective pilot program was unable to secure sustainable funding and closed. A second effective program, currently being piloted with foundation and state grant support, involves having a van parked outside Baltimore Detention Center staffed

[60] Upon review, BHSB staff noted that 1). Many/most discharge planners only see a client for a short time period 2). Most services discharge planners are referring to do not necessarily include an assertive engagement component 3). There's a need for high-quality CM/CC services to provide both pre/post discharge care planning and to ensure continuity of care planning as persons transition in/out of institutional care and through different community-based levels of care.

with doctors and nurses, distributing buprenorphine and connecting people to community resources, including primary care.

In terms of financing challenges or barriers to discharge planning and community reintegration, it was noted that Medicaid expansion has had a significant effect on increasing access to community-based services. Although there is presumptive eligibility for Medicaid for those discharged from a correctional facility, it was noted that individuals still need to actually complete the enrollment process within 30-days after release. It was suggested that the ability to enroll while still incarcerated would be useful, as individuals are often focused primarily on finding a place to live and getting a job after discharge, whereas health and health coverage may be secondary concerns for them.

There were multiple populations identified as experiencing additional challenges during the discharge or community reintegration process. Individuals who have a challenge with immigration status were identified as being particularly hard to successfully connect with community-based services and resources. It was noted that individuals' criminal histories, especially sexual charges, can make it nearly impossible for them to access housing and community behavioral health programs. As mentioned under inpatient services, older adults experience difficulty finding community placements coming out of inpatient beds, as many nursing facilities refuse referrals due to mental health diagnoses. It was suggested that a specialized psychiatric nursing facility might be useful as a step-down option. Medical co-morbidities can also make placement more difficult; for example, requiring an oxygen tank for breathing can limit the options available. Individuals who are homeless at admission were also mentioned as facing challenges (securing housing) that resulted in an average length of inpatient stay twice as long as individuals who were not homeless. Youth were also identified as getting stuck in inpatient beds due to a lack of community service options to discharge to.

Other Findings

CONSUMER INVOLVEMENT

Key informants indicated there was room for improvement in regard to consumer involvement in systems design and governance. While there is a lot of data collected directly from consumers (e.g., satisfaction surveys) which are used to inform service delivery, and the Consumer Quality Team (CQT) effort remains a strength, opportunities for a direct say in decision-making processes through involvement on advisory or oversight committees are much more limited. Numerous key informants identified examples of such levels of involvement within their organizations and of individuals with lived experience leading or playing key organizational roles; however, the dominant theme was that consumer involvement was largely limited to being a source from which data was collected. Recent efforts by BHSB to increase consumer involvement in the CPIC were commended, and it was suggested that supporting individuals in preparation for their roles and compensating people for their time help increase involvement. It was noted that the state has historically been progressive in

the area of consumer involvement and actively invested in trying to incorporate the voices of individuals receiving services, especially under a recent former BHA director, but that the current administration is much more controlled about who has input and that has served to negatively impact the level of consumer involvement statewide. It was noted that consumer-run advocacy organizations are largely dependent on state funding for their existence, which in turn can limit the independence or perceived independence of their voice, and it was suggested that some groups are even worried about retribution for attempting to influence key policy debates.

Key informants also commented on consumer involvement in service planning and treatment decisions, identifying this as an area in significant need of improvement. Individuals receiving services reported that there is little to no individualization of care in their experience, and that, overall, they had little say in what services they received. For example, one person shared that they had just been told by their provider to go to another floor in the organization and speak to a person, and not told why. When they did so, they discovered that the person was part of employment services, and were baffled as to why they had been referred there because there had never been any discussions between this individual and their provider about attempting to return to work, let alone asking if it was a goal they wanted to pursue. Others reported they had similar experiences throughout the city. Many service users reported feeling that many of their service providers did not respect or truly care for them as individuals, or were not passionate about the work they were doing; individuals got the sense that many were working in the positions simply for the paycheck or benefits. This was an unexpected bit of feedback given the proliferation of "psychiatric rehabilitation" programs within the city, given it runs directly counter to multiple core principles and values of Psychiatric Rehabilitation (see https://www.psychrehabassociation.org/about/core-principles-and-values) to which the program should be adhering. It was also mentioned by multiple key informants in service delivery roles that the system has lost sight of individualization of services, and did not value consumer voices or experiences.

PROVIDER COLLABORATION

One key informant characterized the public behavioral health system in Baltimore as a system built on relationships, in contrast to other systems they had worked in which the system was more formal and procedural. Baltimore is also often described as a city of neighborhoods. According to the key informants interviewed, this largely describes the state of cross-provider collaboration in Baltimore. Key informants that felt there was strong collaboration in the city often referenced personal and organizational relationships built over years of working together, while those that felt collaboration was lacking described a siloed system, with providers looking out for their own immediate vicinity or collaborating with others in their immediate vicinity but unwilling to collaborate on a deeper or broader level (focused on their own "neighborhoods"). Many noted the efforts of BHSB to pull providers together and promote collaboration, and felt they were having an impact. The CPIC was identified by some as the most collaborative body they've ever been a part of. However, they

were also quick to note several barriers to increased levels of collaboration, such as the amount of unreimbursed time that collaborative efforts can take and competing demands for that time, as well as a limited pool of resources to go around that organizations are in direct competition for. Key informants indicated that while there are some territorial issues here and there, for the most part there is an interest in and willingness to engage in provider-to-provider collaboration.

SERVICE COORDINATION

Overall, key informants indicated that coordination of individual level services could be improved, with real challenges maintaining continuity of care across different levels of care within the system as well as across systems. Much like other provider collaboration, it was indicated that some organizations were better at service coordination than others, with some having integrated data systems and IT (such as the CRISP system) and others noting ongoing city initiatives to develop solutions to assist all provider organizations (the real-time SUD registry). Key informants indicated that the major barriers to improved service coordination are privacy and protection laws (HIPAA, 42CFR) and the fact that service coordination is largely a grant funded service and not billable through Medicaid or other payors.

Key Takeaways from Stakeholder Interviews

The key informants interviewed presented a picture of the Baltimore public behavioral health system as one with many strengths, but also facing many challenges. The strengths include being a relatively service-rich environment, with many key stakeholders already together at the table collaboratively attempting to address the challenges facing the system (e.g., the CPIC). Some of the gaps and needs identified by system stakeholders already have initiatives underway or in the planning stages to address key challenges; although these were known to the key informants, key informants stressed the need for more to be done. Looking across all of the interviews and across all services and topics, the following key takeaways were apparent:

- Neighborhoods need 24/7 access to community-based behavioral health services. Community-based, non-police led mobile crisis response teams should be greatly expanded, and need to be supplemented with crisis stabilization, community behavioral health (e.g., CCBHC), or peer-run drop-in centers, as well as residential crisis and peer-led respite beds and other round-the-clock options that divert individuals from emergency departments and police contacts by providing alternative disposition options to inpatient care or jail for those still coming into contact with police. Enhancing these types of community-based services will greatly relieve the pressures currently observed on law enforcement and other first responders, emergency departments, and inpatient beds.
- Community education efforts need to be enhanced, with two main areas of focus: anti-stigma efforts targeting both providers and members of the public

(and public education about MH and SUD in general) and campaigns aimed at increasing awareness of service options and the resources for accessing them.

- There needs to be a continued focus on increasing the use of non-methadone MAT services. Also, while stakeholders indicated progress has been made in the adoption of harm reduction approaches, more efforts are needed to educate providers and the community in general about harm reduction.
- Peer services and consumer involvement at all levels (individual service planning through systems planning and oversight) need to be enhanced. Expansion of the formal certification processes (including exploration of exam-based certification that can test competencies) can help ensure a qualified peer workforce, critical for opening additional funding streams and overcoming provider resistance to peer services. There needs to be continued education of providers about Certified Peer Recovery Specialist (CPRS) roles and practices. Peers were widely viewed as bringing added value to Outreach and Navigator roles. Efforts need to be made to ensure there is more peer involvement in systems planning and oversight.
- Workforce development efforts need to continue to target trauma-informed care and enhanced cultural competence (e.g., working with Spanish-speaking or LGBTQIA community members), as well as providing person-centered individualized care.
- The following services need to be increased: care coordination from the ED or inpatient at discharge, criminal justice reintegration, and community-based case management and systems navigation, including ACT.
- Monitoring and oversight of community-based services needs to be enhanced, with the widest variability in quality reported with PRPs and MAT programs.
- Additional services that need to be expanded include housing with supportive services, evidence-based supported employment programs, and prevention and early intervention efforts (such as Early Childhood Mental Health Consultation, or ECMHC, in the schools and other Early Childhood Education sites)

Law Enforcement Crisis Interaction

The consent decree required the City to analyze a sample of police interactions with people with behavioral health disabilities to identify systemic barriers and solutions (a "root cause analysis"). HSRI attempted but was unable to obtain detailed individual level data about police interactions with people with behavioral health disabilities required for such analysis. This was because the data needed are not widely or consistently collected- and when collected, information is often missing (see Dispatch and Behavioral Health Form Data below). While BPD is taking steps to collect these data through the development and piloting of a behavioral health reporting form, the

piloting of the form with the CRT and in the Central District (the district with the highest percentage of CIT trained officers) means that the behavioral health contacts data that do exist are from the most highly-trained officers on the force and therefore are not likely to be representative of a typical behavioral health contact elsewhere in the city. In order to conduct the root cause analysis as called for in the consent decree, data on behavioral health contacts will need to be widely and consistently collected across the city to allow for a representative analysis, with the individual-level data from the forms made available to researchers so there can be direct follow-up with individuals involved in specific incidents for further exploration of precipitating or contributing factors. Access to such individual level data will also allow for advanced statistical analysis that can quantify the impact of factors such as race, age, gender identity, service utilization, and more on incident outcomes.

However, despite the limitations of the data available and inability to conduct the root cause analysis as initially intended, HSRI was still able to obtain or directly collect some data that provide insight about individuals' interactions with law enforcement officers during a time of behavioral health crisis.

Dispatch and Behavioral Health Form Data

In order to better understand the prevalence of such interactions and the perspective of individuals who had experienced contacts with law enforcement during a time of crisis, HSRI obtained data from BPD on numbers of calls for services, numbers of calls related to behavioral health, types of behavioral health calls, CIT training status of responding officers, and summary descriptives of more detailed information that had been collected for a subset of behavioral health calls, through the behavioral health forms initially developed and undergoing revision by the CPIC data subcommittee, in accordance with the consent decree. In addition to the data from BPD, HSRI also conducted three focus groups at community organizations that included 29 individuals who self-identified as having personally had a recent contact (within the past few years) with Baltimore police during a time of behavioral health crisis.

Error! Reference source not found. notes both the total number of behavioral health–related calls and the proportion of all calls that are related to behavioral health. Even though there are roughly 13,000 behavioral health calls per year, or around 35 per day, behavioral health calls remain a small percentage of the total calls for service received by the Baltimore Police Department. **Error! Reference source not found.** breaks that total number of calls per year down by police district. As demonstrated, the Northeast district has received the highest number of behavioral health calls for each of the past three years. The CIT training has been heavily concentrated in the Central district. Other than a few minor decreases in some districts from 2017 to 2018, the data show a steady pattern of an increasing number of behavioral health–related calls across districts each year, suggesting both a need for increasing community crisis and other services to reverse this trend and also a need for BPD to resume and continue expansion of CIT training in order to better respond to such calls.

Figure 8

Behavioral health calls compose only a small proportion of BPD dispatch calls

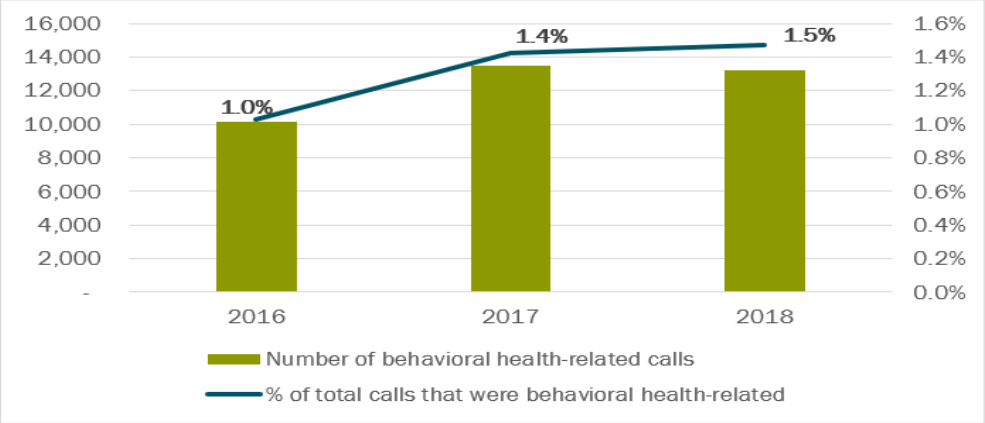
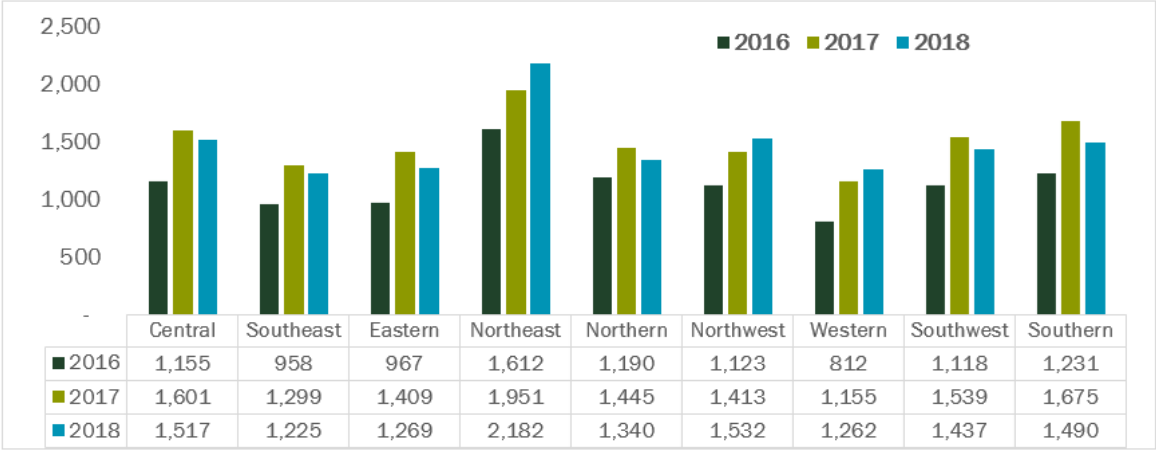


Figure 9

Number of behavioral health–related calls to BPD by police district

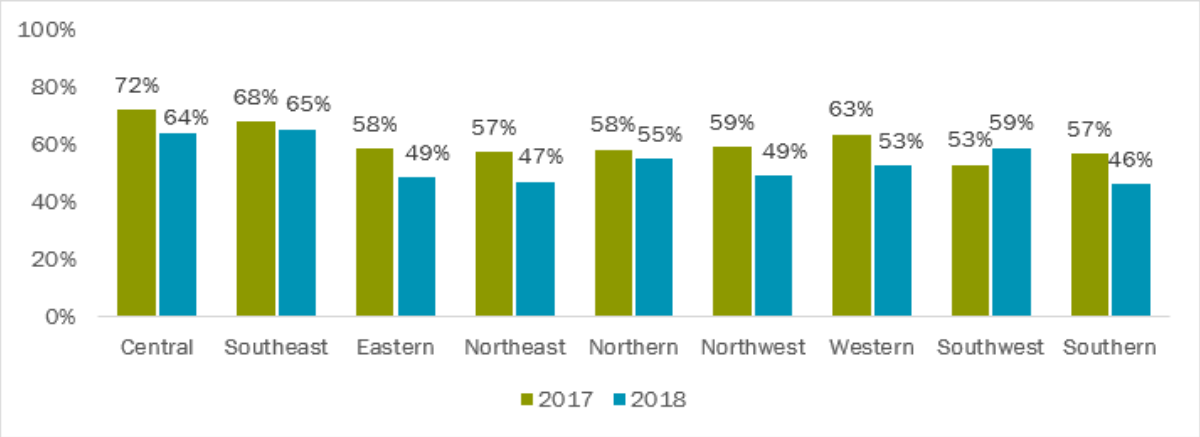


	Central	Southeast	Eastern	Northeast	Northern	Northwest	Western	Southwest	Southern
2016	1,155	958	967	1,612	1,190	1,123	812	1,118	1,231
2017	1,601	1,299	1,409	1,951	1,445	1,413	1,155	1,539	1,675
2018	1,517	1,225	1,269	2,182	1,340	1,532	1,262	1,437	1,490

Despite the emphasis in the consent decree on better preparation of officers to respond to behavioral health calls, the data show that fewer specialty trained officers are being dispatched to handle such calls—and, in fact, the odds are little better than a coin flip that a designated officer will be dispatched to an incoming, recognized behavioral health–related call. **Error! Reference source not found.**10 shows that eight of the nine police districts showed fewer CIT-trained officers being dispatched for behavioral health related calls in 2018 than in 2017, with only the Southwest district showing an improvement.

Figure 10

Percent of behavioral health calls responded to by a CIT-trained officer



Note: Data on 2016 call responses by officer type were unavailable.

This is particularly interesting in light of the fact that all dispatchers went through CIT training in 2017; it might be assumed that post-training, dispatchers would be better at identifying behavioral health calls when they come in and better recognize the importance of dispatching a CIT trained officer to them, yet this does not appear to be the case. It is possible that with the training active in 2017, this issue was more at the forefront of dispatchers minds, being reinforced by the trainings or communications about them, and that, with the passage of time and relatively rare occurrence (roughly 1.5% of calls handled, as indicated in Figure 8) the issue has become less of a priority. If this is the case, booster trainings and reminders might have an impact.

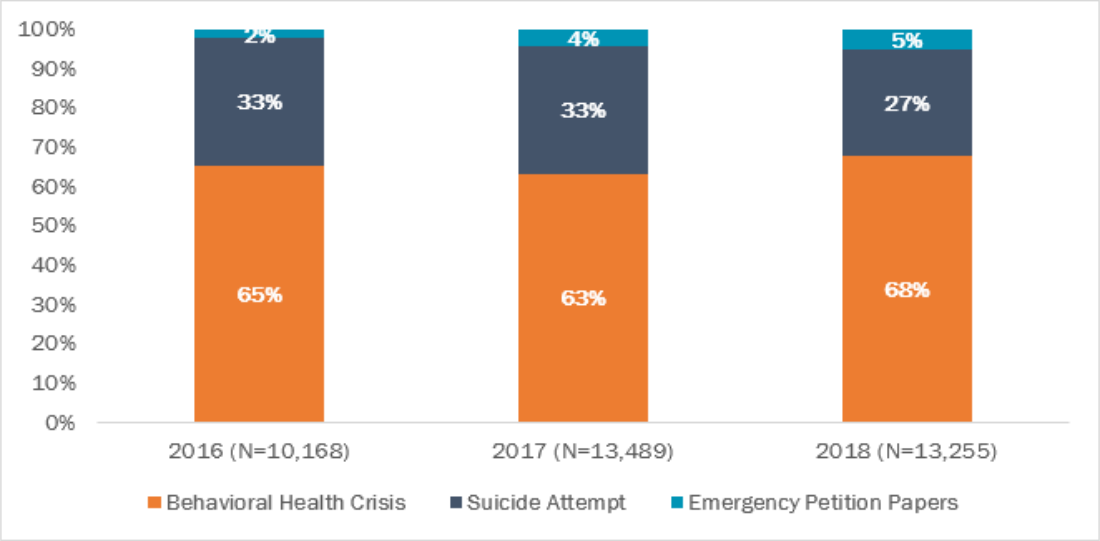
An alternate explanation might be that the number of CIT-trained officers available to respond dropped in 2018. Although the CIT training was suspended before the start of 2019, it seems doubtful that attrition of CIT-trained officers alone would account for the double-digit percentage drops seen in many districts. It is also interesting to note that even in the district where CIT training has been targeted with the highest saturation of trained officers, only 64% of calls were responded to by one of those officers in 2018. The reasons why so few calls identified as being behavioral health–related are being responded to by CIT-trained officers need to be explored in more depth, as well as why those efforts appear to be moving in the wrong direction.

It occurred to us that maybe dispatchers were flagging calls as being behavioral health–related but were not viewing the situation as being serious enough to require a response by a specialty trained officer, so we took a look at the types of behavioral health calls that came in. Key informants had noted that people in Baltimore tend to call 911 for everything, and though a call may be behavioral health–related, the dispatcher might not think that a CIT response was necessarily needed. **Error! Reference source not found.** shows the breakout of the types of behavioral health calls. Roughly two thirds were for some sort of behavioral health crisis. Given the hypothesis that dispatchers may be recognizing the behavioral health aspect of a call but not feeling a specialized response was required, we decided to look at the response

rate to calls that came in as emergency petitions (EP), orders for police to pick up a person and take them to the nearest ED.

Figure 11

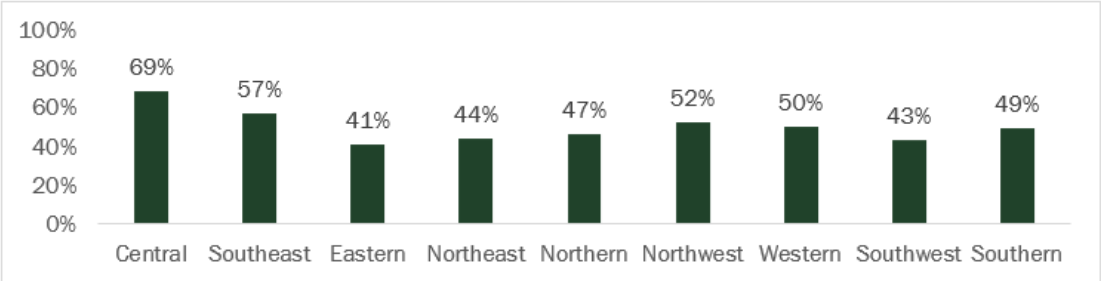
Two thirds of behavioral health calls were related to behavioral health crises



EPs are pursued when an individual is at imminent risk of harm to themselves or others. Given that, we would expect that surely a call for an EP would be recognized as an acute crisis—one in need of a specialized behavioral health response. However, as **Error! Reference source not found.** demonstrates, with the exception of the Central district, these calls were responded to by a CIT/BEST trained officer at a *lower* rate than behavioral health calls in general (**Error! Reference source not found.**).

Figure 12

Percent of emergency petitions responded to by CIT-trained officers, 2018



We also examined the timing of behavioral health calls for service during 2016, 2017, and 2018, and found that roughly one third of these calls occurred during the hours of 6 pm – 6 am, when most community-based service providers are currently unavailable. This highlights the need for police officers to have after-business-hours non-ED community options available for disposition.

INDIVIDUALS WITH LAW ENFORCEMENT CRISIS INTERACTIONS

The BPD is in the process of updating its data collection forms and processes as part of the CPIC work that is being done. Currently, CIT-trained officers responding to calls in the Central district and all Crisis Response Team (CRT) response calls citywide are supposed to have a Behavioral Health Form completed along with other documentation. These Behavioral Health Forms contain more detailed information about the nature of the call and what happened during the call. The vision is to have a form completed for a behavioral health call by all CIT-trained officers, and eventually all officers, citywide.

HSRI attempted but was unable to obtain the individual form data from BPD for further analysis during the timeframes of this project. However, BPD does contract with the Center for Gun Policy and Research at the Johns Hopkins Bloomberg School of Public Health to conduct analysis of those forms, and both BPD and Johns Hopkins shared aggregate summary analyses done for BPD for use in the gap analysis.

The latest update received (3/29/19) indicated there had been 658 behavioral health forms completed between 6/14/2017 and 3/24/2019. The average age of individuals was 37.7 years, 56.4% were male, and 78.4% were African American. A fair proportion were homeless (21.1%), and 3.3% were veterans. Officers indicated alcohol use on 7.5% of forms, drug use on 11.1%, and concurrent alcohol and drug use on 3.5%, suggesting that over 20% of calls involved active use of substances. In terms of services received, 38.9% of forms indicated that the individual had been prescribed medication, 12.3% indicated current usage of medication, 33.7% indicated the individual had a previous psychiatric hospitalization, and 44.2% indicated the individual was suicidal.[61]

Although there was some information about the type of training the responding officers had received, this was missing on 27.7% on forms, and 14.1% had indicated more than one training received, limiting the usefulness of that information.

Error! Reference source not found. displays the disposition of the contact indicated on the behavioral health form. Of note, only 0.8% of contacts resulted in arrest, while most (89.2%) resulted in an emergency petition. Only 0.6% ended with the individual going to BCRI, presumably for a residential crisis bed. While this data indicates that the CIT officers and CRT are successfully diverting individuals experiencing a behavioral health crisis from jail, there appears to be much room for improvement in terms of diversion from inpatient usage to appropriate community-based alternatives. Key informant interviews would suggest that this is largely because of the lack of knowledge, availability, or accessibility of such alternatives.

[61] Marisa Booty, Johns - "Behavioral Health Form Summary (3.29.19 Update)"

Table 11

Disposition of contacts from BH forms

Disposition	Frequency	Percent (%) out of 658
Arrest	5	0.8
BCRI	4	0.6
Emergency petition	587	89.2
Information/referral	43	6.5
Provider contacted	8	1.2
Voluntary ER intake	29	4.4

Note: Some incidents resulted in more than one disposition, so frequency total exceeds 658.

Source: Marisa Booty, Johns Hopkins- "Behavioral Health Form Summary (3.29.19 Update)"

Of the 658 forms completed, 216 (32.8%) indicated that a call for specialized resources was made. **Error! Reference source not found.** identifies what those resources were, and also indicates that there is a lack of usage of community-based resources, with only 5.6% of the 216 forms indicating that BCRI/Mobile Crisis was called.

Table 12

Specialized resources requested

Resource Requested	Frequency	Percent (%) out of 216 forms
BCRI/Mobile Crisis Response	12	5.6
CIT officer	111	49.1
CRT unit	175	81.0
Homeless outreach	10	4.6
SWAT	4	1.9
Emergency Service Unit	1	0.5
Negotiation team	2	0.9

Note: Some officers requested more than one specialized resource

Source: Marisa Booty, Johns Hopkins- "Behavioral Health Form Summary (3.29.19 Update)"

Error! Reference source not found. shows the hospitals that individuals were transported to by officers. Consistent with the close to 90% rate of emergency petitions (**Error! Reference source not found.**), 90.7% (597) of the forms indicated that the individual was transported to a hospital. Upon an initial glance, it appears that there are certain hospitals greatly favored over others, with the vast majority of calls going to University of Maryland Medical Centers. However, this is simply an artifact of most of the Behavioral Health forms largely being completed by officers in the Central district and the legal requirement to transport someone to the closest emergency department possible.

Table 13

Transportation to hospitals

Hospital Name	Frequency	Percent out of 597 (%)
Bon Secours	8	1.3
Greater Baltimore Medical Center	1	0.2
Harbor Hospital	6	1.0
Johns Hopkins Bayview Medical Center	4	0.7
Johns Hopkins Hospital	50	8.4
MedStar Union Memorial Hospital	2	0.3
Mercy Medical Center	3	0.5
Sinai Hospital	9	1.5
St. Agnes Hospital	2	0.3
University of Maryland Hospital/Medical Center	132	22.1
University of Maryland Medical Center- Midtown Campus	376	63.0
Other	4	0.7

Source: Marisa Booty, Johns Hopkins- "Behavioral Health Form Summary (3.29.19 Update)"

In summary, the behavioral health forms are only currently being collected on a fraction of the behavioral health calls that are occurring.[62] There are 658 total forms for Central district (all CIT trained officers within the district should be completing) plus including CRT (which would be across all districts) in about two years, with roughly 1,500 behavioral health calls per year for the Central district alone (Figure 9). Of these roughly 1,500 calls, an average of about 68%—or roughly 1,000 calls per year—are being responded to by a CIT-trained officer (Figure 10), suggesting that the number of total forms completed would be close to 2,000 if done for every contact by a CIT-trained officer. This suggests that over the nearly two-year period of time they have been collected, the Behavioral Heath forms are being filled out for roughly one third of the contacts that they should be, and when filled out, some key fields such as training of the responding officer are frequently being left blank.

Although limited, the data contained in these forms show that while the responding officers are doing a great job at diverting individuals with behavioral health disorders from jail—which should be recognized and strongly commended—there remains a heavy reliance on transportation to EDs and pursuing emergency petitions with little utilization of the crisis system and associated community-based alternatives. This lack of utilization of the crisis system is particularly surprising given that the clinicians for the CRT are housed within BCRI, as it might be expected that they would not only be aware of crisis options available but be fully familiar with BCRI referral policies and procedures. It also should be noted that this is data from the best-trained officers within the department (CRT and the district that has been priority for CIT training).

[62] The form is currently in a pilot phase, being used in only the Central district and with the CRT team. The form will be used city-wide once the approved draft of Policy 712, *Crisis Intervention Program* is trained upon and implemented.

Summary of Key Themes from Focus Groups

In June, we held three focus groups focused solely on the interactions that people had with law enforcement officers during a time of behavioral health crisis. A total of 29 individuals with lived experience participated and shared their experiences, perceptions, and suggestions for how people could be better supported by law enforcement during a time of crisis. Please refer to Appendix F for a copy of the discussion guide used.

Participants in all three focus groups pointed out that not all interactions with law enforcement officers were negative, and that there were some officers who were helpful. One individual stated that the interaction had gone well because the officer understood him and saw him as a person, and attributed this understanding to the fact that the officer disclosed that his brother had schizophrenia, too. However, this proved to be the exception instead of the rule.

Many individuals indicated that the way law enforcement treats people during a time of crisis is traumatizing in and of itself; people spoke of calling for help and being handcuffed with no explanation given, being hauled off in front of family, friends, and neighbors. Individuals reported that they have been "roughed up" or "taken down." Other major themes were that officers are quick to make assumptions about people and resistant to change those assumptions; for example, assuming someone was on some sort of drug and repeatedly asking the individual what they have taken when they had already indicated they hadn't used any substances. People indicated that this sort of experience- where they shared information with the officers and the officers either flat out did not believe or discounted what they had to say- was not uncommon. They also indicated that the tone of some interactions would change for the worse as soon as any sort of mental health history was disclosed. A few individuals felt that the militarization of the police force was perpetuating an "us vs. them" attitude, assuming people are criminals instead of in need of some help. Individuals in two of the groups indicated that they had experienced racial profiling in the past. Individuals felt that there was a lack of competence on the part of law enforcement in working with individuals from the LGBTQIA community, or in understanding brain injury. Individuals in all three focus groups indicated that their experiences with law enforcement during a time of crisis had made them reluctant to share their mental health or substance use status or reach out in a time of crisis for fear of getting a response by law enforcement.

The focus group participants had a number of suggestions for how law enforcement interactions with people experiencing a behavioral health training could be improved. Many centered around training: general anti-stigma training around behavioral health, additional training on mental health and substance use disorders and services, and much more training on trauma-informed care, cultural competence, and how to be sensitive in interactions with LGBTQIA individuals. Other common suggestions were that officers need to listen to all sides of the story, including that of the individual experiencing the behavioral health crisis, and that they needed to be more kind in the way that they interact with people, treating the individual in crisis with

respect—or how they themselves might want to be treated if they were going through a difficult time. Multiple focus groups stressed that there needs to be some sort of specialized response with police for mental health calls: either specialty officers with advanced training or models like the CRT where an actual mental health clinician is part of the response. Some felt that advanced behavioral health training should be a part of the police academy experience. Many recommended that there should be non–law enforcement alternative responses available, and be robust enough that they can actually respond to calls for service; multiple individuals noted that they had called BCRI attempting to access crisis services and received a law enforcement response instead—in some cases because BCRI was not available at that time or until the following day, but at other times they weren't sure why police had been the ones to respond.

Key Takeaways from Law Enforcement Crisis Interaction

The dispatch data, behavioral health forms, and focus groups with individuals with lived experience identified a number of key takeaways related to law enforcement interactions with individuals during a time of behavioral health crisis. These are:

- The lack of data available hampered the ability to conduct a detailed root cause analysis, though some data were able to be obtained. Data needs to be more widespread and consistently collected on law enforcement contacts with individuals experiencing a behavioral health crisis.
- There needs to be deeper exploration into reasons that CIT-trained officers are not responding at higher rates to what are clear behavioral health calls (e.g., emergency petitions). Even in the district targeted with training efforts, many calls are responded to by non-specialty officers.
- Officer training efforts need to be ongoing. Intensive behavioral crisis training should be occurring with all officers. All officers need exposure to advanced behavioral health training, and training must be sure to include trauma and working with subpopulations such as the LGBTQIA community as well..
- There needs to be access to, awareness of, and further development of community-based alternatives to emergency departments, such as residential crisis beds and other diversion services within the system of care, such as 24/7 mobile crisis for adults and youth that operates as true mobile crisis (e.g., response at the client's location, within an hour of the client's call for service).
- Officers need to interact with individuals in the manner they themselves would like to be treated during a time of distress. This would mean treating all individuals encountered with respect and understanding, and not immediately discounting information shared simply because an individual has a behavioral health disorder.

Despite the best efforts of the system, there will still inevitably be contacts with police at times for individuals experiencing behavioral health crisis—even with a full continuum of community-based crisis services. Therefore, it is critical that police

officers be better prepared for such contacts, so that individuals (both in crisis and the officers, family members, and other individuals responding to it) are not at risk of further traumatization from the act of seeking help.

Consumer Outcomes

HSRI attempted but was unable to obtain individual level consumer outcome data from the Behavioral Health Administration (BHA) of the Maryland Department of Health (MDH) within the timeframes of the current project. While there had been hope of combining individual level claims data with individual level outcome data to closely examine the relationships between types of services received and outcomes experienced, publicly available aggregate outcome data can still provide some hints into how well the system is currently achieving its goals of improving the recovery and functioning of the individuals it serves. It is important to note that this outcome data is not collected from all individuals served, only those being served by certain types of providers, though they represent a large proportion of those submitting claims data. Consequently, the data may not represent the effectiveness of the entire system and all the services within it but do provide insight into how part of the system is working.

The BHA's Outcomes Measurement System (OMS) DataMart displays data on various domains, including living situation, psychiatric symptoms, substance use, recovery and functioning, legal system involvement, and employment among individual's receiving outpatient behavioral health treatment services in Maryland's public behavioral health system (PBHS).

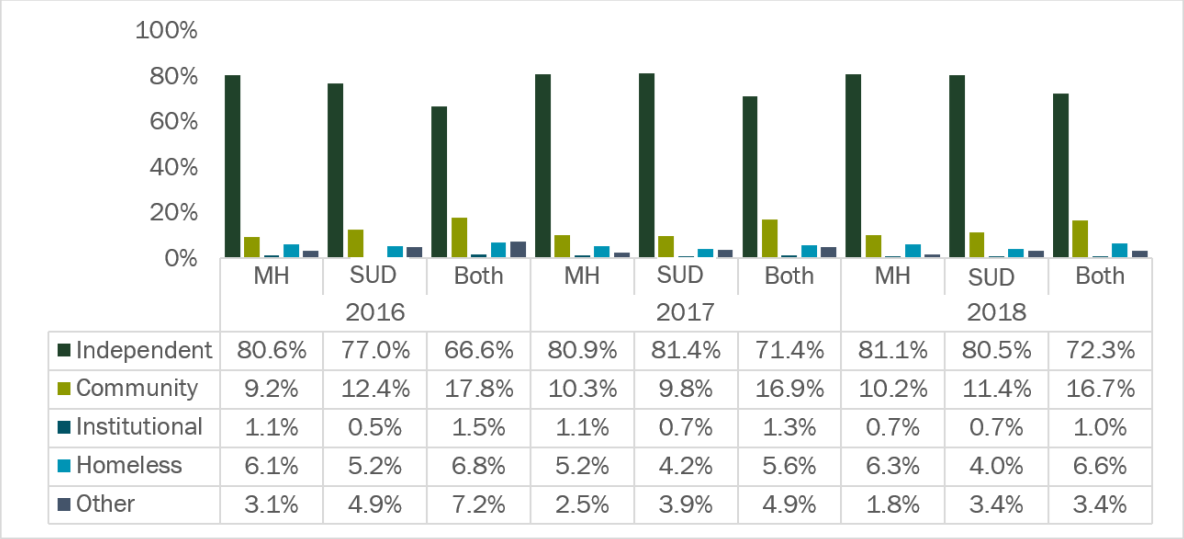
Providers in the PBHS are required to submit OMS data if they provide outpatient treatment at the following facility types: Outpatient Mental Health Centers (OMHCs); Federally Qualified Health Centers (FQHCs); Hospital-Based Clinics (also known as "HSCRC" clinics); Local Health Departments; Chronic Hospital Clinics; and Special Chronic Hospital Clinics. Additionally, Level I Substance-Related Disorder (SRD) providers are required to submit OMS data. Clients under age 6 or over age 64 are not included in the OMS data, nor are clients who are dually eligible for Medicare and Medicaid.

Providers administer the questionnaire to service recipients at program entry, every six months thereafter, and at program discharge. Data are then uploaded to the OMS DataMart for public querying at the aggregate level. Data can be queried by type of services received (mental health or substance-related disorder, only mental health, only substance-related disorder, or both), age (child and adolescent or adult), interview type (most recent interview only or initial interview compared to most recent interview), and fiscal year or calendar year. Once these selections are made, you can further select by location, age, gender, race, and time in treatment. For this assessment, we selected most recent interview data for adults ages 18 to 64 in Baltimore City receiving mental health services only, substance-related disorder services only, and receiving both services for calendar years 2016, 2017, and 2018.

Figure 13 displays the living situations for individuals in 2016, 2017, or 2018. Individuals receiving only mental health services had a slightly higher percentage of living independently compared to individuals receiving services for SUD or both mental health and SUD, with all showing mostly increases in the proportion of individuals living independently over time and a general reduction in the percentage living in institutional settings.

Figure 13

Living Situation



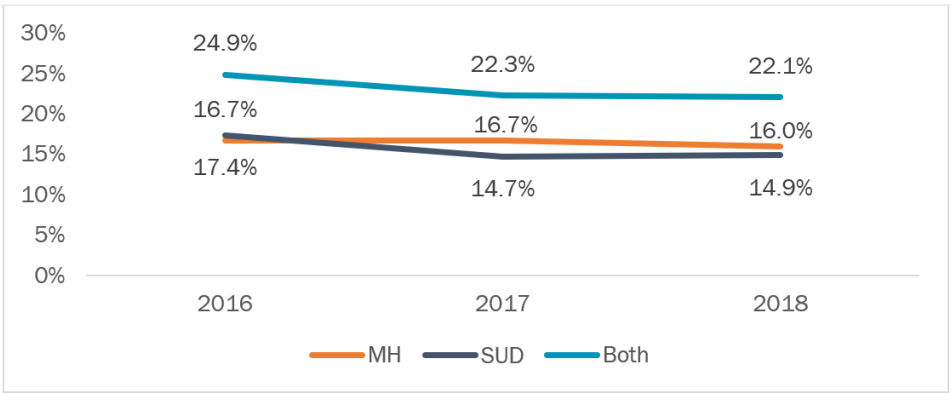
	2016			2017			2018		
	MH	SUD	Both	MH	SUD	Both	MH	SUD	Both
Independent	80.6%	77.0%	66.6%	80.9%	81.4%	71.4%	81.1%	80.5%	72.3%
Community	9.2%	12.4%	17.8%	10.3%	9.8%	16.9%	10.2%	11.4%	16.7%
Institutional	1.1%	0.5%	1.5%	1.1%	0.7%	1.3%	0.7%	0.7%	1.0%
Homeless	6.1%	5.2%	6.8%	5.2%	4.2%	5.6%	6.3%	4.0%	6.6%
Other	3.1%	4.9%	7.2%	2.5%	3.9%	4.9%	1.8%	3.4%	3.4%

Source: OMS DataMart

There also appears to be a general downward trend in the proportion of individuals reporting any homelessness within the 6 months prior to their last interview. Figure 14 shows that individuals receiving both mental health and SUD services experience the highest rates of homelessness, but this group also showed the greatest improvement between 2016 and 2018.

Figure 14

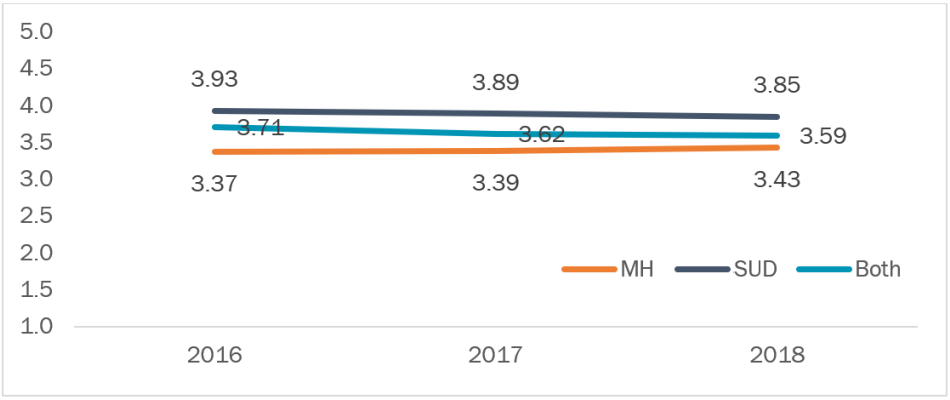
Percentage reporting they have been homeless at all in the past six months



Source: OMS DataMart

Figures 15 and 16 display recovery and functioning outcomes. The Maryland Assessment of Recovery Scale – Short Form consists of five items. Scores range from 1 to 5, with higher scores indicating that participants perceived they were making greater progress toward recovery. Although the differences were small in magnitude, Figure 15 indicates that recovery is slightly improving for individuals receiving mental health services but slightly decreasing for individuals receiving substance use–related or both mental health and substance use–related services. A similar pattern is observed in relation to functioning (Figure 16) with essentially no change in scores (.03-.06 of a point).

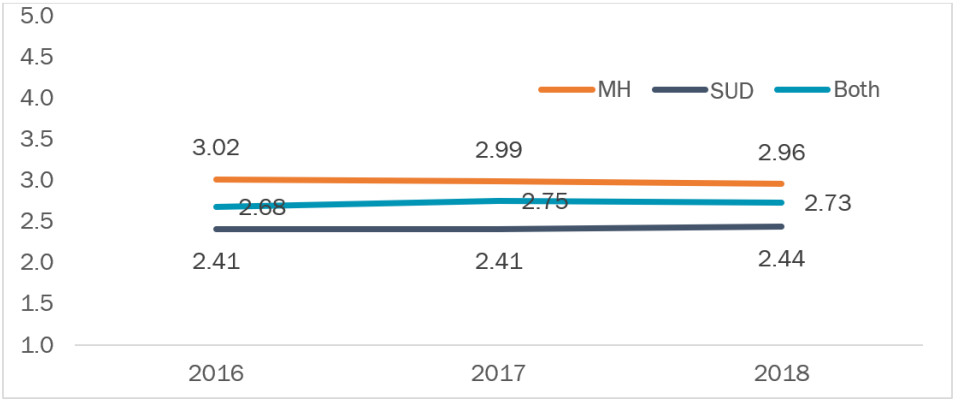
Figure 15
MARS 5 Score



Source: OMS DataMart

Taken together, these suggest that while services may be impacting things like living situations, they are not resulting in improvement in key outcome areas like perception of recovery or functioning.

Figure 16
Functioning Overall Score



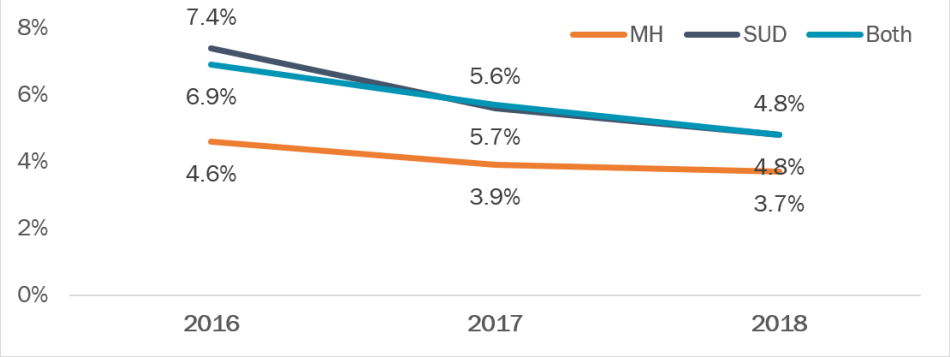
Source: OMS DataMart

Error! Reference source not found. and 18 demonstrate that involvement with the criminal justice system appears to be decreasing for all groups, at least in terms of self-report arrest and recent incarceration. This suggests that efforts to reduce the criminalization of behavioral health disorders may be having an effect, though this

cannot be definitively stated given the limitations of the data available. At least one BPD stakeholder had noted that overall arrests had been falling since the spike around the civil unrest in 2015. However, it is encouraging to see that arrests and reports of being in prison or jail are falling during a time that the overall number of police calls for behavioral health disorders was rising (see **Error! Reference source not found.**8), and this is also consistent with the avoidance of arrest in the disposition figures from the BH contact forms (see **Error! Reference source not found.**), suggesting general consistency across the data sources.

Figure 17

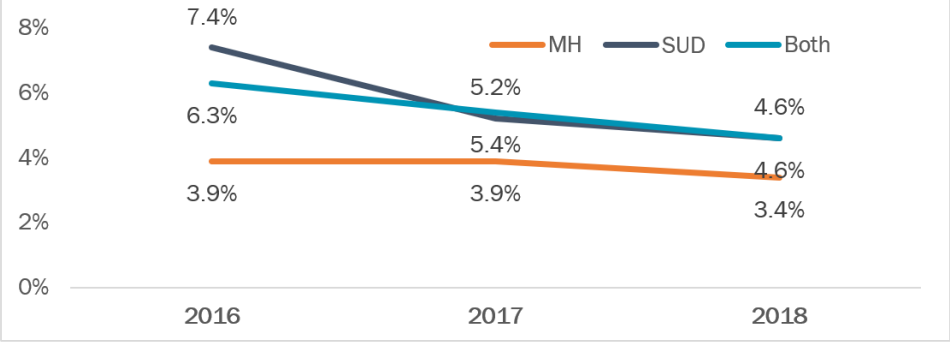
Percentage reporting they have been arrested in the past 6 months



Source: OMS DataMart

Figure 18

Percentage reporting they have been in jail or prison in the past 6 months

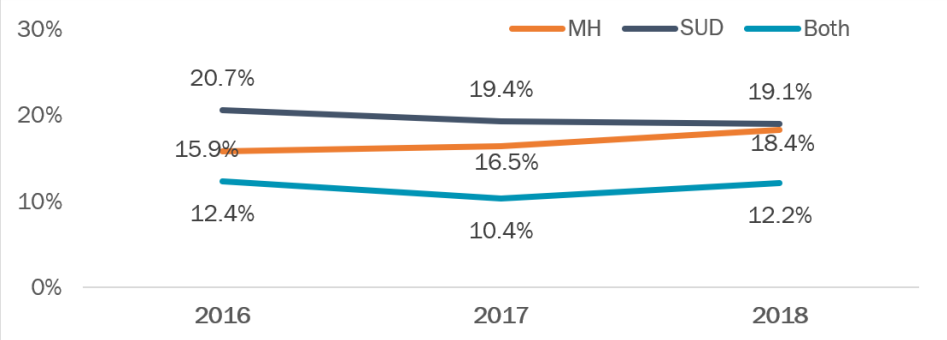


Source: OMS DataMart

Figure 19 shows a mixed bag when it comes to employment outcomes. Outcomes improved slightly for individuals receiving mental health services, remained essentially unchanged for individuals receiving both mental health and SUD services, and decreased for those receiving SUD services. This lack of change in employment outcomes is not surprising, given the lack of individuals being exposed to supported employment services in the utilization data and what people had to say about employment services in the key informant interviews. It is also influenced by supported employment services only being a covered service in the PBHS for people with primary mental health diagnosis.

Figure 19

Percentage reporting they are currently employed



Source: OMS DataMart

In summary, the available outcome data, while limited, hint at a system that is making some progress in some areas, such as increasing independent living while reducing institutional settings and showing some possible gains in decreasing the criminalization of behavioral health disorders, but that is struggling to effect change in the ultimate desired outcomes of increasing functioning, increasing perceived level of recovery, and helping people return to work, a key recovery and community integration outcome.

Recommendations

Context

The following recommendations are based on a combination of a review of the current system, analysis of data, interviews with stakeholders and an understanding of services and practices that constitute a "good and modern behavioral health system."[63] In 2016, BHSB conducted a strategic planning process, incorporating input from staff, external stakeholders and the Board of Directors, for the purpose of developing goals, objectives, and strategies to guide activities through 2020.[64] Additionally, in 2018, seeing the need for enhanced crisis response services, BHSB conducted a review of the crisis response system.[65] It is noteworthy that most of the issues identified in our interviews with key informants are also addressed in these two reports. Examples are the need for more services for children and transition aged youth, need for more flexible access to services such as walk-in clinics, need for expansion of mobile crisis response capacity and functions, need for more and better housing, and a need for an increase in peer support services. Many of these recommendations are so recent that full implementation may not have occurred, so their full impact may not be evident yet in the community, and it is possible that at least some of the issues identified by key informants are already being addressed or will be as these initiatives expand their reach. Many key informants indicated that they were aware of efforts currently underway but that the need is felt so strongly that those efforts need to be enhanced or expanded. But it is also possible that some of the perceptions of key informants reflect circumstances that existed prior to these new programs. We discuss these issues in more detail below in the section on Public Information.

In the short period since the strategic planning process, BHSB has begun initiating a considerable portion of this ambitious agenda of new programs, initiatives and collaborations. Many of these are consistent with recommendations coming out of this gap analysis, so our report in part represents an endorsement of, and an elaboration upon, these activities. Also, because the initiatives in the strategic plan are so recent, their viability and effectiveness has yet to be demonstrated. Accordingly, many of our recommendations are less about the need to fill obvious gaps in the service system, which BHSB has been active in doing during the past several years, and more about strategies for fully implementing, expanding,

[63] https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf
[64] Behavioral Health System Baltimore (2019). FY 2018 Activities, Behavioral Health Indicators and System Utilization.
[65] Behavioral Health System Baltimore (2018). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System.

monitoring, improving, sustaining, and ensuring the success of these nascent initiatives, with a particular emphasis on meeting the requirements of the consent decree and improving the intersection between law enforcement and the behavioral health system.

As the following recommendations are implemented and new programs are developed, it will be important to ensure that they remain consistent with *Olmstead* requirements for community-based services. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court held that Title II of the Americans with Disabilities Act (ADA) prohibits the unjustified segregation of individuals with disabilities. The ADA and its regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[66] Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies, and with persons of an individual's choosing; afford individuals choice in their daily life activities; and provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities. Therefore, when a public entity such as Baltimore or the State of Maryland plans or funds the development of new resources such as comprehensive crisis resource centers, it is critical that the public entity be aware of its obligations under *Olmstead* and ensure that these programs and other systems improvements do not simply become new forms of unnecessary institutions within the community.

Key Recommendations – Crisis Services

Follow the recommendations made in the June 2019 Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System

In the spring of 2018, BHSB engaged stakeholders in a planning process to strengthen the behavioral health crisis response system in Baltimore City, with the goal of describing existing behavioral health crisis services, identifying service gaps and access barriers, and making recommendations to improve the behavioral health crisis

[66] 28 C.F.R. § 35.130(d) (the "integration mandate")

response system. The impetus for this process was the recognition that the functions of the behavioral health crisis system were integral to the issues involving law enforcement addressed by the consent decree. In the course of this planning process, it was recognized that these issues would be addressed as well by the broader gap analysis; however, it was decided to proceed with the process, and a final report with recommendations was issued in June 2019.[67] The report contains a number of recommendations, all of which are endorsed, with some additions and elaboration, by the HSRI gap analysis team. In summary, the report's recommendations are the following:

- Establish processes and practices for seamless referrals to community-based behavioral health care
- Expand the use of evidence-based screening and assessment tools
- Track outcomes of ED visits
- Expand follow-up for high-risk incidents
- Expand buprenorphine induction
- Expand mobile crisis teams including youth community stabilization (currently limited to schools and foster care, and limited hours)
- Establish Comprehensive Crisis Response Centers operating 24/7 as an alternative destination for EMS transport and a receiving center for emergency petitions
- Assess the pilot Stabilization Center program established in 2018
- Consider expansion of the 24/7 Urgent Opioid Use Disorder Crisis Service, now with 12 beds for a 96-hour stay
- Expand the currently limited number of Urgent Behavioral Health Clinics and implement Open Access or same-day scheduling models in existing outpatient programs
- Expand the use of existing but underutilized Medicaid billing codes for crisis services
- With the Maryland Hospital Association, explore inpatient discharge processes with the goal of identifying post-discharge crises and readmissions
- Consider expansion of residential crisis bed capacity
- Assess capacity of withdrawal management services: there are 48 hospital-based withdrawal management beds and approximately 58 non-hospital community residential withdrawal management beds, but outpatient capacity for withdrawal management is unknown

[67] Behavioral Health System Baltimore (2019). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System

- Assess capability of withdrawal management services for meeting the needs of people with serious mental illness
- Assess the need for additional in-home and out-of-home respite services for youth
- Expand the capacity (hours and geographical reach) of street outreach workers, and develop integrated teams since most are currently specialized in either mental health or substance use
- Partner with peer organizations to develop peer-run respite services
- Implement Sequential Intercept Mapping for individuals released from incarceration
- Establish a single point of responsibility for crisis system coordination, tracking provider availability and individuals' progress
- Develop protocols for high-risk individuals and high-utilizers
- Plan for and implement a data-sharing platform, such as an "air traffic control" system that tracks individuals through the continuum of crisis response services and provides the data needed for partners to more effectively provide care and for the system to monitor outcomes.
- Infuse peer support specialists through all components of the crisis service system

In addition to these specific recommendations, the gap analysis team recommends that planning and enhancement of crisis services be conducted within a broader conceptual framework that incorporates the overarching principle of a continuum of care.

Adopt a Crisis Service System model

In general, crisis service systems correspond to one of three models. We recommend that planning for Baltimore's crisis system consciously adopt one of the three as a conceptual framework to guide planning:

1. A centralized system organized around a single large psychiatric emergency facility, having arrangements with hospital emergency departments to receive individuals who have been medically stabilized. It may or may not be hospital-adjacent and may or may not be hospital-operated/staffed.
2. A decentralized system, with multiple sites providing a diverse array of crisis services including some capacity for receiving individuals on petitions. This array of smaller sites could be adjacent to or affiliated with other types of facilities such as shelters or FQHCs and would be strategically located in the community to provide accessible crisis walk-in services. Sites could be a mix with some providing voluntary services only and others accepting involuntary admissions.

3. A dispersed system with public investments largely in non-emergency department settings, with an intention of shifting the bulk of crisis episodes out of the ED. In contrast to the second model, in which publicly operated EDs are major component, this model would direct public funding primarily to diversion services, relying on private health system emergency departments to serve a smaller group of individuals with more complex healthcare needs that require this level of care.

Adopt a least restrictive setting/care framework for planning expansion of crisis services

High-quality, effective behavioral health crisis services represent a mini-version of the larger 'good and modern' behavioral health system.[68] That is, they provide a variety of service types with different levels of intensity, with an emphasis on "upstream" prevention and diversion—resolving potential crises at the community level to the maximum extent possible in order to minimize involvement of law enforcement and "downstream" utilization of emergency departments and inpatient admissions. The recommendations offered in BHSB's June 2019 report on crisis system planning[69] are consistent with this framework; in making the framework explicit, the report facilitates an understanding of crisis services as being linked in a coordinated system rather than functioning discretely.

Establish community providers as part of the crisis service continuum

When crisis services are viewed in a least restrictive setting framework, community providers are a part of the system at the low intensity end of the scale, rather than there being a disjuncture between routine community-based care and crisis services. This includes the entire range of community-based services for both mental health and substance use treatment. To serve this function, however, community providers need to have the necessary training and resources to anticipate and intervene to prevent crises before they develop and to rapidly restore routine services for individuals transitioning from more intensive services.

ACT programs may be especially important in this respect if they prioritize for enrollment those individuals who are at high risk of ED utilization and especially at risk of police involvement. Staff of all ACT programs (as well as other providers) should be trained to identify the precursors of a behavioral health crisis and to respond appropriately—for example, by directing the individual to a respite center before an emergency petition is necessary.

We also recommend that BHSB consider whether there is a need for more ACT teams. Researchers have developed formulas for estimating the appropriate number of ACT

[68] https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf
[69] Behavioral Health System Baltimore (2019). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System

slots for a given population.[70] These standards vary depending on the assumptions on which they are based: for example the level of functional impairment that determines need, the estimate of the prevalence of serious mental illness, the number of ACT teams that may be feasible, the current status of the system with regard to use of inpatient services, etc. The estimates range from 0.1% to 0.6% of the total general population, based on typical SMI prevalence rates (though the latter figure is considered too high by some researchers), we recommend that these standards be considered as benchmarks for assessing current capacity. A number of the key informants cited the Baltimore City Capitation Project as a model that has been very effective in its capacity to provide intensive ACT-like services, among other services, for individuals with complex needs.

Consider expansion at the mid-level of crisis service intensity

Between routine community care and the ED, there are a variety of models, all of which have been demonstrated to reduce demands on law enforcement and avoid ED and inpatient admissions. A number of these are identified in the BHSB plan for expanding the crisis service system[71]; here, for purposes of the gap analysis, we underscore and elaborate upon these.

- *Mobile crisis teams*: Optimally, they operate 24/7 and have capacity not only to facilitate emergency petitions but to provide community-based treatment, referral and follow-up. Stakeholder interviews and BHSB's own strategic plan identifies a need for expansion of mobile crisis services, especially for children beyond the current capacity of the Baltimore Child and Adolescent Response System (BCARS).
- *Crisis Services Care Coordination (CSCC)*: These programs provide for short-term (up to 6 months) Care Management for clients with recent psychiatric emergencies, including those who have had contacts with Mobile Crisis, ED, or walk-in clinics. The programs utilize crisis assessment and development of a plan of care with consumers, and provide peer support and prescriber services.
- *Crisis Stabilization Houses (CSH)—Hennepin County (MN) model:* This is a residential step-down (from inpatient care) program for individuals with complex needs who would benefit from longer-term (30-day) transitional support. This non-hospital based intermediate level of care provides specialized support for individuals who are experiencing a mental health crisis; it could also be utilized for individuals on an involuntary commitment and who require a medically managed care plan. This model is a treatment alternative for individuals who require a medically managed service.

[70] Bond, Drake, et al. Assertive Community Treatment for People with Severe Mental Illness Critical Ingredients and Impact on Patients (2001) Disease Management and Health Outcomes; 9 (3)
[71] Behavioral Health System Baltimore (2019). Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System

- *Federally Qualified Health Centers (FQHCs)*: To capitalize on the array of FQHC services and their favorable reimbursement structure, consider a collaboration with Baltimore's FQHCs that involves embedding behavioral health staff to provide short-term high-intensity behavioral health services, same-day walk-in urgent care, and navigation services to the full continuum of PBHS community mental health and substance use services.
- *Comprehensive Crisis Response Centers:* This would be distinct from outpatient clinics, located either adjacent to a crisis resource center or an ED. It would operate 24/7 for walk-in and police drop-off with the primary function of diversion from EDs, inpatient admissions, out-of-home placement, and police custody. The service would assist with the de-escalation of a person's clinical behavioral health crisis by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability (including medication), delivered in a timely manner and leading to stabilization. The clinic would serve in coordination with outpatient services if currently being received, or if not, as an entry point to long-term, ongoing service delivery and care. Anyone experiencing a mental health and/or substance-related crisis would be eligible for acceptance.
- *Living room model dedicated psychiatric ED*: This is an alternative to hospital EDs that provides crisis support services in a non-medical setting by clinicians and often rely extensively on peer specialists.
- *High Crisis Service User Strategies:* This is a data-driven process of identifying individuals who are frequent users of crisis services, conducting targeted outreach and interventions to identify unmet needs, and developing treatment plans that would provide alternatives to use of crisis services. BHSB has convened an internal work group to develop a systematic approach to coordinating care for high utilizers with goals of improving wellness, providing more effective care, increasing community-based as opposed to institutional care, and reducing the cost of care. We recommend a data-based assessment of this initiative, and any modifications that are indicated.
- *Collaboration with hospitals and managed care organizations*: To the extent that this is not already underway in Baltimore, hospitals and community providers need to be at the table together to ensure collaborative planning and interventions to address many challenges presented by behavioral health admissions to EDs and inpatient units that the hospitals themselves are not in the best position to address. This benefit to the hospitals is often an incentive for funding various coordination activities.

The organization CrisisNow (www.crisisnow.com) provides extensive information about these various models, including a calculator to assess how many mobile teams, crisis beds, etc. are required for a given population and the associated costs, including offsets related to reductions in inpatient admissions, examples of exemplary crisis systems (for example, in Arizona), and tools for assessing a crisis system.

Explore implementation of an "Air Traffic Control" system for crisis service management

Air Traffic Control in crisis services consists of software systems that emulate those in the aviation field that insure continuous tracking and hand-off responsibility for aircraft in flight. These systems, for example the Georgia Crisis & Access Line, utilize sophisticated software to help the crisis staff assess and engage individuals at risk who have contacted or been referred to the crisis system, tracking them throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Real-time dashboards display the pending linkage status of individuals, color coded by how long they have been waiting for hand-off to follow-up services, and identify when a warm-handoff has occurred. These systems also provide scheduling solutions that allow crisis staff, contracted providers, and others to know and access real-time resources such as hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, peer services, psychotherapy, and other services. Such a system would support real-time, same-day access to care, help ensure full utilization of available resources and provide system level metrics to measure the success of the crisis response system.

Improve the quality of law enforcement interactions with individuals experiencing a behavioral health crisis

Key informants widely endorsed the crisis intervention training. Our analysis of police response to behavioral health crisis calls indicates some variation in the extent to which CIT-trained officers are involved. We recommend coordinating with the BPD to track and maximize the use of CIT trained responders. We suggest the following sub-recommendations be followed in order to achieve this goal.

1. **There needs to be consistent collection of detailed encounter data for all behavioral health contacts by all officers in all districts of the city**. More consistent collection of more detailed data will enable a more complete understanding of the nature and quality of contacts between law enforcement officers and individuals with behavioral health disorders experiencing crisis, which in turn can inform efforts to reduce such contacts while improving the helpfulness of those that do occur. The efforts by the CPIC data committee to revise the BH contact forms to improve their quality and collect more data about such contacts represent a good start. Requiring all officers to undergo CIT training will help ensure that officers city-wide will have the basic minimum behavioral health vocabulary needed for completion of the BH contact forms. Consistent completion of BH contact forms can also be facilitated through technology; for example, it may be possible to make the form data elements "required fields" that need to be completed to close out incident reporting.

2. There needs to be **deeper exploration into reasons that CIT-trained officers are not responding to what are clear behavioral health calls**

at higher rates. Even in the district targeted with training efforts, many calls are responded to by non-specialty officers.

3. **Officer training efforts need to be ongoing**. Intensive behavioral crisis training should be occurring with all officers. All officers need exposure to advanced behavioral health training, and training must be sure to include trauma and working with subpopulations such as the LGBTQIA community as well.

4. **Ensure that officers are aware of and using existing community-based alternatives to EDs such as residential crisis beds, and other diversion services need to be developed within the system of care, such as mobile and residential crisis and other services.** There should be planning with BHSB on policy development, training about the behavioral health services that exist, and when/who/how to refer to them.

5. **Officers need to interact with individuals in the manner they themselves would like to be treated during a time of distress**. This would mean treating all individuals encountered with respect and understanding, and not immediately discounting information shared simply because an individual has a behavioral health disorder.

Key Recommendations – Data Systems

Require collection of key outcome measures for all PBHS services

While regular outcome measurement is already occurring for programs reporting into the OMS system, not all programs and services within the PBHS are utilizing the system and its outcome assessments. While some of the measures used may be brief but attempting to measure complex constructs (e.g., MARS-5), the system does provide coverage of a number of key outcomes and offers the advantages of a known system (already familiar to providers, having developed protocols, etc.). Collection of individual-level client outcomes is essential for furthering understanding of what services within the PBHS in Baltimore are effective and if they are functioning as intended. The OMS assessment could serve as a core providing a common metric for assessment of client outcomes across a variety of program types, to be supplemented by additional program specific outcomes of interest if needed to more fully paint the picture of program effectiveness. In the future, such efforts will go far towards helping BHSB and other stakeholders make more robust assessments of PBHS system functioning and inform system planning efforts.

Expand efforts of law enforcement in the collection of data related to behavioral health crisis

In addition to expanding the use of the BH forms for all behavioral health contacts by all officers across all districts, officers need to be sure to be consistently collecting identifying information so that follow-up can be made with individuals. While

identifying information is being more consistently collected by the CRT since they are doing follow-up with individuals, when we explored getting this data for purposes of the root cause analysis of law enforcement crisis interactions called for in the consent decree, we learned that this is not consistently collected across the department in general. This can make it impossible to thoroughly evaluate such interactions through direct follow-up with the individuals involved or to gain insight through the examination of service utilization data before and after such encounters on any sort of consistent basis.

Leverage any community crisis service coordination system to enhance data collection related to community crisis services

As noted in the crisis system recommendations above, one of the benefits of adopting a real time "air traffic control" system is that, in addition to supporting real-time, same-day access to care and helping to ensure full utilization of available resources, it can also provide system level metrics to measure the success of the crisis response system.

Key Recommendations - Implementation & Oversight

Develop a comprehensive implementation plan

The recommendations in this report, as well as the numerous initiatives underway under the consent decree and other activities in BHSB's strategic plan are complex, multi-faceted, and interconnected. Additionally, many connect to existing initiatives and projects with which BHSB and other community partners are currently engaged. BHSB management capability, organizational structure, and the activities to date by the CPIC to address requirements of the consent decree suggest a high probability of success with these ventures. Nonetheless, nearly every one of them will be faced with significant challenges for implementation, quality performance, and sustainability.

Therefore, we recommend that BHSB, in partnership with the city, BPD and CPIC, work to develop a single, overarching, and comprehensive implementation plan for moving forward. The plan should be informed by values and vision as well as addressing concrete service-related issues, and should have clear actions, timeframes, and deliverables.

We offer the following concrete steps to support that process.

1. Form an oversight steering committee to coordinate with key stakeholder groups

As part of the implementation plan, a strong foundation of oversight should be established through a steering committee. The CPIC in its expanded form is responsible for overseeing action on the behavioral health requirements of the

consent decree, and this work has begun. The CPIC has developed a charter[72] to guide its work and views its work as broader than the specifics of the consent decree and as responsible to help develop the overall scope and range of the behavioral health system in Baltimore City. The CPIC also has formed a gaps analysis subcommittee to guide the work of the activities leading to this report. It is recommended that this subcommittee expand its purview to include implementation of the recommendations from this gap analysis and, when appropriate and possible, also include items from the BHSB strategic plan. By enhancing the role of this subcommittee, the full structure of the CPIC (co-chaired by BHSB, the City and BPD) will help guide and support the implementation process. Resources should be put in place to support the structure, membership, staffing and convenings of the CPIC (and all of its subcommittees) which will allow for sustaining the work after the specifics of the consent decree have been resolved. This may be a topic to explore with the city. This committee should expand its membership to include experts who have close working relationships with each of the stakeholder groups that will be involved in implementing the recommendations, but it should also be inclusive to represent key stakeholders including consumers. The steering committee should be small enough to meet regularly, maintain consistent communication with one another and with stakeholder groups, orchestrate coordinated action across multiple areas, and take responsibility for overseeing progress of various work groups discussed in the next recommendation.

Because the ultimate goal of this effort is to create a behavioral health system that best meets the needs of the community and promotes recovery at all levels, it is critical that service users and their families are fully involved in all aspects of the implementation phase. Our experience has shown that to reduce the effect of tokenism and promote full and active involvement, it is necessary to have more than one service user and more than one family member represented on committees and workgroups. SAMHSA's guidelines on consumer and family participation do not offer a number or percentage of members that should be consumers or family members, but SAMHSA does stress that participation should be "meaningful" and span all aspects of organizational planning and implementation activities.[73] Moreover, support needs to be available to help promote their involvement (e.g., orientation to CPIC and processes, financial support for time spent, meetings held at accessible times in accessible places, etc.). Because service users and family members are themselves a diverse group, care should be taken to involve individuals who are reflective of the diversity of Baltimore City.

2. Establish work groups to address common themes identified in this report

The challenge with work groups is that they need to be large enough to include diverse stakeholder perspectives and incorporate the necessary range of expertise but small enough to be flexible and efficient. A common model to achieve this balance in multi-

[72] https://www.baltimorepolice.org/transparency/behavioral-health
[73] https://www.samhsa.gov/grants/applying/guidelines-consumer-participation

pronged system change initiatives is to establish smaller, more focused work groups that complement and enhance the implementation and oversight efforts of the steering committee to facilitate more detailed work plans in key areas that were identified in this report.

There are a variety of topics that might be addressed by workgroups. We suggest that the formation of these be preceded by a planning process in which topics are prioritized based on greatest need and most immediate impact and include consideration of groups already working to plan system change in the city and state—for example, the City's Continuum of Care for homeless services system, and the quality work group for MAT led by MDH. Possible topic areas for focused workgroups include:

- Crisis Responses and Inpatient Alternatives
- Prevention and Wellness Promotion
- Community Education and Awareness
- Behavioral Health Workforce Issues
- Program Oversight and Quality Improvement (e.g., PRP, MAT)
- Discharge and Community Reintegration Services
- Peer Support Services
- Employment Services
- Outpatient and Community-Based Services
- Trauma-Informed Care, Cultural Competence, and Disparities
- Consumer Involvement
- Peer and Family Advocacy
- Youth Services
- Law Enforcement Partnerships
- Housing
- Financing and Sustainability
- Data Systems and Program Monitoring

Some of the above topics may already be addressed by existing work groups and task forces within the city and at the state level. We recommend that the steering committee work with those existing groups whenever possible, rather than forming new groups that may duplicate efforts and create additional burdens on members. In Baltimore many of these existing groups have been established only recently and may not be adequately prepared to take on this significant additional level of effort; careful assessment of their capacity will be necessary and possible commitment of additional resources.

3. Draw upon research in the field of implementation science

In recent years, the rapidly growing field of implementation science has generated a great deal of information about what is necessary for the successful implementation and sustainment of many types of programs and initiatives, along with common

barriers to implementation and effective strategies to overcome them. A wide variety of tools and exercises have been developed to assess factors that influence implementation such as organizational readiness. For example, implementation researchers have identified a set of factors that determine the success of program implementation such as facilitative leadership, training, workforce competency, data systems, fidelity etc.[74] The oversight group should at a minimum familiarize itself with this literature and optimally include one or more experts in this area.

Key Recommendations – System Integration

Promote a "No Wrong Door" approach

System integration refers to the extent to which the component elements in a system operate in a coordinated fashion versus separately and independently. Sometimes referred to as "systemness," this occurs (or not) in multiple levels and functions of behavioral health systems. A gap analysis must address not only whether there exists a full array of critical services but also whether there is adequate coordination and integration of these services to ensure continuity of care for consumers and efficiency in operations. For a complex system such as Baltimore's, with hundreds of organizations and consultants, fostering systemness will be an ongoing work in process.

For example, with regard to initial access to the system, the "current system of care is not designed for a consumer to have a no wrong door experience when requesting help, i.e. the provider directly serves the client or fully links them with a warm hand off to a service that would better meet their needs if they are unable to provide the service."[75] We recommend development of a no-wrong-door approach as a high-priority, though a long-range goal and one significantly influenced by the structure of the behavioral health system at the state level. A starting point for such development might include review of existing contracts for ways to enhance these services and promote a no-wrong-door approach.

Consider the care coordination model as a framework to guide strategic planning for promoting system integration

Systemness also relates to coordination of care by multiple providers—for example, through the use of shared care plans, which are patient-centered health records designed to facilitate communication among members of the care team, including the patient and providers. These may be developed through electronic medical record systems—for example, the system operated by MaineHealth Behavioral Health Integration program. MaineHealth is an integrated healthcare system of providers and other healthcare organizations across Central and Southern Maine. The Behavioral Health Integration program consists of approximately 30 clinicians

[74] https://nirn.fpg.unc.edu
[75] Behavioral Health System Baltimore (2019). FY 2018 Activities, Behavioral Health Indicators and System Utilization.

working in close to 40 different practices within seven hospital system members of MaineHealth. Primary care providers operate directly in the electronic medical record (EMR) with record keeping occurring in relatively real time, as do behavioral health specialists, and a flag alert communication tool provides a means for a patient's various providers to send messages to one another.[76]

As described by the Agency for Health Research and Quality (AHRQ), "Care coordination involves optimally organizing patient care and information-sharing activities. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. Coordination among health care providers improves outcomes for everyone by decreasing medication errors, unnecessary or repetitive diagnostic tests, unnecessary emergency room visits, and preventable hospital admissions and readmissions—all of which together lead to higher quality of care, improved health outcomes, and lower costs."[77] Citing the National Quality Strategy, AHRQ identifies three goals for coordinated care models, all of which apply equally to the behavioral health care system and are well-suited to strategic planning processes for the city and state:

- Improving the quality of care transitions and communications across care settings
- Improving the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status
- Establishing shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities

AHRQ provides a variety of tools such as quality measures for components of the model, many of which would be useful for monitoring the progress of system integration initiatives.

We also recommend that BHSB address continuity of care issues in contracting with providers (requiring warm hand-offs, for example) for those services directly funded through grants at the local level

Promote integration of mental health and substance use services and workforce

Stakeholders and BHSB's own reports document the need to integrate the separate silos of mental health and SUD services, and the continuing challenges of achieving this goal involving numerous structural, regulatory, financing, and cultural barriers. We concur with BHSB's recognition of the importance of this issue and support the continuing efforts to surmount these challenges. In the meantime, there may be

[76] https://integrationacademy.ahrq.gov/node/33076#group-section-4

[77] https://www.ahrq.gov/topics/care-coordination.html

opportunities for more immediate strategies such as cross training of workers through the regular convenings that BHSB hosts with providers, integrating the existing behavioral health police partnership initiatives like LEAD, CRT and HOT, and evaluating opportunities to integrate mental health and SUD services in the criminal justice system such as the specialty courts. The "No Wrong Door" approach is critical to engagement and successful treatment and service delivery.

Support and coordinate efforts to enhance availability of behavioral health outpatient services in primary care

By providing treatment earlier in the progression of behavioral health disorders, individuals may be less likely to require specialty behavioral health services like psychiatry and case management. In addition, some individuals may perceive behavioral health care received from their primary care provider as being less stigmatizing than specialty behavioral health care. This is particularly important for older adults and for certain racial and ethnic groups whose cultural beliefs and preferences may be inconsistent with the traditional Western/European approaches to behavioral health treatment.

Successful expansion of behavioral health capacity in primary care requires surmounting many significant challenges, including reorienting professional cultures, implementing evidence-based practices and practice guidelines, and changing funding structures. Ensuring that behavioral health is "at the table" at all initiatives to integrate behavioral and physical health care will be a first step in capitalizing on opportunities to expand behavioral health outpatient services in primary care. To strengthen and align integration efforts, we recommend the following:

- Explore emerging national models that build on integrated team-based approaches to care, such as health homes and Certified Community Behavioral Health Clinics.
- Consider integration with reference to the four-quadrant model developed by the National Council of Behavioral Health Care.[78] This model categorizes service users according to higher or lower complexity and risk for primary care and behavioral health needs.
- Build partnerships with medical providers (primary care physicians, clinics, and hospitals) to explore opportunities and create a cross-sector team care approach, improve care coordination and expand access to health services. This may include psychiatric consultation models to PCPs who are treating individuals with mild to moderate mental illness, such as the ECHO model.[79]

[78] Mauer, Barbara J. Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home. April 2009. The National Council for Behavioral Health Care.

[79] Hager, B., Hasselberg, M., Arzubi, E., Betlinksi, J., Duncan, M., Richman, J., & Raney, L.E. (2018). Leveraging behavioral health expertise: Practices and potential of the Project ECHO approach to virtually integrating care in underserved areas, *Psychiatric Services;* https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700211

- Prioritize and formalize essential care coordination functions across physical and behavioral health and determine roles and responsibilities across partners.
- Standardize navigation protocols, including referral pathways, cross-sector provider communication, and follow-up practices to ensure greater consistency of model implementation across sites.
- Ensure that the primary care workforce receives basic and ongoing trainings to ensure basic clinical competencies in working with populations with behavioral health needs and confront misperceptions regarding this population.

Federally Qualified Health Centers (FQHCs) in particular are opportunities for integrating care for persons receiving publicly financed behavioral health care. Under the Affordable Care Act, the FQHCs have received substantially increased funding to provide behavioral health services and to promote integrated care. One of the primary benefits of expanding behavioral health service capacity in FQHCs is the opportunity to integrate behavioral health care with comprehensive patient-centered medical homes for low-income individuals. FQHCs and similar health centers serve as medical homes, providing integrated medical, behavioral, dental, and vision care, as well as care coordination.

Because this expansion of behavioral health capacity is relatively recent, and links between behavioral health systems and FQHCs have not been extensive in the past, many areas have yet to fully take advantage of this opportunity to increase the supply of innovative outpatient care. We recommend that BHSB work with area FQHCs in the city to ensure that services that could be provided by FQHCs are being fully utilized, and to provide regular outreach to FQHCs to coordinate system planning activities.

Consider shifting resources from poor-quality programs to more effective services

While BHSB's direct authority to change Medicaid fee for service policies is limited, BHSB can function as an influential advocate at the state level for changes in such policies. At least a few key informants asserted that some rehabilitation programs merely provide custodial "babysitting" rather than active treatment and support for recovery. The scope of the gap analysis did not allow for a granular examination of individual program quality to determine the extent to which this perception is accurate. It is often the case, however, that a system may have a disproportionate share of resources committed to programs such as passive day treatment that have limited therapeutic benefit, simply as result of historic practices that that have not been modified in keeping with more recent models. The remedy in these cases is to shift resources away from low-quality programs that are unable to demonstrate improvement in their practices to more effective and beneficial services such as supported employment and ACT. This is not to suggest that it is a simple process,

however; researchers and policymakers have recently begun to recognize and explore the challenges involved in "de-implementation"—the process of "identifying and removing harmful, non-cost-effective, or ineffective practices based on tradition and without adequate scientific support."[80] The challenges are numerous and involve many diverse factors including organizational culture, provider and consumer behavior change, contracting, reimbursement policy, workforce considerations, etc. However, we recommend reviewing psychiatric rehabilitation and MAT programs to determine the extent to which they are providing quality services, or whether these resources might be redirected to providers delivering such services at a high level of quality or to more beneficial services. Such a review of program quality will likely require additional resources at the local level, given the numbers of providers of these services and consumers involved. Technical Assistance focused on quality improvement should also be made available.

Additionally, a values-based purchasing strategy might be considered as a way to increase the effectiveness of these programs. BHSB and the city should continue to advocate for increased local control in managing quality in the system of care and for a system structure that promotes quality perhaps through a values based-payment strategy.

Key Recommendations - Workforce

Address workforce recruitment, retention, and competency

A critical but challenging need is to address the workforce issues, as the success of most if not all of the initiatives highlighted will be determined by the competency and stability of the workforce. It is widely assumed that challenges of workforce recruitment and retention in public behavioral health systems are at a competitive disadvantage due to disadvantageous salaries compared to other settings; however, this disadvantage may be offset by a variety of workforce enhancement strategies. A 2016 survey by the Behavioral Health Workforce Research Center found that behavioral health workers are generally satisfied with their jobs and their workplace, but a large proportion expressed a need for information to guide career advancement and leadership training, and many also perceived limited opportunities to advance despite feeling qualified for leadership positions.[81]

Another aspect of workforce competency is related to comments by some key informants about a lack of respect for the dignity of consumers. It is difficult to determine how pervasive this issue is, though it was a frequently shared sentiment during our focus groups, but it merits review.

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[80] Upvall, M. J. and A. M. Bourgault (2018). "De-implementation: A concept analysis." Nursing Forum.

[81] Buche, J., Beck, A. J., & Singer, P. M. (2016). Behavioral Health Workforce Challenges: Recruitment, Retention, and Work Environment (Policy Brief). Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2016/10/FA2P1_Workforce_Challenges_Policy_Brief.pdf

The following are specific recommendations related to enhancement of the behavioral health workforce:

1. **Explore strategies to attract and retain qualified providers to work in community-based mental health settings.** Strategies should include efforts to address the salary gap for the community behavioral health workforce and exploring the possibility of loan repayment programs, but they should also consider non-monetary incentives such as working with provider organizations to develop more leadership opportunities for clinicians and establishing employee recognition programs.
2. **Explore opportunities for funding workforce training presented by the community benefits requirements for nonprofit hospitals** (see the discussion under "Social Determinants of Health" below).
3. **Ensure that front-line providers have the necessary training, qualifications, supervision, and support to a) engage and support individuals with complex needs, b) to understand the nature of trauma and provide trauma-informed care, and c) de-escalate crises so that BPD needs to be called into fewer crisis situations**. Possible areas of training include person-centered planning, wellness, recovery, psychiatric rehabilitation, motivational interviewing, etc. Peers should be involved in providing these trainings, as well as receiving them.
4. **Explore additional training and supervision regarding respect for the dignity of consumers**.
5. Work with local training programs, colleges, and universities to **support work in community behavioral health as a career choice**.

Key Recommendations – Peer Support

BHSB acknowledges the value of including peer support specialists in the behavioral health workforce, though it also recognizes the challenges of limited funding and access for training and certification of peer support specialists, and funding for developing and providing peer-delivered services. Without ignoring these challenges, we offer the following specific recommendations for developing the peer support workforce and services.

Support the financial sustainability of peer-run organizations through a variety of funding streams

This should include public dollars, private and philanthropic investments, and other revenues. This should include partnering with peer-run organizations and other local providers to use local data to articulate a local business case for investment.

Work with the state, other funders (e.g., public and private foundations), and local partners, private insurers, and other offices and departments to develop additional funding streams for peer provided services

A primary purpose of the collaboration would be to identify additional funding for these services to expand capacity, such as seeking Medicaid reimbursement.

Create a strategy to increase public awareness of peer services

The focus of this strategy would be on increasing knowledge of existing drop-in and self-refer peer services, and to identify and address policy or programmatic barriers to access. It should also stress all the various types of peer support, such as mental health, SUD, and family support, as well as the varied settings in which peer support is offered.

Support current local and statewide efforts to strengthen the peer support workforce

Such efforts should take advantage of proven workforce development strategies including ensuring adequate support, supervision, and flexibility for peer workers. These efforts should be informed by the literature on national and international best practices and should focus on all members of the peer support workforce, including those providing SUD and family support peer services.

Support and enhance efforts for formal exam-based certification for peer support

While there is currently a formal certification process for peer support workers in the state of Maryland, it is based on attending trainings and having experience in peer support roles. Simply attending a training comes with no guarantee of either knowledge or behavior change,[82] and experience in a peer support role in and of itself also does not guarantee that quality peer support was being provided during that time. An exam-based certification process, though, can directly assess the presence or absence of key knowledge, skills, and competencies. This will help ensure that individuals operating in peer support roles have a minimum amount of demonstrated knowledge and skills, providing some basic assurance of quality thereby helping to overcome a major point of resistance to peer services voiced by some providers.

Reduce ambiguity around peer roles within the system through training to ensure providers and administrators have adequate understanding of the peer role

Efforts should build on best practices, including consideration of local programs that are successfully incorporating peer roles. As peer roles are further incorporated into

[82] Chow, C. & Cichocki, B. (2009). The need for evidence-based training strategies. Psychiatric Rehabilitation Journal, 33(1), 62-65.

the system, providers and administrators will have increased understanding through working alongside people with lived experience, which has been shown to be the most effective means of education about peer support. Peers should have roles in a variety of services such as ACT, case management, PSH, mobile crisis, in emergency departments, and community reintegration efforts, among others.

Work with provider communities to expand professional development for peer support workers

Enhancing professional development includes promoting a "career ladder" with managerial and leadership positions that involve lived experience within agencies and entities throughout the city. Professional development also includes trainings, conferences, and other formal and informal leadership opportunities.

Key Recommendations – Community Education

Enhance information about how to access behavioral health services

Because many of BHSBs initiatives to promote the Crisis, Information and Referral line as a single access point are so recent, it is likely that the full potential impact has yet to occur—or at least has yet to be felt throughout the community. This is supported by the comment by a number of focus group participants that it is difficult for the public, such as families of someone in a behavioral health crisis, to know what services are available. The Crisis, Information and Referral (CI&R) line, which BHSB oversees, responds to calls related to a variety of topics including need for crisis intervention, information about behavioral health services, recovery supports and insurance, as well as providing telephonic outreach to individuals in need of intake appointments. 211 provides a similar service in the city but is not specific to behavioral health and does not provide crisis intervention services; however, a caller in need of behavioral health crisis services is connected directly to the CI&R line if they call 211. BHSB has widely promoted the availability of CI&R line by means of posters and cards in both English and Spanish distributed at community events and posted in public areas including public transportation. It has also promoted the hotline through social media. Maryland Department of Health has actively promoted the use of 211 across the state.

It may be, however, that stakeholders' experience with lack of information relates to an event that pre-dates the CI&R information and 211 campaigns. BHSB might consider an evaluation to determine the effectiveness of these campaigns—for example, whether it is reaching family members of someone experiencing an early episode of a behavioral health issue, and whether the information is available in a way that an individual or family will be aware of when in the midst of a crisis.

Continue with and expand anti-stigma campaign efforts

Key informants noted that stigma and discrimination against individuals with behavioral health disorders is common among members of the general public as well

as service providers. BHSB has recently undertaken anti-stigma campaigns (e.g., *See Past the Stigma*), which should be continued and expanded to counter the pervasive stigma associated with behavioral health disorders.

Key Recommendations – Social Determinants of Health

BHSB has given appropriate attention to the importance of social determinants of health (SDOH) as a factor affecting the behavioral health of Baltimore's population, such as the prevalence of racism, poverty and adverse childhood experiences. Comments by key informants also address SDOH—notably with respect to the lack of adequate and affordable housing. Generally, however, these are identified as challenges, but without explicit strategies for addressing them. This is understandable since many factors such as poverty are perceived to be outside the realm of the behavioral health system's influence. Also, it is likely that these issues are addressed in some of the numerous coalitions in which BHSB participates, and they are touched on by several of the policy priorities identified in the FY2017 report[83]. One opportunity for increasing impact in this area, however, is presented by the requirements of nonprofit hospitals to invest in activities that benefit their communities.

Build upon the community health benefit requirements for nonprofit hospitals

In exchange for their tax-exempt status, nonprofit hospitals are required by the Internal Revenue Service (IRS) and the Affordable Care Act to conduct "community health needs assessments" every three years and to develop plans for activities to address the needs that are identified. While the federal regulations provide few requirements on how hospitals are to address these needs, a recent report from the National Academy for State Health Policy (NASHP) describes how various states are establishing more specific requirements for hospitals' activities.[84]

Community benefit spending by Maryland nonprofit hospitals in 2016, the most recent year for which data are available, totaled $1,395,197,784 with a mean of $33,503,129 for the 48 hospitals included.[85] By far the largest category of spending at almost $485 million was for "health professions education" (see comments in the "Workforce" section above) and the second largest at $417 million was for "subsidized health services." Smaller amounts were allocated to categories that could potentially impact SDOH that affect behavioral health: "cash and in-kind contributions to community groups," "Community building," and "Community health improvement and community benefit operations." We recommend that BHSB

[83] Behavioral Health System Baltimore, Three Year Strategic Plan: 2017 – 2020

[84] Clary, A. (2019) "States Work to Hold Hospitals Accountable for Community Benefits Spending.". National Academy for State Health Policy, https://nashp.org/states-work-to-hold-hospitals-accountable-for-community-benefits-spending/

[85] http://www.communitybenefitinsight.org

include in its policy priorities and in its collaborations with area hospitals consideration of how community benefits might be most effective in addressing SDOH.

Given the level of trauma, violence, and poverty in the city, it is important to note that the efforts to address SDOH should not lie with BHSB and the hospital systems alone. It is suggested that the City of Baltimore could take a leading, coordinating role in figuring out how to have an organized strategy around how to address the social determinants of health for all Baltimore residents.

Coordinate with HUD housing programs for people with disabilities

In addition, we recommend that BHSB continue to be at the table for every housing development initiative that is underway in the city to advocate for people with behavioral health disabilities to be considered as a priority population. BHSB is an active participant in the City's Continuum of Care activities to promote efficient and effective use of limited HUD resources. The system of care could benefit from assessing the need for PSH and other housing models specifically for people with MI/SUD, and developing strategies with housing partners to address this need. For example, in recent years Congress has authorized millions of dollars for HUD's mainstream voucher program for people with disabilities, which requires local housing authorities to coordinate with community agencies to provide the appropriate services. BHSB has supported the Housing Authority of Baltimore City's application for these vouchers. Continued coordination of this nature to expand housing opportunities for individuals with behavioral health disabilities is needed.

Some health care systems, including Bon Secours in Baltimore, recognizing the importance of stable housing for community health, are engaging in housing development themselves. Even small-scale investments, such as one-time rent support during a crisis or assistance with relocation, can make a critical difference in maintaining the stability of individuals in the community, preventing homelessness and use of crisis services. Some behavioral health systems have created a position for a housing specialist to promote these various strategies.

Increase the availability of housing vouchers and subsidies

Stakeholder collaboration needs to continue around ways to increase the availability of tenant-based housing vouchers and subsidies for individuals in need of housing, specifically for Rapid ReHousing (RRH) and Permanent Supportive Housing (PSH) units. Strategies such as reallocation[86] and bonus funds[87] can be used to expand PSH and RRH units within the Continuum of Care (CoC) Program. The CoC should continue to pursue the development of a Local Housing Voucher Program (LHVP) that would "make rental housing accessible for extremely low income and homeless

[86] https://www.hudexchange.info/faqs/1648/what-is-reallocation/
[87] https://www.hudexchange.info/faqs/3658/what-is-the-difference-between-the-coc-bonus-and-the-dv-bonus-for-the-fy/

individuals and families by providing a monthly rental subsidy to cover the difference between what a household can afford to pay and the cost of renting a unit on the private market"[88]. Efforts should continue around robust implementation of Coordinated Access (a Coordinated Entry System), to help ensure that people are connected to vouchers and subsidies that provide the appropriate services for needs and that the individuals with the greatest needs are able to access housing. In addition to vouchers, flexible sources of funding should be pursued to create needed "tools" such as deposits and furniture assistance, landlord bonuses, or damage payments.[89,90]

Enhance efforts related to landlord engagement and education to combat stigma and increase the availability of units

Opportunities to partner with landlords and property management companies should be explored. One potential way of engaging these key stakeholders might be to establish a landlord subcommittee within the Baltimore City Continuum of Care (also known as "The Journey Home"), with a goal being to develop a city-wide landlord recruitment and engagement plan.[91] Another strategy might be to create a Landlord Liaison position within the Mayor's Office of Homeless Services, if such a position does not already exist. Recruitment of new landlords may also occur through a media campaign or Public Service Announcement (PSA efforts) and through systematic outreach such as presentations to chambers of commerce, Rotary Clubs, and/or landlord associations.

Stakeholders we interviewed also stressed the need for education and stigma reduction efforts among landlords. Public education campaigns specifically targeting landlords and landlord associations/events can reduce stigma about individuals who are homeless or have mental health and substance use issues, thereby increasing the acceptance of vouchers and subsidies for these populations. Such efforts can also be used to advocate for more tolerant screening policies at properties to reduce the impact of criminal backgrounds and no credit/bad credit and rental histories.

Ensure that Permanent Supportive Housing (PSH) program models are being implemented with fidelity

The lack of regulation and oversight of housing programs was identified as a major gap impacting accessibility to quality housing services. PSH is recognized by SAMHSA as an evidence-based practice that contains numerous program elements, with a structural relationship between those elements that is directly related to client outcomes- indicating that it is critical to assess how the program is being implemented in order to ensure that the program is having the desired effect. The

[88] Baltimore City Continuum of Care. (June 2019). Action plan on homelessness.
[89] https://www.usich.gov/solutions/housing/landlord-engagement/
[90] https://www.hud.gov/sites/documents/LANDLORD-DESKBOOK.PDF
[91] https://www.usich.gov/news/core-components-centralized-landlord-engagement-programs-community-landlord-engagement-initiatives

Housing First model is one of the most widely disseminated PSH models and has been a major focus of PSH expansion efforts in Baltimore City. Consequently, to ensure that these programs are being implemented in an effective way and as intended, regular assessment of program fidelity to the Housing First model for these programs needs to be occurring, as recommended by HUD.[92]

Next Steps

It is anticipated that the recommendations from this report will help guide the work of CPIC, BHSB, and Baltimore City for the next several years. In addition to their participation on the CPIC, BPD will use the recommendations from this report to guide the growth of their CIT program and officer training efforts, especially as it relates to interacting with the community of providers.

CPIC is an open advisory group that stakeholders, including members of the general public, are encouraged to participate in to help inform the implementation of these recommendations. There are opportunities to participate in monthly meetings to get updates or be more involved in specific projects through the subcommittee structure. Please contact Shanna Borell at Shanna.Borell@bhsbaltimore.org or 443-615-7798 if you are interested in learning more about CPIC or attending a meeting.

[92] https://www.hudexchange.info/resource/5294/housing-first-assessment-tool/

Appendices

Appendix A: References

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Appendix B: List of Acronyms

ACE	Adverse Childhood Experience
ACS	American Community Survey
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
BCARS	Baltimore Child and Adolescent Response System
BCRI	Baltimore Crisis Response, Inc.
BEST	Behavioral Emergency Services Team
BH	Behavioral Health
BHA	Behavioral Health Administration (part of MDH)
BHSB	Behavioral Health System Baltimore
BPD	Baltimore Police Department
BRFSS	Behavioral Risk Factor Surveillance System
CADC	Certified Alcohol and Drug Counselor
CCAP	Continuity of Care Advisory Panel
CCBHC	Certified Community Behavioral Health Clinic
CCC	Comprehensive Crisis Center
CCRC	Comprehensive Crisis Response Center
CDC	Centers for Disease Control
CES	Coordinated Entry System
CI&R	Crisis, Information & Referral
CIT	Crisis Intervention Team
CoC	Continuum of Care
CPIC	Collaborative Planning and Implementation Committee
CQT	Consumer Quality Team
CRS	Crisis Response System
CRT	Crisis Response Team
CSCC	Crisis Services Care Coordination
CSH	Crisis Stabilization House
DHMH	Department of Health and Mental Hygiene (now MDH)
DOJ	Department of Justice
DORS	Division of Rehabilitation Services
EBP	Evidence-Based Practice
ECMHC	Early Childhood Mental Health Consultation
ED	Emergency Department
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EP	Emergency Petition

ER	Emergency Room
ESMH	Expanded School Mental Health
FAST	Forensic Alternatives Services Team
FDA	Food and Drug Administration
FFS	Fee For Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GED	General Educational Development
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HOPE	Helping Other People through Empowerment
HOT	Homeless Outreach Team
HSCRC	Health Services Cost Review Commission
HSRI	Human Services Research Institute
IDD	Intellectual and Developmental Disability
IOP	Intensive Outpatient Program
IPS	Individualized Placement and Support
IRB	Institutional Review Board
IRS	Internal Revenue Service
LADC	Licensed Alcohol and Drug Counselor
LEAD	Law Enforcement Assisted Diversion
LGBTQIA	Lesbian, Gay, Bi, Transgender, Queer or Questioning, Intersex, Asexual or Allied
LPC	Licensed Professional Counselor
MARS	Maryland Assessment of Recovery Scale
MAT	Medication-Assisted Treatment
MCF	Maryland Coalition of Families
MCH	Maryland Crisis Hotline
MCO	Managed Care Organization
MDH	Maryland Department of Health
MH	Mental Health
MHAMD	Mental Health Association of Maryland
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MOHS	Mayor's Office of Human Services
MP	Monitoring Plan
NAMI	National Alliance on Mental Illness
NASHP	National Academy for State Health Policy
NSDUH	National Survey of Drug Use and Health
NTU	Ntu Psychotherapy Approach
OMHC	Outpatient Mental Health Center
OMS	Outcomes Measurement System

PBHS	Public Behavioral Health System
POSCOD	Place of Service Code
PRP	Psychiatric Rehabilitation Program
PSH	Permanent Supported Housing
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral for Treatment
SDOH	Social Determinants of Health
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SWAT	Special Weapons and Tactics
TAY	Transitional Aged Youth
UMD	University of Maryland
WRAP	Wellness Recovery Action Planning
YRBSS	Youth Risk Behavioral Surveillance System

Appendix C: List of Documents Reviewed

- Behavioral Health System Baltimore FY 2017 Activities, Behavioral Health Indicators and System Utilization
- Behavioral Health System Baltimore FY 2018 Activities, Behavioral Health Indicators and System Utilization
- Behavioral Health System Baltimore "THREE YEAR STRATEGIC PLAN: 2017 - 2020."
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- Maryland Behavioral Health Administration (2014). Outcomes Measurement System (OMS) OMS Interview Guide [Version 3; December 13, 2014].
- NAMI Maryland Summit Report Course Correction Collaboration of Criminal Justice and Behavioral Health Advancing New and Proven Models for State and Local Government.
- Outcomes Measurement System Child Adolescent and Adult Workbooks with support materials.
- Outcomes Measurement System (2014). Child and Adult Questionaires.
- Two Gems Consulting Services "Findings from Key Informant Interviews from select fields of practice and Interactive Groups with Young People."
- White Bird Clinic CAHOOTS Mobile Crisis.
- Wilder Research (2018). Maryland Hospital Association Mental and Behavioral Health Data Collection Protocol with support material.

Appendix D: System Inventory/Description

Community Education

Community Education initiatives are designed to educate members of the general public about behavioral health disorders and the services available to assist people with them. Public education campaigns are one key strategy for community education. Effective public education campaigns influence the public's view of behavioral health disorders to reduce stigma and improve access to care as well as increase awareness of service options available in the community.

One recent community education effort is the BHSB-led anti-stigma campaign, "See Past the Stigma," launched in September 2018 to complement other National Recovery Month community education efforts. As described by BHSB, "this campaign used a personal appeal from a Baltimore Ravens player who was deeply interested in helping others overcome stigma, stories from a range of individuals to make clear that a behavioral health condition does not define them and high-caliber graphic design and video to connect visually with the public. BHSB created a unique website, www.seepastthestigma.org, and used paid advertising, social media, earned media, and community engagement to promote the campaign."

In addition to the public education activities such as See Past the Stigma that BHSB staff directly produced, BHSB provides funding to partner organizations active in community education. The bullets below, taken from the same report, describe some of those partner activities.

- Mental Health Association of Maryland (MHAMD) provides children's mental health information and campaign materials for Children's Mental Health Matters, participates in health fairs, conducts older adult mental health and advanced directive trainings, collaborates with BHSB to disseminate Mental Health First Aid throughout the city, and oversees a public education project to address the behavioral health needs of new mothers.
- NAMI (National Alliance on Mental Illness; local and state chapters) provides family support trainings and workshops on mental health topics and coordinates its annual NAMI Walk, a public education event that promotes awareness of mental illness.
- Maryland Coalition of Families (MCF) provides webinars and family trainings on mental health topics and coordinates the Family Leadership Institute, which provides education and resources to parents, caregivers and family members of children with behavioral health challenges. It also provides education to families on the Good Samaritan Law.
- On Our Own of Maryland provides presentations on the stigma of mental illness, partners with local consumer-run organizations in various educational

events, and provides assistance and referrals to consumers via telephone and in person.

- Bmore POWER developed the Go Slow campaign to educate people who use drugs about fentanyl. This campaign utilizes a harm reduction approach to inform users that fentanyl is in their drugs and that injecting slowly could save their life. The website is www.20secondssaves.org.

There are also non-BHSB-led or -funded community education efforts. For example, Baltimore Crisis Response, Inc.'s (BCRI) ED has a "Mental Health Matters" TV show on local cable that shares information, including first-person recovery accounts. Another example is the city Department of Health's "Don't Die" campaign to educate people about suboxone and naloxone.

Promotion, Prevention, and Early Intervention

Promotion, prevention, and early intervention services are intended to help change the risk factors associated with the development of a behavioral health disorder, enable people to increase control over their own health, or to intervene with treatment at an early stage to prevent the development of chronic disease. BHSB conducted a strategic planning process during FY 18 that resulted in an implementation plan that includes strategies to address policy and structural issues, increase community education and awareness, implement school-based interventions, and support community-based capacity building.

Key informants noted a number of prevention, promotion, and early intervention activities. The following are just some of the examples of the types of prevention, promotion, and early intervention programs active within the city. Passive Nursing out of Sarah's Hope (a women's shelter) focuses on healthy attachment and parenting skills with young mothers; BMore for Healthy Babies conducts Parent Cafés and outreach around health socio-emotional development; the Family League of Baltimore focuses on socio-emotional development and Adverse Childhood Experience (ACEs) assessments; Infants and Toddlers is another developmental support program; HeadStart programs; the Baltimore City Public School System partners with BHSB on the Expanded School Mental Health program and is implementing the Incredible Years and Second Step evidence-based practices in the schools in this network; Catholic Charities is involved in numerous school-based mental health initiatives; BMore Power, BHSB's Maryland Harm Reduction Training Institute and the Baltimore Harm Reduction Coalition are focused on harm reduction; Maryland Coalition of Families has early intervention services; and SBIRT has been implemented in 11 emergency departments city-wide. These are just some of the examples of the types of prevention, promotion, and early intervention programs active within the city.

Community-Based Services

ASSERTIVE COMMUNITY TREATMENT (ACT) AND OTHER HIGH-INTENSITY COMMUNITY-BASED MOBILE TREATMENT AND SUPPORT

Assertive Community Treatment is a multidisciplinary team-based approach with the ability to conduct mobile outreach in the community and to deliver community-based treatment, support and rehabilitation services on a daily basis or more frequently if needed. ACT teams typically serve people with a severe mental illness that frequently have contact with or are at high risk of contact with crisis services, hospitalization, and criminal justice involvement. Interviewees indicated that there are seven ACT teams active in the city, plus three additional mobile treatment teams that do not follow the ACT EBP model and two Capitation Project providers, which provide intensive ACT-like services and are responsible for covering the full cost of mental health care for the client including inpatient care. ACT, mobile treatment and Capitation Project services are available for Medicaid recipients and uninsured individuals and are billed through the ASO. People Encouraging People, University of Maryland Medical System, and Johns Hopkins Bayview had the largest number of claims for mobile treatment services (including both ACT and non-ACT services).

CASE MANAGEMENT

Case management services help connect individuals with resources in the community and help coordinate services across multiple providers. Case managers can help connect people with not only behavioral health services but also housing, employment, food assistance, etc.—all services that help address the social determinants of health. Case management services are available for youth, adolescents, adults, older adults, and for various subpopulations like individuals living with HIV or substance use disorder. Some hospital systems and service providers in Baltimore offer in-house case management services. Case management services have a diverse array of funders, with different definitions, standards, and expectations, often focused on one issue of interest to the funder (e.g., substance use, treatment, housing) without a model or standards to support a more integrated, holistic approach to service delivery. Targeted Case Management services (Medicaid and uninsured) are a billable service through the ASO for children, youth and adults with mental illness. There were roughly 20 organizations billing the ASO for case management services for individuals residing in Baltimore City in FY2018.

HOUSING AND SUPPORTIVE SERVICES

Housing and supportive services provide individuals with a place to live, help them access resources to cover costs, and provide ongoing support to individuals to help them remain in their housing. In addition to the Housing Authority of Baltimore City, many other community and provider organizations also focus on housing. For example, some of the hospital systems such as Bon Secours are actively developing housing for the individuals they serve; the Capitation Project providers can also subsidize housing given the flexibility of their funding model. There are also Community Action Programs that can help connect individuals with housing

resources. Housing options include ones with 24/7 on-site support services, some on-site support services, Permanent Supportive Housing, independent housing, and in congregate and scattered site settings. Housing and housing support services are almost solely funded through grants.

INTENSIVE OUTPATIENT AND PARTIAL HOSPITAL PROGRAMS

Intensive Outpatient Programs (IOP) and Partial Hospital Programs are treatment and support programs for people recovering from substance use or mental health disorders. These programs are usually reliant on group therapy, but individuals may also see an individual therapist. Services are often more intensive than a regular outpatient program; some IOPs or partial hospital programs may offer 30+ hours/week of programming. Most area hospitals have partial hospital and IOP services available, according to key informants. MedStar's hospitals offer IOP services; others include Harbor Hospital, Johns Hopkins, Union, UMD, Shepard Pratt, and Bon Secours. Bon Secours operates the only partial hospitalization program for children; Shepard Pratt, Hopkins, and UMD have some IOP capacity for adolescents. Some community providers also offer IOP services; these are predominately outpatient SUD providers and Federally Qualified Health Centers, such as Health Care for the Homeless. IOP and partial hospital services are available for Medicaid and Medicare recipients, for some private pay individuals, and for uninsured individuals through the ASO.

OUTPATIENT BEHAVIORAL HEALTH SERVICES

Outpatient services are less intensive than inpatient or IOP/partial hospitalization levels of services and are available for children, youth, and adults with substance use disorder, mental illness or a co-occurring diagnosis, and are billable through Medicaid, most private pay plans, and through the ASO for uninsured individuals. Individuals usually access these services in the community while living in community settings. Services may consist of individual therapy, group therapy, medication management, etc. Outpatient services are typically offered by all community-based behavioral health–focused organizations in Baltimore City and are provided in a clinic setting or by independent practitioners. In FY2018, there were well over 1,000 organizations and individual providers that billed the ASO for outpatient mental health services for people residing in Baltimore City.

Outpatient services for individuals with substance use disorders are also offered following national ASAM criteria for Level 1. Outpatient SUD services are delivered across a variety of settings, with regularly scheduled sessions totaling less than 9 contact hours a week for adults or 6 hours a week for adolescents, with services tailored to address individual needs for maintaining their recovery. Services may include withdrawal management or Medication Assisted Treatment. The number of outpatient substance use disorder service providers for youth is limited in the city with Treatment Resources for Youth (TRY) and Mountain Manor being mentioned by stakeholders. In FY2018, there were over 400 organizations and individuals that billed outpatient substance use treatment services to the ASO for individuals residing in Baltimore City. Outpatient behavioral health services are available for Medicaid

and Medicare recipients, most private pay individuals, and for uninsured individuals through the ASO.

OUTREACH

Outreach services are those that reach out to individuals who are not already connected to services or those who are resisting connection to services. Outreach teams attempt to engage individuals, develop a therapeutic relationship, and connect individuals with other needed services. These teams are able to go out on the streets and into communities to connect with people where they are at. Outreach services are predominately grant-funded and have a variety of focuses depending upon the funding source or provider, e.g. outreach with clinical expertise vs. outreach with public safety expertise. Because of this, there are significant differences in staffing, services, objectives, and outcomes. For example, some teams address short term public safety issues (move people along) with occasional brokering of referrals to service providers whereas other, clinically focused teams will develop comprehensive care plans and provide therapeutic interventions on the street with a focus on long-term health and housing outcomes.

Key informants indicated that there was a need for more outreach teams that provide clinical expertise for both mental health and substance use disorder services that were truly mobile in nature, able to go into the community and meet people where they are at. The Homeless Services program with the Mayor's Office of Human Services has an outreach team; Health Care for the Homeless does; BPD has a Homeless Outreach Team; and BHSB funds outreach services for individuals with mental illness and substance use disorder. ACT teams are also able to provide outreach services for individuals already enrolled in their care.

PEER SUPPORT

According to the International Association of Peer Supporters, "peer support providers are people with a personal experience of recovery from mental health, substance use, or trauma conditions who receive specialized training and supervision to guide and support others who are experiencing similar mental health, substance use or trauma issues toward increased wellness."[93] Although peer support is not currently a Medicaid-billable service in Maryland, it is offered through a variety of settings in the city with public and private financial support from the federal, state and local level. There are efforts underway at the state level to pursue Medicaid reimbursement for peer support services through a state plan amendment. The state also has a certification process in place for peer support. Maryland's Certified Peer Recovery Specialist program, in conjunction with the Maryland Addiction and Behavioral health Professional Certification Board (MABPCB), provides State certification for individuals who provide direct peer-to-peer support services to others who have mental health, substance use, or co-occurring disorders. Certification requirements include 46 hours of training across four domains (Ethics, Advocacy, Mentoring & Education, Wellness & Recovery), current employment as a peer support

[93] https://www.inaops.org/what-is-a-peer-supporter-

worker, 500 hours of peer support provision over the last two years, and 25 hours of supervision by a Registered Peer Supervisor.

Baltimore has seven Wellness and Recovery Centers. One center is focused on LGBTQIA persons, and two of the others follow the Clubhouse International Model. One of the Clubhouse International Centers targets adolescents aged 13-17 at risk for behavioral health issues (Progressive Life Center Adolescent Clubhouse) and provides a culturally centered and spiritually based Afrocentric therapeutic approach called NTU, with a focus on harm reduction and reducing high-risk behaviors such as alcohol and drug use and unsafe sex. The adult center, B'More Clubhouse, has official accreditation through Clubhouse International and offers a transitional employment program among other services.

All Recovery and Wellness centers provide "consumer-centered peer support services, such as anti-stigma workshops, Wellness Recovery Action Planning (WRAP), educational sessions such as parenting and GED classes, one-on-one peer counseling, peer-led group support (e.g., SMART Recovery®, Alcoholics Anonymous and Narcotics Anonymous), acupuncture, tai chi, and other activities that reduce isolation and promote family and social support."[94]

While the Wellness and Recovery Centers such as H.O.P.E., On Our Own and Hearts and Ears and the clubhouses compromise the majority of the formal infrastructure for peer support services, peer specialists are involved in the needle exchange services van program, and through Bmore POWER, NAMI Metro Baltimore, Roberta's House, Power Inside, Sistas of the T and other grassroots community organizations, on ACT teams, in outpatient clinics and emergency departments, in outreach programs, and elsewhere throughout the system in a variety of roles.

PSYCHIATRIC REHABILITATION PROGRAMS (PRP)

According to the Psychiatric Rehabilitation Association:

> Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person-directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.[95]

PRPs are housed in a variety of settings within Baltimore, with some offered by hospitals and large community-based behavioral health organizations, as well as smaller independent or grassroots organizations and some offered in a residential setting called Residential Rehabilitation Program (RRP) services. PRP services are

[94] BHSB, "FY 2018 Activities, Behavioral Health Indicators and System Utilization"
[95] https://www.psychrehabassociation.org/about/who-we-are/about-pra

available for Medicaid recipients and uninsured individuals through the ASO. In FY2018, there were over 200 organizations that billed the ASO for psychiatric rehabilitation services for Baltimore City residents.

RESIDENTIAL SERVICES FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS

Residential services for individuals with substance use disorders are offered in a variety of levels of care following national ASAM criteria including intensive withdrawal management (detox), therapeutic community and low intensity residential. Residential SUD services are available through Medicaid as of January 2018 and also for uninsured individuals and are available for both youth and adults. The number of residential service providers for youth is limited in the city with Mountain Manor being mentioned by stakeholders. According to the claims data received, there were about 20 providers of residential SUD services that treated Baltimore City residents served through the PBHS.

MEDICATION-ASSISTED TREATMENT

According to SAMHSA, "Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders."[96] MAT is provided in a variety of settings and in conjunction with a variety of levels of care and for uninsured and private pay individuals and Medicaid recipients. Key informants noted that there are a multitude of MAT providers within the city and that it is a service that is increasing given the resources being directed toward the opioid epidemic. Currently there are three FDA-approved medications for use in Maryland.

- *Methadone:* Used for decades to treat opioid addiction, methadone binds with and blocks the opioid receptors in the brain, reducing the symptoms of opioid withdrawal while blocking the effects of opioids if taken. Methadone can be offered in pill, liquid, or wafer form and is usually taken once a day.[97] In Maryland, methadone can only be prescribed in an outpatient setting through an Opioid Treatment Program (OTP). Services through an OTP are available for Medicaid recipients, some private pay individuals, and for uninsured individuals through the ASO. There were roughly 50 OTPs that billed the ASO for methadone treatment services for Baltimore City residents in FY2018 with 32 of the OTPs located directly within city limits.
- *Buprenorphine:* A partial opioid agonist, buprenorphine has low potential for misuse and decreases withdrawal symptoms and cravings. Because it is long-acting, it often does not need to be taken every day and can be offered in offices and a variety of other community settings.[98] Buprenorphine is available for individuals with access to a prescribing physician and with the means to pay for the medication either through insurance or out of pocket.

[96] https://www.samhsa.gov/medication-assisted-treatment
[97] https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone
[98] https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

There were roughly 25 organizations that billed the ASO for non-methadone MAT services for Baltimore City residents in FY2018.

- *Naltrexone:* Unlike methadone and buprenorphine, which activate opioid receptors in the body that suppress cravings, Naltrexone[99] binds and blocks opioid receptors, and is reported to reduce opioid cravings. If a person relapses and uses the problem drug, naltrexone prevents the feeling of getting high. There is no abuse and diversion potential with naltrexone. Naltrexone can be used for both opioid and alcohol use disorders. As noted above, there were roughly 25 organizations that billed the ASO for non-methadone MAT services for Baltimore City residents in FY2018; the data did not allow for identification of which non-methadone MAT service they were providing.

EMPLOYMENT SERVICES

Employment services assist individuals with mental health disorders to return to work, providing an opportunity for individuals to increase their economic self-sufficiency and returning taxpayers to the system. Employment services are offered in a variety of settings and with a variety of funding sources in the city. Employment services are only billable through the ASO for Medicaid recipients and uninsured individuals with mental illness. Johns Hopkins Bayview was identified as offering the evidence-based Individualized Placement and Support (IPS) model services. ACT teams and clubhouses were identified as other sources for supported employment services. There were fewer than 20 organizations that billed Medicaid for employment services for Baltimore City residents in FY2018.

Crisis Services

COMMUNITY-BASED CRISIS SERVICES FOR ADULTS

Baltimore Crisis Response, Inc. (BCRI) is the only adult crisis services provider for Baltimore City. BCRI operates the Crisis, Information & Referral (CI&R) hotline (in partnership with Health Care Access Maryland who provides a warm handoff to callers to the CI&R line during normal business hours), the mobile crisis team, a 21-bed residential crisis program, and a 13-bed residential withdrawal management program for adults. Targeted case management services for short-term follow up after discharge are also provided.

Hotline and mobile crisis services are provided to individuals regardless of their ability to pay. Other than the residential withdrawal management services as described in the previous section, the majority of community-based crisis services are grant funded and are not eligible for Medicaid reimbursement.

In FY 18, BCRI[100]:

- Responded to 42,990 hotline calls.

[99] https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
[100] Ibid

- Provided mobile crisis response to 2,599 individuals.
- Successfully diverted 1,034 of 1,461 (71%) emergency department referrals from inpatient hospitalization.
- Completed 724 admissions to residential crisis services, with 71% of those served having a co-occurring substance use disorder.
- Maintained an occupancy rate of 91% for the residential crisis beds.
- Completed 679 admissions to residential withdrawal management (level 3.7D), with 47% of those served having a co-occurring mental health disorder.

COMMUNUTY-BASED CRISIS SERVICES FOR CHILDREN AND YOUTH

Baltimore Child and Adolescent Response System (BCARS) is the youth crisis services provider for Baltimore City. BCARS' main hours of operation are Monday through Friday from 8:30 am to 7:00 pm, though they partner with the BCRI CI&R Line to provide 24/7 availability of telephonic support for youth and family in crisis. Their main service is the youth community stabilization program, which offers urgent care appointments and two- or six-week in-home/community/school stabilization services to youth and families. BCARS also provides limited mobile crisis response services to the public school system and youth in foster care.[101] The majority of BCARS crisis services are provided regardless of the individual or family's ability to pay and are funded by a combination of grant funds and Medicaid reimbursement.

CRISIS STABILIZATION CENTERS

In April of 2018, through federal funding targeted toward ending the opioid epidemic, BHSB opened a new service that provides 24/7 crisis services for adults in need of a safe place to sober in the community and a real-time connection to ongoing care. The center is temporarily located within Tuerk House (who is also the service provider) and has the capacity to serve up to 15 individuals at a time. A permanent location has been identified next door to Tuerk House's facility and will be able to serve up to 35 individuals at a time when the building is fully renovated.

RESIDENTIAL CRISIS BEDS

Residential crisis beds are located in the community and offer 24-hour staff supervision, providing an alternative disposition to inpatient levels of care for people experiencing a psychiatric crisis. BCRI operates the mental health crisis residential bed program in the city, with 21 beds available. The average length of stay is around 9-10 days. Crisis residential services are not billable Medicaid services and because of that, the ability to become a crisis residential provider is limited within the state. There are no peer-run crisis respite beds available within the city.

[101] BHSB, "FY 2018 Activities, Behavioral Health Indicators and System Utilization"

MOBILE CRISIS AND OTHER CRISIS SERVICES

Mobile crisis services consist of teams of mental health service providers (e.g., nurses, social workers/therapists, psychiatrists) that are able to travel within the community to meet individuals experiencing a behavioral health crisis in their immediate location. That is, they are crisis services that come to the individual rather than the individual having to go somewhere for services. Mobile crisis responses ideally would be available within an hour of a call. In addition to providing a response to an acute crisis, mobile crisis teams should also function as a gateway to further connection of services. BCRI is contracted to operate the only Mobile Crisis team active within the city. They operate from 7 am to midnight. Last year, they responded to about 2,100 calls for service.

EMERGENCY DEPARTMENTS

There are 12 hospitals in Baltimore City with an emergency room.[102] There were a few hospitals identified as having specialty psychiatric emergency departments; these were Johns Hopkins Bayview and Downtown, University of Maryland and Harbor Hospital. Franklin Square hospital, which is in the Medstar system, serves a large number of people from Baltimore City but is located just outside city limits. In FY2018, Johns Hopkins, University of Maryland Medical System, Johns Hopkins Bayview, Sinai, and Bon Secours had the most ASO ED mental health claims. For substance use ED claims, Johns Hopkins, Johns Hopkins Bayview, Maryland General, Mercy, University of Maryland Medical System, and Bon Secours had the largest number.

ROLE OF LAW ENFORCEMENT AND COURTS

Baltimore Police Department officers frequently find themselves in the role of responding to individuals who are experiencing a behavioral health crisis when many of these crisis situations could be handled better in other systems if there were streamlined processes for diversion and if the other systems were appropriately resourced. Most officers lack sufficient training to effectively de-escalate crises.

Baltimore Police Department Initiatives. The BPD, in collaboration with the service delivery system, has developed a number of specialty initiatives to better serve individuals in the community. The major initiatives that have been developed are:

- *Crisis Intervention Team Training (CIT):* BPD has had some training of officers in mental health in place prior to the consent decree. That training, known as Behavioral Emergency Services Team (BEST), was converted to the current CIT training. The CIT curriculum has been based on national best practice models, such as the Memphis model. The training consists of 40 hours focused on mental health, including de-escalation techniques and hearing from individuals with lived experience, with the goal of diverting individuals with behavioral health disabilities from the criminal justice

[102] BHSB, "FY 2018 Activities, Behavioral Health Indicators and System Utilization"

system. Officers who have gone through the CIT training can volunteer to be a designated CIT response officer.

- *Crisis Response Teams (CRT):* The CRT is a specialized unit composed of certified officers who are paired with a licensed mental health professional. CRT is available 7 days a week from 11 am – 7 pm and is usually called as backup to another responding officer, though they can be dispatched directly as well. The hours of operation were chosen based on data showing when the most behavioral health calls were received. Initially, the CRT covered only the Central district, but they have since expanded their service area and are now able to respond anywhere in the city.
- *Homeless Outreach Team (HOT):* As the name indicates, HOT provides outreach services with a public safety focus (i.e., encouraging people to go to shelters, move tents, and referral to services if possible) to individuals living on the streets or otherwise. There is a single HOT team available for the entire city.
- *Law Enforcement Assisted Diversion (LEAD):* LEAD is a post-arrest, pre-booking diversion program that connects individuals with case managers and peer support services, who then connect individuals with other community-based services. It is modeled after a program in Seattle. To be eligible for LEAD, individuals must have a substance use disorder and be arrested for either drug possession, drug distribution (subsistence level dealing), or prostitution. LEAD services are not available for someone with only a mental health diagnosis. LEAD services are limited to a pilot zone within the Central District.

Specialty Courts and Service Programs. In addition to the BPD initiatives, key informants discussed a number of criminal justice system initiatives intended to reduce the criminalization of behavioral health disorders and to connect people with needed services:

- *Drug Courts:* There are two court levels with active drug court programs. These are the district court level, with limited jurisdictions and non-juried cases, and the circuit court level, with unlimited jurisdiction and all kinds of cases. Drug courts are diversion programs for people with pending charges and diagnosed as having a major substance use disorder. Participants are usually facing charges related to possession or intent to distribute, theft, and assault. Instead of going to trial, they enter the program which typically lasts for a period of two years. The program enables the judiciary and service provider stakeholders to take a team approach, and mandates that individuals receive SUD treatment at approved, quality treatment programs.
- *Mental Health Courts:* As with the drug courts, there are mental health courts active at both the district and circuit level. Individuals must be diagnosed with a serious mental illness or trauma-related disorder, be eligible for public mental health services, agree to comply with program requirements, be

charged with a misdemeanor or felony within the jurisdiction of the court, have never been convicted of a violent crime, and not be currently facing domestic violence charges. Participation in the district court program is reviewed by the FAST team (see bullet below). Once accepted, the defendant is assisted in developing an appropriate community-based treatment plan to address their needs, with treatment conditions then being court-ordered as conditions of pretrial release or probation.

- *Forensic Alternatives Services Team (FAST):* FAST consists of five masters-level clinicians who identify individuals with pending criminal charges who are diagnosed with a serious and persistent mental illness or trauma. Although they are housed administratively within the Medical Office of the Circuit Court, FAST team members are independent of the court; they perform their own assessments, do treatment consultation with individuals and their service providers, and make treatment recommendations which are proposed to the court in lieu of incarceration. FAST coordinates with the CRT and receives some referrals from police when a known individual is facing some charges, but the majority of the team's referrals come from judges, lawyers, and others in the court system. While FAST is able to take referrals from a wide range of sources, their capacity is limited given the volume of people with mental illness within the various components of the criminal justice system.

Inpatient Services

Key informants noted that Baltimore is a rich environment when it comes to inpatient mental health and SUD beds, given the large number of hospitals within city limits. In terms of inpatient mental health services billed to the ASO for Baltimore City residents in FY2018, Sheppard Pratt, Johns Hopkins, University of Maryland, Bon Secours, and Sinai hospitals had the largest number of claims. For inpatient substance use treatment services, the hospitals with the most ASO claims for Baltimore City residents were Johns Hopkins, University of Maryland Mid-town, Sinai, and University of Maryland Downtown.

Discharge and Community Reintegration

Discharge planning and community reintegration services are focused on connecting individuals with community-based care upon release from an institutional setting, such as a release from an inpatient stay or incarceration within the criminal justice system. The hope is that by connecting individuals to community-based resources, inpatient readmissions and recidivism can be avoided. Discharge planning and community re-integration efforts can occur in various level of intensity, from providing an individual with a phone number to call directly upon release to facilitating in-person meetings with community service providers prior to release. Discharge planning and community reintegration efforts should be occurring in all services, including anywhere that provides an institutional level of care.

Appendix E: Key Informant Interview Guide

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Baltimore Public Behavioral Health System Gap Analysis: Key Informant Interview Questions- Stakeholder Interviews

October 23, 2018

Background Information

1. Tell me about yourself/your organization.
    - Populations of focus? Explore if any of following served:
        i. Early childhood
        ii. Youth (under 18) and transition-aged youth (ages 18-25)
        iii. New Americans/immigrant communities
        iv. People of color
        v. LGBTQ populations
        vi. Individuals experiencing homelessness
        vii. People with active SUD
        viii. People with brain injury
        ix. People with co-occurring mental health and substance use issues
        x. Military service members and family
        xi. Older Baltimorians
        xii. Persons with non-behavioral health related disabilities/physical disability
        xiii. Justice-involved populations
        xiv. People without insurance
    - Services provided or issue you work on?
    - Mission and values?
    - How long in the area?
    - Involvement in any state or local behavioral health-related initiatives or workgroups?
    - Any previous relevant work experience?
    - [If a service user or family member] How long have you or your family member been receiving services through Baltimore City's Public Behavioral Health System (PBHS)?
    -

Promotion, Prevention, and Services and Populations in Need of Services

2. What behavioral health promotion and/or prevention activities are taking place in Baltimore City? Promotion activities may include strategies to promote mental health and wellbeing for all residents, whether or not they are experiencing a mental health or

substance use problem. Prevention activities may also be targeted interventions to prevent the development of more serious problems for people who are at risk of developing or already have mental health or substance use issues.

- What data are available for us to understand more about these activities? [probes for expenditures, numbers reached/numbers targeted, impact]
- In your view, are these prevention activities adequate in regard to quality and quantity?
- Are there any prevention activities that should be added or expanded? Please describe any particularly innovative and/or successful initiatives related to prevention or promotion?
- Are there any prevention activities that are not useful or should be curtailed?
- In your opinion, are prevention activities culturally and linguistically appropriate?
- Are there any populations that you feel aren't being reached by prevention activities? Why do you think has there been difficulty reaching them?
- What specific drug and alcohol prevention services are available? What are the barriers to providing these services or accessing them?

3. In your view, are the services and supports provided by Baltimore City's Public Behavioral Health System (PBHS) sufficient to meet the behavioral health-related needs of people who rely on publicly funded services in Baltimore City? Is there sufficient **workforce capacity** to implement such services?
    - What services are missing or available in insufficient quantities? Probe specifically for availability of crisis response services, alternatives to hospitalization?
        - Also probe for: evidence-based practices (**including peer support,** peer mentoring, **supported employment**, **supported housing**), community-based services (including **outreach**, skills training, ACT, **crisis care** and supports including mobile crisis services, child crisis services and help lines, peer respite, trauma informed care training, and **CIT or de-escalation training for first responders**, behavioral health within schools), **outpatient treatment (MH, SUD, brain injury**), emergency room and inpatient, hospital discharge planning and transition support, corrections-based care and community reintegration services, mental health and drug courts, and uninsured/unreimbursed care, care coordination and **continuity of care**
    - Are there services that should be preserved or expanded? Please describe any particularly innovative and/or successful services and supports in your area.
    - Are there services or supports that you think are not useful or should be curtailed?
    - In your opinion, are services and supports culturally and linguistically appropriate?

- Are there any populations that you feel aren't being reached or served adequately? What do you think is getting in the way of adequately serving or reaching this/these population(s)?
- Are there sufficient numbers of qualified service provider agencies and individual practitioners to meet the demand for services?
- Beyond OMS, what data are available for us to understand more about these services? [probes for expenditures, numbers reached/numbers targeted, impact/outcomes]
- What is the availability of housing and housing support services for those you serve? What are the barriers to obtaining housing? What are the barriers to maintaining housing?
- What housing related resources are you aware of? Please describe any particularly innovative and/or successful housing supports in your area.
- Do you feel there is adequate inpatient capacity within the system? What challenges have you encountered when seeking inpatient services for someone? Has there been anything that facilitated access to inpatient services?
- What do you feel is the number one contributor to individuals experiencing long wait times in ERs when accessing inpatient services?
- What is the availability of services and supports for individuals with intensive/acute service needs?
- What types of services and supports are available to individuals after receiving intensive/acute services such as inpatient? Probes for discharge plans, bridging and coordination, referrals and follow-up
- What types of services and supports are available to individuals to avert the need for an inpatient stay? Probes for mobile crisis response, warm lines, crisis residential
- What are the barriers to meeting the needs of individuals with intensive and/or acute service needs?
- Are there any particularly innovative and/or successful programs, services, or supports for individuals with intensive/acute service needs?

4. Where do you think people in Baltimore first go for help with a mental health or substance use problem?
    - How is the experience different – if at all – for:
        - People who are brand new to the system?
        - People with no health insurance?
        - Parents of children and adolescents with potential behavioral health issues?
        - Military service members and their families?
        - New Americans?

5. Are there population groups that are being served particularly well? If so, please describe.

System and Financial Issues

6. How are the formal and informal policies or practices of providers, BHSB, or other funders affecting the delivery of mental health and/or substance use services?
    - Are there any policies that are impeding the delivery of mental health and/or substance use services?
    - Are there any policies that are helping to ensure adequate services are available?

7. Are the rates being paid to providers adequate for them to provide high-quality versus "medically necessary" services? Are any rates too high?

8. Are there any licensing or certification issues that you are aware of affecting the supply of individuals to provide services?

9. What mechanisms for coordination among and between provider organizations exist? In what ways might coordination of services be improved?

10. What mechanisms for coordination among and between relevant state and local agencies exist? In what ways might inter-agency coordination be improved? Probe for education, early intervention, vocational rehabilitation, justice systems (law enforcement, prisons, jails, courts), physical health systems including federally qualified health centers (FQHCs), aging and disability systems, child welfare, public health

11. Are telehealth systems readily available? What barriers exist for accessing telehealth services? Please describe any particularly innovative or successful telehealth initiatives.

12. What sorts of data does your organization collect? As part of regular program administration (e.g., units of service provided)? Service user experience?
    - How frequently are these types of data collection?
    - How are these data used? Are these data reported to any other parties? Does your organization coordinate its data collection and analysis efforts with other organizations or report data in a centralized way (e.g., participate in some sort of larger, system-wide data initiative at the state or local level)?
    - Are there any types of data that your organization should be collecting?
13. Do you believe providers, BHSB, and/or funders are conducting adequate oversight processes to assure that services are of high quality? If not, what do you think they should be doing differently?

14. What has been the impact of Medicaid expansion on the behavioral health service system?

Community and Service User Involvement

15. Is there sufficient public input into decisions that impact the behavioral health system?
    - Are there forums and avenues for the public to have a voice in the behavioral health systems?
        - Are the forums and avenues provided for individuals with limited English proficiency?
        - Are the forums and avenues provided for all major groups represented in the community, including racial and ethnic minorities?
    - Do entities within the behavioral health system reach out to the public to seek their views? If so, how effective are these processes?
    - Are they receptive to feedback from the community?
    - Are there specific groups in the community that are given fewer opportunities to provide feedback, or whose feedback is overlooked?

16. Is there sufficient service user and family member input into decisions that impact the behavioral health system?
    - Are there forums and avenues for service users and their families to have a voice in the behavioral health systems?
        - Are there forums and avenues for service users and family members with limited English proficiency to have input into service delivery decisions?
        - Are there forums and avenues for service users and their families in all major groups represented in the community, including racial and ethnic minorities, to have input into service delivery decisions?
    - Do entities within the behavioral health system reach out to service users and family members to seek their views? Do they make use of bilingual staff, interpreter services, and translated materials?
    - Are entities within the behavioral health system receptive to service user and family member feedback?

17. Is there sufficient provider input into service delivery decisions?
    - Are there forums and avenues for providers to have a voice in the behavioral health service delivery systems?
    - Do entities within the behavioral health system reach out to providers to seek their views?
    - Are entities within the behavioral health system receptive to provider feedback?

Sources of Information

18. Are there documents, needs assessments, or data that you believe would be helpful to this project?
    - If so, what are they, and where can we get them?

19. Are there other people or groups you believe we should be talking to about the needs in your area?
    - Who are they, and how do we contact them?

BPD Specific Questions (only for BPD interviewees)

BPD1. How well prepared do you feel for identifying when a person is having a behavioral health-related issue? Has this changed over time? If so, what do you attribute this change to?

BPD2. What factors do you consider when deciding how to respond to a behavioral health-related issue (e.g. whether to bring someone to treatment/ED or jail)?

BPD3. What do you see as the greatest need within the community for individuals with behavioral health concerns?

BPD4. When were you trained in CIT, and what types of CIT training did you receive? Have you received any other behavioral health training? What was it and when?

BPD5. Has CIT or other behavioral health training you've received impacted the way you interact with individuals experiencing a behavioral health crisis? In what ways? (e.g., improved relationships, more confident in what to do, etc.)

BPD6. What sorts of further training do you think might be helpful?

General Questions

20. Any other ideas for changes that would make the system work better?

21. Is there anything else that you think is important to know about the Public Behavioral Health System in Baltimore City that we did not get to today?

22. Of all of the things we discussed today, please highlight the most important points. What are the key takeaways from this conversation?

Appendix F: Law Enforcement Interactions Interview Guide

Baltimore Public Behavioral Health System Gap Analysis: Key Informant Interview Questions- Police Interaction Interviews

October 22, 2018

1. How long have you or your family member been receiving services through Baltimore City's Public Behavioral Health System (PBHS)?

2. Please tell us a little about your most recent interaction with the Baltimore Police Department, when you were in crisis. What happened?

3. What precipitated that event/the crisis?

4. Is there anything that could have been done that would have helped you avoid this situation? Are there any services that you feel, if they had been available at that time, would have helped you avoid the crisis altogether?

5. How did the police become involved?

6. What was the effect of having the police become involved? Did you feel it helped the situation get better or worse?

7. Is there anything the police did that was helpful?

8. Is there anything the police did that was not helpful?

9. How could the officers have responded to you differently, that you think would have helped you more in that moment?

10. Are there any types of service that you are aware of that you think might help you avoid such encounters with police in the future? (Probe for mobile crisis teams, hotlines/helplines, crisis resource centers, peer respite)

11. What have been the barriers to accessing those types of services?

12. What might help you overcome those barriers?

13. Are there any of those services that you feel there should be more of? In what ways (providers, hrs, etc.)

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14. Is there anything you can think of that would help make people more aware of the types of programs and services that might be available to them?

15. Do you consider yourself to be any of the following?
    - Member of a racial or ethnic minority
    - LGBTQ
    - Immigrant/new American
    - Homeless
    - Active/recent user of illicit drugs

16. Did this have anything to do with the way the police treated you? If yes- what did they say or do that made you feel this way?

17. Is there anything else you would like us to know about your interaction with police?

18. Is there anything you would like us to know about the needs of the public behavioral health system in general in Baltimore City?

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Appendix G: Key Informant Organizations and Sample Roles

Organizations Represented by Key Informants

- Associated Catholic Charities
- B'more Clubhouse
- Baltimore City Dept. of Social Services
- Baltimore City Fire Department
- Baltimore City Health Department
- Baltimore City Public Schools
- Baltimore City Substance Abuse Directorate
- Baltimore Crisis Response, Inc.
- Baltimore Harm Reduction Coalition
- Baltimore Police Department
- Baltimore Transgender Alliance
- Beacon Health Options
- Behavioral Health Administration, Office of Crisis and Criminal Justice Services
- Behavioral Health System Baltimore
- Bmore POWER
- Bon Secours
- Catholic Charities of Baltimore
- Charm City Care Connection (aka Charm City Clinic)
- Community Behavioral Health Association of MD
- Disability Rights Maryland
- District Court for Baltimore City
- Drug Treatment Court
- Family League of Baltimore
- Forensic Alternative Services Team (FAST)
- Health Care for the Homeless
- Hearts and Ears
- Helping Other People through Empowerment (HOPE)
- Housing Authority of Baltimore City
- IBR Reach
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Hospital
- Johns Hopkins School of Public Health
- Maryland Department of Health, Behavioral Health Administration
- Maryland Hospital Association
- Maryland Medicaid
- Mayor's Office of Human Services
- MedStar Health Inc., Harbor Hospital
- Mental Health Association of Maryland
- Mercy Health Services
- NAMI Metro-Baltimore
- Office of Public Defender
- Open Society Institute
- Power Inside
- Roberta's House
- The Trill Foundation
- Transgender Response Team, MDH Prevention and Health Promotion Administration
- Tuerk House
- United Way of Central MD
- University of Maryland Downtown
- University of Maryland Innovations Institute
- University of Maryland School of Social Work
- Youth Empowered Society

Sample Titles and Roles of Key Informants

- Administrative Policy Analyst
- Ambulatory Services Manager
- Assistant Professor
- Associate Director
- Attorney
- Captain
- CEO
- CFO
- Chief Information Officer
- Chief of Staff
- Clinical Director
- Clinical Nurse Specialist/Manager
- Clinician
- Committee Chair
- Coordinator
- Crisis Intervention Manager
- Deputy Director
- Director
- Discharge Coordinator
- Division Chief
- Division Director
- Division Head
- ED Social Worker- Psychiatric
- Emergency Department Director
- Emergency Department Supervisor
- Evaluator
- Executive Director
- Family member
- Founder
- Head of Operations
- Judge
- Lieutenant
- Major
- Managing Attorney
- MCO Nurse Liaison
- Medical Director
- Mental Health Therapist
- Operations Manager
- Peer Recovery Coach
- Policy Director
- President
- President & CEO
- Prevention Service Coordinator
- Professor
- Program Coordinator
- Program Director
- Program Manager
- Program Specialist
- Public Defender
- Regional Medical Director
- Rehabilitation and Treatment Coordinator
- Research Analyst
- Research Data Analyst
- Resource Database Administrator
- Senior Analyst
- Senior Director of Policy
- Senior Director of Public Policy
- Sergeant
- Social Work Intern
- Social Work Supervisor
- Social Worker
- Special Projects Director
- Special Projects Manager
- Training Institute Manager
- Vice President