Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES

STATE SUMMIT ON BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM

Utilizing the Sequential Intercept Model (SIM) Mapping Initiative

November 2022

Prepared by: The Governor's Office of Crime Prevention, Youth, and Victim Services

Centers of Excellence

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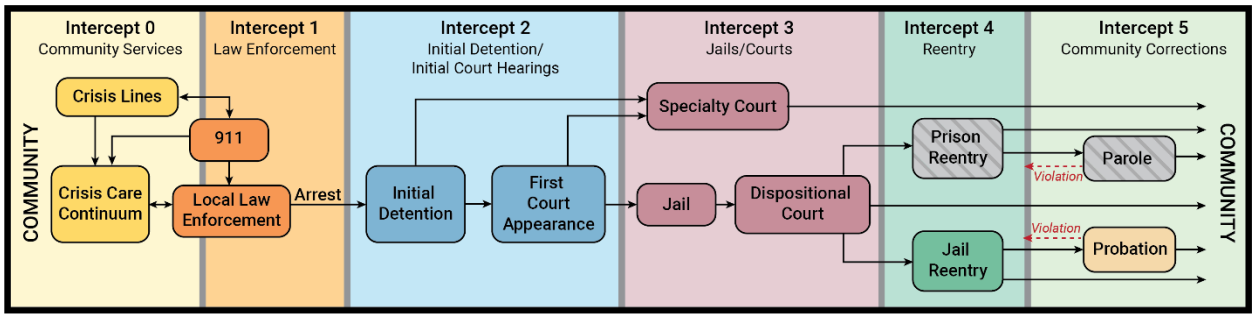
BACKGROUND

The Sequential Intercept Model (SIM), developed in the early 2000s by Mark R. Munetz, M.D., and Patricia A. Griffin, Ph.D.,[1] has been used as a framework to help states and communities assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

The SIM illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through a Sequential Intercept Mapping workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the decriminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services, 57*, 544-549.

Maryland's 2022 State Summit on Behavioral Health and the Justice System consisted of a presentation of the SIM and best and evolving practices to:

- Prevent individuals with behavioral health disorders from entering the criminal justice system.
- Divert individuals from further penetration into the criminal justice system.
- Engage individuals in treatment as they exit the criminal justice system.

Dan Abreu, Senior Project Associate with SAMHSA's GAINS Center, and the Centers of Excellence co-facilitated the two-day Summit and invited stakeholders from all regions of the state and SIM intercepts to attend. On day one, there were 76 stakeholders in attendance. Mr. Abreu provided an overview of the SIM, followed by a series of intercept-specific panels that highlighted a sample of Maryland's Best Practice Programs. On day two, stakeholders participated in one of three focus groups: Intercept 0-1: Crisis Response and Pre-booking Diversion; Intercept 2-3: Court Diversion and Jail Services; or Intercept 4-5: Reentry and Community Corrections. Each group consisted of two facilitators who were trained through the Train-the-Trainer workshop with the Governor's Office of Crime Prevention, Youth, and Victim Services as well as SAMHSA's GAINS Center. The facilitators of each focus group led discussions that identified resources statewide, identified gaps in programs or planning for their specific workgroup, and prioritized the identified gaps through a voting process. The work from these focus groups informed recommendations listed later in this report.

INTRODUCTION

In January 2019, Maryland's Lieutenant Governor established the Commission to Study Mental and Behavioral Health (Commission). The Commission requested that SAMHSA's GAINS Center provide a state-level strategic planning workshop to better understand Maryland's resources for those with mental health and behavioral health concerns, and to guide legislative appropriations for crisis services and jail diversion. SAMHSA's GAINS Center is a technical assistance entity that focuses on expanding access to services for people with mental health and substance use disorders who come into contact with the adult criminal justice system. Through the coordination of Senator Katie Fry Hester and her co-chair, Dr. Lynda Bonieskie, and the help of SAMHSA's GAINS Center, the first strategic planning workshop, "State Summit on Behavioral Health and the Justice System," was held virtually on November 17-18, 2020.

In 2020, Senate Bill 305 established a Crisis Intervention Team Center of Excellence (CITCE) within the Governor's Office of Crime Prevention, Youth, and Victim Services to provide technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers; and to develop and implement a 'crisis intervention model program.' In 2021, in an effort to implement policies and address gaps and challenges identified during the 2020 Summit, the Maryland General Assembly made recommendations to create a center of excellence that would expand the current evaluation system within criminal justice to track program development, centralize resources, and provide technical assistance. The recommendation to expand the Crisis Intervention Team Center of Excellence's roles and responsibilities led to the creation of the Maryland Behavioral Health and Public Safety Center of Excellence within the Governor's Office of Crime Prevention, Youth, and Victim Services, pursuant to Chapters 68 and 69 of 2021 (Senate Bill 857/House Bill 1280). Chapters 68 and 69 of 2021 also require the Maryland Behavioral Health and Public Safety Center Center of Excellence to act as a statewide information repository for behavioral health treatment and diversion programs, and to begin the "Train-the-Trainer" process related to SIM and host annual statewide SIM Summits. Collectively known as the Centers of Excellence - the Crisis Intervention Team Center of Excellence and the Maryland Behavioral Health and Public Safety Center Center of Excellence - advises the Governor's Office of Crime Prevention, Youth, and Victim Services on efforts that support Maryland communities in improving the criminal justice response to, and treatment of, individuals with mental health illness, reducing the incarceration of individuals with behavioral health needs, and providing linkages to treatment.

In 2022, Executive Order 01.01.2022.02 established a Maryland Behavioral Health and Public Safety Center of Excellence Advisory Group (Advisory Group) to advise the development and implementation of the Maryland Behavioral Health and Public Safety Center of Excellence. The

Advisory Group members will meet bi-annually once they are appointed in early 2023, by the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services.

In 2022, the Centers of Excellence hired an Assistant Director, Data Analyst, and Policy and Advocacy Coordinator. It also moved the Law Enforcement Assisted Diversion (LEAD) program in the Centers of Excellence to increase cross-collaboration and minimize working in silos; and hired a Law Enforcement Assisted Diversion (LEAD) Program Coordinator. As a collaborative unit, staff members help to build the foundation for, and the implementation of, programs and initiatives that are within the purview of the Centers of Excellence, as required by law.

This *State Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model (SIM) Mapping Initiative* (report) summarizes the November 2022 Summit which utilized the SIM tool, taught by Policy Research Associates (PRA) and SAMHSA's GAINS Center, to inform efforts in Maryland.

SUMMIT GOALS

- To identify opportunities for coordination and collaboration among state and local stakeholders;
- To inform state and local stakeholders about best practices in the behavioral health and correctional fields;
- To consider the impact of healthcare reform and state behavioral health and criminal justice initiatives on justice-involved populations;
- To introduce the SIM as a planning tool to strategically inform legislation, policy, planning, and funding; and
- To introduce the Centers of Excellence and its multi-year strategic plan within the Governor's Office of Crime Prevention, Youth, and Victim Services.

Summit participants represented multiple stakeholder systems, including mental health, substance treatment, health care, human services, corrections, advocates, law enforcement, health care (emergency department and inpatient acute psychiatric care), academia, and the courts. Seventy-six stakeholders were recorded as present at the Maryland Summit in 2022.

SUMMIT DAY ONE

Welcoming and Opening Remarks: Kunle Adeyemo, Esq., Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services, opened the State Summit on Behavioral Health and the Justice System by welcoming participants and recognizing the Lieutenant Governor's efforts in leading the Governor's Commission to Study Mental and Behavioral Health in Maryland since January 2019. He highlighted the creation of the commission to examine access to mental health services and the link between mental health issues and substance use disorders. He further recognized Senator Hester and partners in the General Assembly who have worked to turn the recommendations of the commission and the first annual summit into law. These efforts and collaborations have been a key part of the Governor's legacy of taking a comprehensive approach to building a safer Maryland. Mr. Adeyemo noted the state has taken many strides, specifically through the implementation of both the Crisis Intervention Team Center of Excellence (CITCE) and the Maryland Behavioral Health and Public Safety Center of Excellence to improve the criminal justice response to, and treatment of, individuals with mental illness, reducing the incarceration of individuals with behavioral health needs, and providing linkages to treatment. The Centers of Excellence implemented SIM Mappings and facilitator training workshops to assist local jurisdictions across the state. The Governor's Office of Crime Prevention, Youth, and Victim Services also expanded the Law Enforcement Assisted Diversion (LEAD) program, which works directly with law enforcement agencies to safely divert

low-level offense individuals with behavioral health or substance use disorders into support programs. Additional strides include the launch of the Maryland Criminal Intelligence Network (MCIN) which has dismantled over 2,000 criminal organizations and referred more than 14,000 Marylanders to substance use treatment through its Heroin Coordinator program.

Senator Katie Fry Hester provided remarks and discussed the prevalence of mental health disorders (39%) and co-occurring substance abuse disorders (90%) among inmates in Maryland's criminal justice system.[2] She highlighted the development of the SIM Summit and collaboration with SAMHSA's GAINS Center and PRA for technical support. She also called attention to the recommendations that resulted from the initial summit, to include: improved planning and coordination (e.g., broadening county-level criminal justice/behavioral health planning committees), expansion (e.g., expanding crisis care continuum), formalization (e.g., improving veterans screens), and cross-cutting basics (e.g., increasing transportation access). Finally, Senator Hester emphasized the successful creation of the Centers of Excellence to implement the 2020 Summit goals, assist with mental and behavioral health diversion programs, and provide technical assistance to local governments.

James Rhoden, Assistant Director of the Centers of Excellence at the Governor's Office of Crime Prevention, Youth, and Victim Services, proceeded with a brief elaboration on the centers' current staff members and projects. He concluded his remarks by introducing Dan Abreu, Senior Project Associate with SAMHSA's GAINS Center.

Dan Abreu greeted the participants and delivered a presentation on SIM. He began by addressing major themes participants may come across due to the new 9-8-8 dialing code, the COVID-19 pandemic, and criminal justice reform initiatives. He also discussed the impact of racial disparities across systems emphasizing that participants should consider these differences when presenting existing resources and gaps throughout the Summit. Mr. Abreu also elaborated on each of the six intercepts and clarified examples of existing resources and potential opportunities across all intercepts in Maryland. This included addressing cross-intercept practices such as the risk-need-responsivity model, peer support services, housing and transportation access, and technology use.

Following these opening remarks, attendees were invited to ask questions about the SIM process. Concerns were expressed about the importance of addressing the youth population when discussing available resources and gaps in service for those with behavioral health needs. However, the SIM was developed to identify how the adult population comes in contact with

[2] Mental health treatment a crucial component of criminal justice reform: Reader commentary. (2020). *The Baltimore Sun*. https://www.baltimoresun.com/opinion/readers-respond/bs-ed-rr-mental-health-police-letter-20201116-djsp57zbvveuxmnb7zr5olm2by-story.html

and flows through the criminal justice system. Stakeholders discussed a court and community-based approach, 'Upstream,' that recognizes the juvenile population and their interactions with the criminal justice system as a more relevant model for the given population. Additionally, there was discussion in regards to future collaboration between the models to further improve diversion tactics. Other concerns regarding the ability to differentiate between local and statewide issues were expressed. Mr. Abreu encouraged stakeholders to note their jurisdictions during focus groups so that those with similar resources and gaps in service could concur. Mr. Rhoden also noted that the Centers of Excellence will be offering SIM Mappings for local jurisdictions in addition to the statewide interpretation to assist local jurisdictions in developing their own strategic plans. At the conclusion of these remarks, panel presentations highlighting existing resources across all intercepts in Maryland commenced with moderation by Mr. Rhoden.

Intercept 0/1 Panel Presentation: The intercept 0/1 panel was made up of Jennifer Corbin, Lucy Bill Moore, and Ed Soffe. Jennifer Corbin, Director of Anne Arundel County's Crisis Response System, initiated the discussion about Anne Arundel County's mobile crisis unit, Crisis Intervention Team (CIT) training, hospital diversions, and the Safe Station program. Anne Arundel County's Crisis Response System began in 1999, and expanded in 2014, with approximately 20-26% of the sworn law enforcement officers participating in the International Association of Chiefs and Police's (IACP's) One Mind Pledge. The goal of the One Mind Pledge is to "ensure successful interactions between law enforcement and individuals with mental health conditions and intellectual/developmental disabilities."[3] The Anne Arundel's Crisis Response System actively engages with community members and assists families of those with behavioral health conditions in understanding available resources. Anne Arundel County utilizes a voluntary program called 'Address Flagging' for individual response requests. For example, if an individual has noise-sensitivity, parents may include notes for law enforcement to refrain from using sirens when approaching the family's home or location of a crisis. This flagging system can include an individual's diagnosis, social support, and what may escalate or deescalate the situation. Ms. Corbin mentioned fire departments' expressed interest in CIT training to learn how to approach and intervene in scenarios associated with mental health and or substance use conditions. She also added that 9-1-1 operators in Anne Arundel are CIT trained due to their direct contact with trauma and crisis calls. Ms. Corbin concluded her remarks by emphasizing the importance of having key stakeholders, such as fire, emergency medical services (EMS), courts, health departments, probation and parole, and cross jurisdictional law enforcement involved in crisis discussions to ensure this important work is not occurring in silos.

Lucy Bill Moore, Mobile Crisis Services Program Director for Washington County Social Services, spoke about her experience with crisis response both as a program director and LEAD program

[3] International Association of Chiefs of Police. *One Mind Pledge*. https://www.theiacp.org/one-mind-pledge

manager. Ms. Moore added to Ms. Corbin's statement on a shared response and vision among crisis responders by emphasizing how communication between cross systems should be consistent. Ms. Moore expressed that mobile crisis teams sometimes forget the value in communication despite its invaluable role in crisis response. Increasing communication will assist in streamlining information and maintaining consistency in crisis response procedures. She also discussed the LEAD program that Mr. Adeyemo previously referred to. This program, which originated in Seattle in 2011, is currently used by 40 participating jurisdictions across the country. Specific to Maryland, and through the Governor's Office of Crime Prevention, Youth, and Victim Services, the LEAD program provides technical assistance and resources for the development of new partnerships to address substance use disorders and diversion programs through a collaboration with the Maryland Department of Health and the Opioid Operational Command Center. The goal of this program is to assist law enforcement officers in gaining the necessary expertise in de-escalation of individuals with behavioral health issues. In 2019, the Governor's Office of Crime Prevention, Youth, and Victim Services received a $6.5 million federal grant to support police-led diversion and detention-based referrals across nine communities in Maryland over three years. Through technical assistance, training, targeting low-level offenses for diversion, making individualized referrals, and following up with case management and other recovery resources, Maryland hopes to reduce opioid overdose deaths while increasing access to care and treatment.

Ed Soffe, Program Coordinator for the Early Intervention and Wellness Services at Maryland's Behavioral Health Administration, provided the final information for the 0/1 intercept panel. In 2020, Congress designated the new 9-8-8 dialing code to be operated through the existing National Suicide Prevention Lifeline by July 2022.[4] In response to this change, the State of Maryland applied for a SAMHSA planning grant in 2021, and held stakeholder meetings to discuss its implementation. Mr. Soffe noted the implementation status of the 9-8-8 Suicide and Crisis Lifeline, and identified the difference between this new dialing code and the 2-1-1 Maryland Hotline. 9-8-8 is a universal entry point for mental health-related assistance that is accessible 24/7 with access to trained crisis counselors.[5] Currently, there are eight call centers in the state and a ninth in progress of being operational in 2023. Five of the call centers include 2-1-1, however, they will begin focusing on the utilization of 9-8-8 moving forward. In fiscal 2023, the State of Maryland allocated $5 million to maintain and operate the 9-8-8 hotline. Mr. Soffe explained how 2-1-1 is a free confidential hotline that is available 24/7 to connect Maryland residents with health and human services.[6] Ultimately, the 9-8-8 and 2-1-1 hotlines

[4] Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *988 Key Messages*. https://www.samhsa.gov/find-help/988/key-messages
[5] Ibid.
[6] 211 Maryland. (2023). *About 211 Maryland*. https://211md.org/about/

serve to increase access to behavioral health resources and will require consistent collaboration and communication between cross-systems for increased effectiveness.

Intercept 2/3 Panel Presentation: The intercept 2/3 panel was made up of Robert Weisengoff, Alisha Saulsbury, and Richard "Gray" Barton. All panelists shared their current involvement and expertise in initial detention/court hearings and jails/courts. Robert Weisengoff, Executive Director of the Pretrial Release Services Program for the Department of Public Safety and Correctional Services, noted that there were approximately 850 individuals under supervision as of November 2022. Mr. Weisengoff shared how his team typically contacts those under supervision once a week by a telephone call or an occasional text message. He added that supervisors are responsible for ensuring individuals are kept out of trouble and diverted away from the court system. He also mentioned that those in pretrial are not considered guilty at intercept 2/3 of the SIM model which has created disadvantages, to include the inability to legally require individuals with co-occurring disorders to attend diversion or treatment programs. In addition, there are about 18 pretrial services across the state which operate differently from each other. For this reason, Mr. Weisengoff emphasized how a formalized pretrial services procedure would be beneficial to improve transition of care and reduce episodes of incarceration.

Alisha Saulsbury, Forensic Mental Health Manager at Mid Shore Behavioral Health, discussed her involvement with Caroline, Kent, Queen Anne's, Talbot, and Dorchester County along the Eastern Shore of Maryland. As a program manager, her responsibilities include conducting evaluations of those with behavioral health concerns and providing recommendations for the judicial system. Ms. Saulsbury works closely with law Enforcement officers along the Eastern Shore to complete CIT training and Self Care and Vicarious Trauma training. She also serves to increase awareness on trauma-informed approaches. Throughout the panel discussion, Ms. Saulsbury emphasized the importance of identifying those with co-occurring disorders to ensure individuals receive the proper support for effective treatment. Unfortunately, identifying co-occurring disorders is not always possible despite the prevalence highlighted by Senator Hester during her opening remarks. Creating a system to flag co-occurring individuals and/or instances of crisis could be beneficial at this point of the criminal justice system for improved recommendations. One of the most used assessment tools for recognizing traumatic experiences and identifying risk factors that may occur later in life is the Adverse Childhood Experiences (ACEs) Questionnaire. Ms. Saulsbury utilizes this tool as a starting point to gather information during each forensic mental health evaluation. This tool is important to understand how adverse childhood experiences can place a person at higher risk in developing addiction, mental health issues, and other poor health outcomes.

Richard “Gray'' Barton, Director of Maryland Judiciary’s Problem Solving Court, noted that there are 62 types of problem solving courts in 23 of Maryland’s 24 jurisdictions. The only jurisdiction without a problem solving court is Garrett County. Problem solving courts “focus on collaborating with the service communities in their jurisdictions and stress a multidisciplinary problem-solving approach to address the underlying issues of individuals appearing in court.”[7] Earlier in his career, Mr. Barton did not fully understand that those who reoffend or remain within the criminal justice system possess more complex issues and underlying problems than a drug offense or addiction. Through 20+ years of experience in the judiciary, he learned that individuals entering the criminal justice system need to be treated and viewed more holistically. By addressing underlying problems such as housing, employment, family, and other issues, these individuals may experience a better and long-term recovery. Mr. Barton expressed that judges are more open to the idea of problem solving courts finding solutions for those that flow through initial detention/court hearings and jails/courts rather than using punitive approaches. He also mentioned that the Maryland Judiciary recently received $1.7 million from the Bureau of Justice Assistance for the Adult Drug and Veterans Treatment Court Discretionary Grant Program. The goal of this program is to develop and implement a screening tool for those with mental health and/or substance abuse disorders to be used on each individual that flows through this intercept. This initiative intends to improve intervention approaches and increase treatment opportunities within six selected problem solving court sites. As of December 2022, the sites have not yet been selected, however, there is a working group to discuss what sites will be chosen. With this universal screening tool the goal is to reduce racial and ethnic disparities.

Intercept 4/5 Panel Presentation: The intercept 4/5 panel was made up of Scott Sheldon, Martha Danner, and Mary Ann Thompson. All panelists shared their experience with reentry and community corrections. Mary Ann Thompson, Warden of St. Mary’s County Detention Center, provided an overview of several pathways for an individual who comes into contact with her facility. She emphasized that each pathway includes the development of a plan to assist with reentry into the community. She also mentioned a One-Stop-Shop partnership with the Department of Public Safety and Correctional Services’ Division of Parole and Probation which provides individuals, who are currently incarcerated or recently released, with information on available opportunities and resources, such as Medication-Assisted Treatment (MAT). She further highlighted a site visit in a Washington D.C. jail where therapeutic communities have been implemented which influenced a desire to enhance similar communities within the St. Mary’s County Detention Center. In response to a participant’s question, Ms. Thompson discussed whether or not her correctional staff, specifically guards, are trained in practices such as CIT to better understand the population they work with. She also stated that there could

[7] Maryland Judiciary, Administrative Office of the Courts. (2022). *FY 2022 Problem-Solving Courts Annual Report*. https://www.mdcourts.gov/sites/default/files/import/opsc/pdfs/annualreports/fy2022opscannualreport.pdf

always be more enhancements with current training and mental health first aid. In closing, Ms. Thompson mentioned how the current political environment is seeing more positive change in regards to more collaboration with peer recovery specialists in her county and across the state.

Martha Danner, Director of the Division and Parole and Probation, provided an overview of the Division of Parole and Probation which supervises over 24,000 individuals in Maryland across 36 field offices. In 2021, the Division of Parole and Probation was recognized as an Overdose Response Agency that provides Narcan at all field offices. It is currently in the process of making telehealth appointments more accessible by increasing access in all field offices. In response to a participant's question, Ms. Danner noted that there are no specialized caseloads that solely identify individuals with co-occurring disorders; however, there are specialized caseloads for sex offenders, domestic violence, and those who are considered high risk offenders.

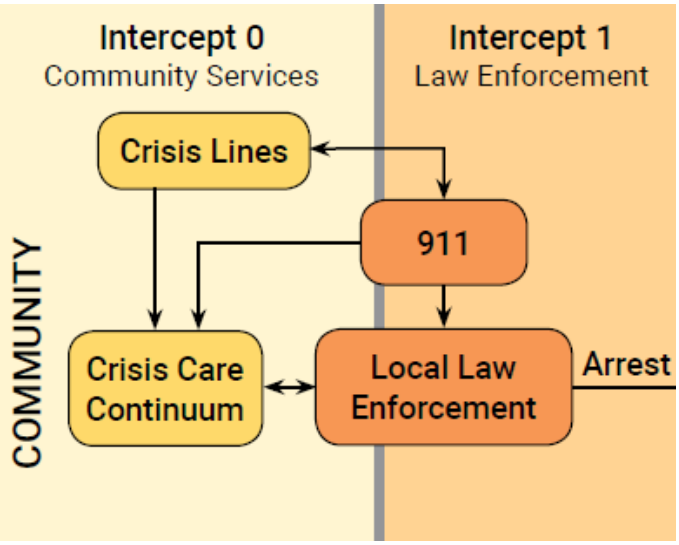
Scott Sheldon, Peer Recovery Specialist Supervisor with the Howard County Health Department, works closely with individuals returning to society post-incarceration by helping them navigate life beyond the system. Mr. Sheldon shared his own personal experiences with behavioral health needs and incarceration, indicating where gaps in service are still evident and even increased due to the COVID-19 pandemic. During his lived and professional experience, Mr. Sheldon noticed a lack of supportive housing for those struggling with mental health issues. As a result, these gaps made it more difficult for those in recovery to pursue treatment. To address this, Mr. Sheldon recommended that peers across the state, especially in neighboring jurisdictions, utilize a network to discuss and bridge such gaps within peer recovery services. He also discussed the importance of peer recovery programs in reducing the likelihood of relapses. He added that communicating with individuals who have been successful in the recovery process helps to encourage engagement in the process from those currently struggling with behavioral health concerns.

Summit Day One Closing Remarks: Dan Abreu, Senior Project Associate with SAMHSA's GAINS Center, provided closing remarks for day one of the summit by highlighting the collaborations and networking that occurred throughout the day. He emphasized how these connections are invaluable for improving both local and statewide programs by increasing access to treatment services and preventing further penetration of those with behavioral health needs into the criminal justice system at all points of SIM. Key concepts that were consistent across all the intercepts included the need for cross-systems communication, awareness of co-occurring disorders, shared data systems, and improved staffing support and crisis intervention/trauma-informed care training.

SUMMIT DAY TWO

On day two of the summit, Mr. Rhoden greeted participants and highlighted the invaluable discussions held on day one. Mr. Abreu then proceeded with a brief explanation on the development of SIM Mappings and the importance of participation to capture an accurate depiction of the current resources and gaps within Maryland's behavioral health and justice systems. Following the welcoming remarks, participants were divided into focus groups based on their respective intercepts. At the conclusion of these breakout sessions, priorities for change were reviewed across intercepts followed by a panel discussion on the multi-year strategic plan presented by the Maryland Crime Research and Innovation Center (MCRIC) at the University of Maryland. The presentation detailed a three-phase approach to strategic planning: (1) information gathering, (2) developing priorities and objectives, and (3) action planning (*in progress*). MCRIC also shared three core themes from identified priorities and key objectives: (1) technical assistance and training, (2) centralized communication, and (3) data, research, and evaluation. Collectively, the priorities and key objectives will help navigate future projects within the Maryland Behavioral Health and Public Safety Center of Excellence.

Intercepts 0 and 1



Resources

- Mobile crisis teams operate in 14 jurisdictions of which six operate 24/7. Others operate select hours and days (e.g., 9:00 a.m. - midnight, Saturday/Sunday for 4 hours).
- LEAD programs in 10 jurisdictions:
    - Serve people coming into frequent contact with the criminal legal system for reasons relating to unmet behavioral health needs, including low-level drug offenses, public order offenses, and crimes of poverty.
    - Provide law enforcement with referral options. Once an individual completes the intake and consents to participate, the client then has access to a wide variety of supports, such as intensive case management, peer recovery support options, an individualized service plan, and Medication-Assisted Treatment (MAT). With the support of a case manager, people can access acute needs like housing, food, and transportation, primary and mental health care, legal aid, inpatient and outpatient substance use treatment, job training, employment support, and education opportunities.
    - Operational workgroups foster collaborative case management across providers.
- 2-1-1 Maryland Hotline offers free and confidential support for people struggling with anxiety, depression, thoughts of suicide and other mental health concerns, through a partnership with the Maryland Department of Health and Behavioral Health Administration.

- 9-8-8 Suicide and Crisis Lifeline became the nation's dialing code for assisting people with suicide crisis and behavioral health crisis in a timely manner in July 2022.
- Dispatcher training is available in select counties to train dispatchers on CIT, diversion, and deflection principals, which results in a good relationship with grassroots organizations and improves law enforcement buy-in with programs like LEAD referrals.
- Local health departments are available in each jurisdiction across the state.
- Safe stations are located in four counties including Carroll, Anne Arundel, Worcester, Wicomico.
- Crisis housing is present in Frederick County.
- Behavioral Health Navigators are available in Howard County – one in the health department and one in the emergency room.
- Urgent care clinic is present within Sheppard Pratt, a nonprofit provider of mental health, substance use, special education, developmental disability, and social services.
- Triage beds are available in Carroll County for people who need a "timeout" to determine their next step towards treatment - they are not typical crisis service beds. The triage beds are offered for a maximum 4-night stay. There are also six beds available on the Springfield Hospital Center campus and a Young Adult Recovery House on campus.
- Detox beds are available in Frederick County, and the Wicomico/Somerset area (eight beds available).
- Intellectual and disabilities training, varied mental health disorders training, and instruction on traumatic brain injury is required in Washington County. The minimum amount of time for crisis/mental health and behavioral health training is approximately 24 hours.

Gaps

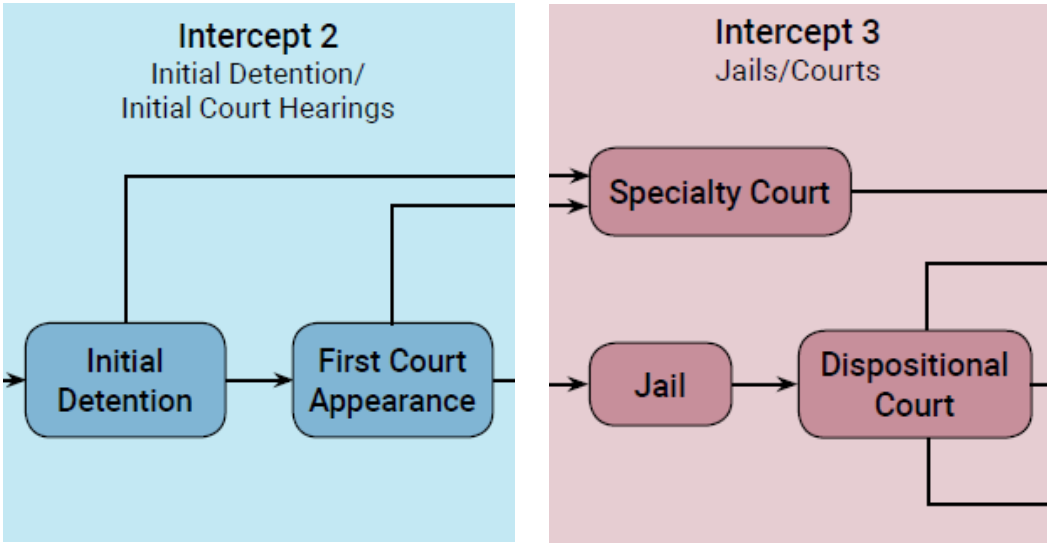
- Lack of staff to support mobile crisis teams. The follow-up mechanisms at each intercept could be enhanced.
- Availability for mobile crisis teams vary and are not all 24/7
- Walk-ins are not always 24/7
- Limiting hours within Sheppard Pratt's urgent care clinic
- Transportation services in rural areas need assistance
- Lack of staffing within hospitals
- Increase training for staff including training on trauma-informed care principles across the board and adding the Adverse Childhood Experiences (ACE) survey to each service
- Cross-systems coordination and communication to improve transition of care
- Improve communication between crisis response teams to ensure fulfillment of requests

- Statewide training and education on the integration and coordination of crisis hotlines
- Improve dispatch and mobile crisis continuum
- Need for behavioral health clinicians within call centers
- Consistency in dispatch protocols across the state
- Law enforcement CIT training
- Officer buy-in for diversion/deflection programs
- Emergency room services need improvement (e.g., long wait times, lack of staffing, inconsistency in transportation services, and lack of psychiatric beds)
- Increase telehealth access – specifically, explore option of telehealth services for law enforcement and division of parole and probation
- Integrate alcohol-related detox centers across the state
- Lack of crisis drop-in centers
- Available housing is a challenge
- Harm-reduction processes could be expanded statewide
- Allinic/Alleny General Hospital in Worcester County experiences an overflow of patients due to a lack of service in Virginia. Their hours are only 8:30 a.m. - 4:30 p.m.

Intercept 0-1 Priorities

1.	Expand lower level crisis services	11 votes
2.	Cultivating the workforce (i.e., practitioners, peer support, social workers, etc.)	9 votes
3.	Increase mobile crisis services	7 votes
4.	Lack of housing and transportation services	7 votes
5.	Expand officer buy-in for diversion/deflection programs	6 votes

Intercepts 2 and 3



Resources

- Cross-systems training in select counties
- Diversion linkages programs – public defender's office receives referral requests from prosecutors for diversion at bond-review hearing
- Correctional facilities are using outpatient treatment programs
- Trauma-informed care training provided for problem solving courts
- Mental health and substance abuse screening at booking, but often done independently
- Task forces - Opioid Operational Command Center
- House Bill 116 (2019) - correctional facilities must assess the mental health and substance use status of each inmate using evidence-based screenings and assessments
- CRISP (Chesapeake Regional Information System for our Patients) - Maryland's designated Health Information Exchange (HIE) is used along the Mid-Shore to track medication and avoid pharmacy hopping/shopping
- Baltimore City maintains a progressive women's health program
- Due to COVID-19 and transportation issues, some facilities have offered remote hearings

Gaps

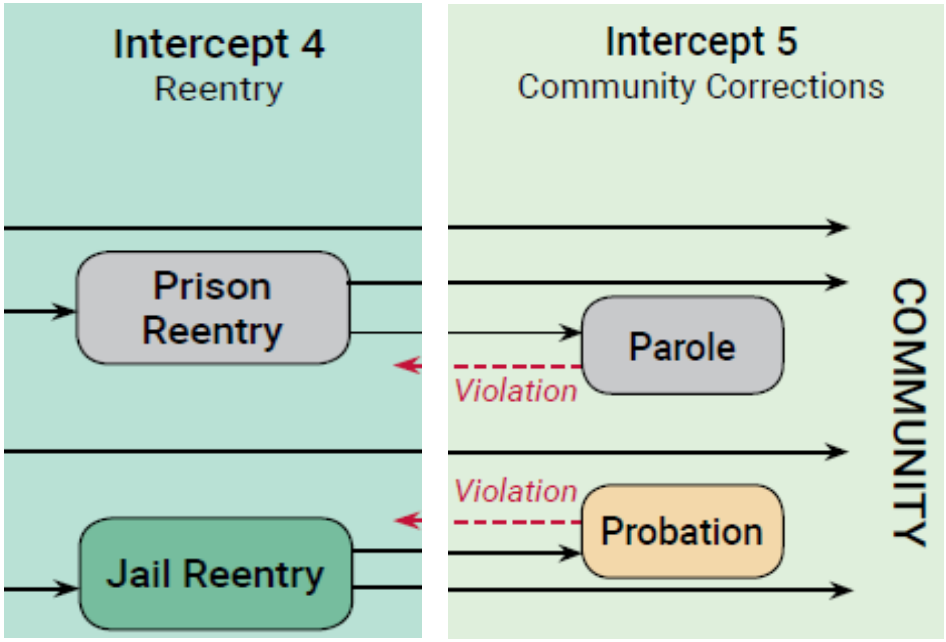
- Cross-systems coordination needs and communication
- Lack of a shared data system to keep track of services – including routinely tracked data on racial and ethnic disparities (written for infractions, referred for work release, etc.)
- Lack of housing – conditional release cannot occur without anywhere to go
- Differentiating between individuals with mental health problems and those who are seriously mentally ill for improved effectiveness of services
- Problem solving courts do not include individuals with co-occurring mental and substance use disorders and only take individuals with certain risk levels
- Lack of mental health courts – currently established court services are punitive with limited diversion for seriously mentally ill
- Space limitations in jails for programming – population needs and therapeutic space needs to be considered when creating the design of new jails/facilities
- Expand assisted outpatient treatment programs
- Lack of transportation for care and services
- Need to improve telehealth access and accessible behavioral health professionals to telehealth
- Funding issue for initiation and sustainability of services statewide, especially after the COVID-19 pandemic
- DataLink Initiative ceased during the pandemic
- Midnight releases from jail makes it difficult to connect individuals to resources
- Disruption with distribution of medications in jails despite preventative measures taken by staff for medication to be available on time and for 30 days – medications are not always maintained for those returning from a state hospital to jail because individuals can refuse medications and providers cannot force medication
- Medical vendors are needed
- Need to increase pretrial planning and linkage – need pretrial services to develop a plan to give to judges at pretrial release with screening and sufficient funding
- Referrals for diversion during initial hearings are made by prosecutors, leaving room for disconnect if prosecutors do not make referrals
- Reentry support services and funding within detention centers
- Need to implement trauma-informed care training across all of the intercepts
- Lack of peer support – many positions are grant-funded which are not self-sustaining
- Improve access to medical staff within facilities – during the pandemic, detention centers upheld a quarantine period which hindered individuals access to medical staff

- Need additional support such as case management and day reporting centers for individuals released and sentenced
- Lack of uniform screening for Veteran status

Intercept 2-3 Priorities

1.	Lack of housing – conditional release cannot occur without anywhere to go	11 votes
2.	Lack of mental health courts – currently established court services are punitive with limited diversion for seriously mentally ill	7 votes
3.	Lack of a shared data system to keep track of services – including routinely tracked data on racial and ethnic disparities (written for infractions, referred for work release, etc.)	5 votes
4.	Increase training opportunities including trauma-informed care training across all of the intercepts	5 votes
5.	Reentry support services and funding within detention centers	5 votes
6.	Cross-systems coordination needs and communication	4 votes

Intercepts 4 and 5



Resources

- Reentry navigators in the American Job Centers – partnership with the Maryland Department of Labor
- Correctional Diversionary Team – a partnership with the Office of the Public Defender, detention centers, and local law enforcement agencies
- Medication-Assisted Treatment (MAT) Coordinators for those in the MAT program
- Maryland Community Criminal Justice Treatment Program (MCCJTP) funds contribute to the health department for the partnership with correctional facilities in every county except for two. MCCJTP is a multi-agency collaborative that provides shelter and treatment services to mentally ill offenders in 18 of Maryland's 24 jurisdictions.
- Monthly collaborative workgroups with housing workgroups that include homeless shelters operated by Mid Shore Behavioral Health
- Judicial partnerships with courts, pretrial supervisors, day reporting, and inpatient treatment
- Narcan and naloxone administration training is available at every probation and parole office
- Telehealth accessible in every probation and parole office

- Reentry simulators in Frederick County – demonstrates individual's post-release struggles
- Community release information at the county level is accessible on the Department of Public Safety and Correctional Services Community Releases dashboard
- Virtual job fairs are offered in Prince George's County for individuals who are reentering the community from correctional facilities
- One Stop Shop for resources is available in Prince George's County
- Reentry classes are offered in Howard County for individuals with a release date or a pending release date to assist with job or treatment opportunities and introductions to case workers or the opportunity to request a 'transitional peer'

Gaps

- Administrative issues with MCCJTP, such as the lack of communication between program officers and program sites.
- Lack of housing for:
    - Severely mentally ill
    - Sex offenders and sex offenders with severe behavioral or mental disabilities
    - Individuals on MAT
    - Individuals seeking sober living options
- Support group for re-orienting individuals in life skills during reentry
- Increase training on Adverse Childhood Experiences (ACEs) and trauma-informed care
- Lack of transportation to help individuals get to treatment, especially along the Eastern Shore
- Lack of therapeutic centers
- Increase training for correctional officers on co-occurring disorders and Crisis Intervention Training
- Increase mental health care medication available upon release from state prisons
- Expand MAT clinic hours in order to increase immediate access for those who are released
- Lack of communication between reentry systems – problems with determining where the initial connection is
- More transitional peers
- Lack of input in Maryland Department Recovery Network (MDRN)
- Create a sliding scale financial planning option for supervision funds
- Address limitations for those reentering the community and applying for treatment – if an individual's previous address is listed in one county, and they are living with a family member in a different county, this may restrict the terms of funding and qualification for

treatment. This is also reflected when an individual is from a different state, yet previously incarcerated in Maryland.

Intercept 4-5 Priorities

1.	Increase opportunities to hire more transitional peers and create transitional plans	12 Votes
2.	Lack of housing for those with extreme mental health issues	10 Votes
3.	Peer support specialist to host monthly workgroups, along with salary support for the peer specialists	7 Votes
4.	Increase opportunities for mental health access	5 Votes
6.	Develop a One Stop Shop for returning citizens	4 Votes
7.	Expand telehealth accessibility	4 Votes

RECOMMENDATIONS

The recommendations below were primarily derived from the priorities in the Summit's focus groups, document review, national initiatives, and MCRIC's informational interviews with other states and localities. Many of the issues raised have been addressed through legislation or other state funding initiatives and are currently at varying stages of implementation. However, there were two overarching topics mentioned throughout the 2020 and 2022 SIM Summit that should be considered across the six intercepts: racial equity and disparity, and trauma-informed care. For more information on these topics, to include prior efforts and current needs, please refer to the following sections below.

Racial Equity and Disparity

Over the past few decades, Maryland has made many improvements to the criminal justice system to lower the state's prison population and to offer more supportive services for those incarcerated. In 2003, Maryland implemented state prison reforms to increase opportunities for rehabilitation. As a result of these reforms, Maryland's prison population decreased by 25% between 2008 and 2018.[8] In addition, and in 2016, the Justice Reinvestment Act (JRA) was enacted into law to divert nonviolent offenders from prison into mental and behavioral health treatment and to lower the population of nonviolent offenders with behavioral health concerns.[9]

Although the prison population has decreased, racial disparities continue to exist. In 2019, the Justice Policy Institute reported that more than 70% of Maryland's prison population was black, compared to 31% of the state population.[10] In addition, "the proportion of the Maryland prison population that is black is more than double the national average" of 32%.[11] There are also geographic disparities that exist within the prison population. For example, Baltimore City residents make up 40% of the state prison population, while Baltimore City residents only make up 9% of Maryland's total population.[12] According to the Department of Public Safety and

[8] Vera Institute of Justice. (2019). *Incarceration Trends in Maryland.* https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-maryland.pdf
[9] Governor's Office of Crime Prevention, Youth, and Victim Services. (2020). *Justice Reinvestment Initiative (JRI) Fact Sheet*. http://goccp.maryland.gov/wp-content/uploads/Maryland-Justice-Reinvestment-Initiative-One-Pager.pdf
[10] Justice Police Institute. (2019). *Rethinking Approaches to Over Incarceration of Black Young Adults in Maryland*. https://justicepolicy.org/wp-content/uploads/justicepolicy/documents/Rethinking_Approaches_to_Over_Incarceration_MD.pdf It is important to note that the data is current as of July 2018.
[11] Ibid.
[12] Justice Policy Institute & Prison Policy Initiative. (2022). *Where people in prison come from: The geography of mass incarceration in Maryland*. https://www.prisonpolicy.org/origin/md/2020/report.html

Correctional Services' *2022 Recidivism Report*, 31.5% of releases returned to prison within three years of their release in 2019, compared to 37.17% in 2016.[13]

Maryland has also made efforts to examine racial justice in prosecution. In 2022, the University of Maryland and Harvard University, in partnership with the Baltimore City State's Attorney's Office, published a *Final Report on Racial Justice in Prosecution in Baltimore* which examined racial differences in prosecution in Baltimore City.[14] It also included recommendations to improve prosecutor-citizen relationships, especially in communities of color, and to continue to engage in ongoing efforts to study and identify sources of racial inequality in prosecution and punishment.[15]

In addition, and in 2021, Maryland created the Racial Disparities on Overdose Task Force as an extension of the Interagency Heroin and Opioid Coordinating Council to investigate "the contributing factors related to increasing overdose deaths among Black Marylanders and recommending solutions to reduce racial disparities in overdose outcomes."[16] The task force also "identified several opportunities for intervention (i.e., policies and programs) that can be implemented to decrease the widening racial disparities in overdose deaths in Maryland and to begin building more equitable behavioral health and crisis response systems that can meet the needs of all Marylanders."[17] The identified intervention opportunities included the following: expand low-barrier and holistic access to treatment services; reduce stigma for people who use drugs; increase harm-reduction in non-traditional settings; and increase transparency in state and local resource allocation.

Although numerous efforts have occurred to address racial equity and disparity in Maryland, more work is needed. For this reason, the Centers of Excellence will continue to partner with a team of stakeholders across multiple systems - mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others - to further reduce racial equity and disparity in the State.

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[13] Department of Public Safety and Correctional Services. (2022). *Joint Chairmen's Report Q00R - Recidivism Report*. https://dpscs.maryland.gov/publicinfo/publications/pdfs/2022_p157_DPSCS_Recividism%20Report.pdf

[14] University of Maryland, College Park. (2022). *Final Report on Racial Justice in Prosecution in Baltimore*. https://content.govdelivery.com/attachments/MDBALTIMORESAO/2022/03/16/file_attachments/2104881/FINAL_REPORT_ON_RACIAL_DISPARITY_FEB_2022.pdf

[15] Ibid.

[16] Maryland Opioid Operational Command Center. (2022). *Inter-Agency Heroin and Opioid Coordinating Council: Racial Disparities in Overdose Task Force*. https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2022/10/Racial-Disparities-in-Overdose-Task-Force-Policy-and-Programmatic-Recommendations.pdf

[17] Ibid.

Trauma-Informed Care

In 2005, House Bill 990 established the Behavioral Health and Criminal Justice Partnership (BHCJP) to "improve services for individuals with mental health and substance use disorders who become involved with the criminal justice system."[18] It also required the workgroup to make recommendations on actions to break the cycle of rearrest and reincarceration for individuals with mental illnesses who became involved with the criminal justice system.[19] As a result of the workgroups' recommendations, Maryland enacted the following:

- House Bill 281 (2007) required the Department of Public Safety and Correctional Services' Division of Corrections to provide an inmate who has been diagnosed with mental illness with access to a 30-day supply of medication for the mental illness upon their release.[20]
- Senate Bill 761/House Bill 1335 (2010) expanded the requirement to provide a mentally ill inmate with a 30-day supply of medication upon release to local correctional facilities.[21]

According to the Centers of Disease Control and Prevention, Adverse Childhood Experiences (ACEs) "can have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity."[22] In 2020, the National Center for Injury Prevention and Control published the *Adverse Childhood Experiences Prevention Strategy* which aims "to prevent ACEs before they happen, identify those who have experienced ACEs, and respond using trauma-informed approaches in order to create the conditions for strong, thriving families and communities where all children and youth are free from harm and all people can achieve lifelong health and wellbeing."[23] Although many factors contribute to Adverse Childhood Experiences (ACEs) - "including personal traits and experiences, parents, the family environment, and the community" - it is essential to address each in order to prevent such experiences and protect children from neglect, abuse, and violence.[24]

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[18] Mental Health Association of Maryland. (2021). *Behavioral Health and Criminal Justice Partnership*. mhamd.org/what-we-do/advocacy/coalitions/behavioral-health-and-criminal-justice-partnership/

[19] Maryland General Assembly. (2005). *House Bill 990 (2005), Benefits and Services for Individuals Who Are Incarcerated or Institutionalized*.

[20] Maryland General Assembly. (2007). *House Bill 281 (2007), Mental Health - Incarcerated Individuals with Mental Illness*.

[21] Maryland General Assembly. (2010). *Senate Bill 761/House Bill 1335 (2010), Mental Health - Local Correctional Facilities - Incarcerated Individuals with Mental Illness*.

[22] Centers for Disease Control and Prevention. (2021). *Adverse Childhood Experiences (ACEs)*. https://www.cdc.gov/violenceprevention/aces/

[23] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2020). *Adverse Childhood Experiences Prevention Strategy*. https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf

[24] Centers for Disease Control and Prevention. (2021). *Risk and Protective Factors*. https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html

In 2018, Maryland implemented the Handle with Care program to increase trauma-informed approaches and to address Adverse Childhood Experiences (ACEs) to prevent future victimization or criminality.[25] The program promotes "school-community partnerships aimed at ensuring that children who are exposed to trauma in their home, school or community receive appropriate interventions to help them achieve academically at their highest levels despite whatever traumatic circumstances they may have endured."[26] It also encourages collaboration between law enforcement and schools, and referrals to counseling, to prevent further victimization or criminality among youth. Maryland piloted the Handle with Care program in Washington County in the 2017-2018 school year and then expanded the program to 11 additional counties in February 2018.

In 2021, Chapters 722 and 723 (House Bill 548/Senate Bill 299) established the Commission on Trauma-Informed Care Commission to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults.[27] The commission works with the National Governors Association and the National Association for State Health Policy's (NASHP) State Trauma and Resilience Network to support best practices; and is currently in the process of developing metrics and an action plan. In a recent report, titled *Commission on Trauma-Informed Care: Findings and Recommendations 2022 Annual Report*, the commission included several recommendations relating to children, youth, families, and older adults in Maryland, to include supporting resources allocated for trauma-informed initiatives.

Between 2018 and 2022, and under the leadership of Maryland's Lieutenant Governor, the Commission to Study Mental and Behavioral Health made a series of recommendations, to include developing trauma-informed care and best practices training for behavioral health practitioners and standardizing mental and behavioral health programming in schools. The 2020 State Summit also highlighted the importance of trauma-informed care which sequentially influenced the passage of Senate Bill 305 (2020), Chapters 68 and 69 of 2021 (Senate Bill 857/House Bill 1280), and House Bill 1018 (2022), and the oversight boards including the Crisis Intervention Team Center of Excellence (CITCE) Collaborative Planning and Implementation Committee (CPIC) and the Maryland Behavioral Health and Public Safety Advisory Group.

The State of Maryland strives to ensure that trauma-informed care is available at various intercepts. In order to build upon current efforts, the Centers of Excellence will continue to partner with stakeholders across multiple systems to further expand trauma-informed care throughout the State.

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[25] Handle With Care Maryland. *Handle with Care*. https://handlewithcaremd.org/handle-with-care.php
[26] Ibid.
[27] Maryland General Assembly. (2021). *Chapters 722 and 723 of 2021 (House Bill 548/Senate Bill 299), Human Services - Trauma-Informed Care - Commission and Training (Healing Maryland's Trauma Act)*.

Priorities Across Intercepts

The illustration below identifies the most important priorities for each intercept. Based on a voting process, which occurred on day two of the Summit, focus groups identified topics that were most important to them. Once the voting process was finalized, the Centers of Excellence summarized the priorities into a comprehensive chart (*as illustrated below*). It is important to note that a few priorities were similar and therefore were merged into one priority category.

Intercept 0/1	**Intercept 2/3**	**Intercept 4/5**	**Total**
Crisis services (11)	Housing (11)	Transitional peers (12)	Housing (28)
Workforce development (9)	Mental Health Courts (7)	Housing (10)	Transitional peers and peer support (19)
Mobile crisis services (7)	Shared data system (5)	Peer support specialist (7)	Crisis services (18)
Housing and transportation (7)	Trauma-informed care training (5)	Mental health access (5)	Workforce development (9)
Expand officer buy-in with diversion and deflection (6)	Reentry support (5)	One Stop Shops (4)	Mental Health Courts (7)
	Cross-system coordination (4)	Telehealth (4)	Expand officer buy-in with diversion and deflection (6)
			Shared data system (5)
			Mental health access (5)
			Trauma-informed care training (5)
			Reentry support (5)
			Cross system coordination (4)
			One Stop Shops (4)

Key Priorities

The following six priorities were developed after the voting occurred in each intercept focus group on day two. Each section below includes different resources to aid in the development of accomplishing such priorities.

Increase Access to Housing

The first priority focused on housing and the lack of housing for specific populations within the behavioral health and criminal justice system. In the intercept 2/3 focus group, participants prioritized planning to increase housing opportunities for those on conditional release from correctional facilities (11 votes). In the intercept 4/5 focus group, participants highlighted the need for housing for individuals with extreme mental health issues (10 votes). The following examples are programs, resources, and research relating to the extent of the issue on lack of housing for specialized populations:

- U.S. Department of Housing and Urban Development. *Section 811 Supportive Housing for Persons with Disabilities Program*. https://www.hud.gov/program_offices/housing/mfh/grants/section811ptl
- National Alliance for Mental Illness. *Housing.* http://namimd.org/resource_center_draft/benefits_and_insurance_/housing
- Loubière, S., Lemoine, C., Boucekine, M., Boyer, L., Girard, V., Tinland, A., & Auquier, P. (2022). Housing First for homeless people with severe mental illness: Extended 4-year follow-up and analysis of recovery and housing stability from the randomized Un Chez Soi d'Abord trial. *Epidemiology and Psychiatric Sciences, 31*, E14. doi:10.1017/S2045796022000026
- Luken, S. (2021). Policy Recommendations to Address Housing Shortages for People with Severe Mental Illness. *Psychiatric Services, 73*(3), 329-334. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202100158

Increase Opportunities for Peer Support Specialists

The second priority highlighted the importance of peer support within the behavioral health and criminal justice system. In the intercept 4/5 focus group, participants discussed the need to create more transitional plans and to hire more transitional peers (12 votes). Transitional peers are individuals who have been successful in the recovery process and able to help others

experiencing similar hardships, especially during reentry. In addition to hiring more transitional peers, this intercept focus group emphasized the importance of including transitional plans for each person returning to the community post-incarceration. This would ensure individuals have workable plans to access necessary resources and services in regards to medication, treatment, housing, etc.[28] Another priority identified within the intercept 4/5 focus group was the need to increase opportunities for peer support specialists across the state (7 votes). These opportunities include peer support monthly workgroups. The focus group further advocated for a salary increase for peers. The following resources demonstrate the quantifiable evidence of peer support for individuals in recovery:

- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. (2022). *Peer Recovery Support Services in Correctional Settings.* https://bja.ojp.gov/library/publications/peer-recovery-support-services-correctional-settings
- Adams, W., & Lincoln, A. (2021). Barriers to and Facilitators of Implementing Peer Support Services for Criminal Justice - Involved Individuals. *Psychiatric Services, 72*(6), 626-632. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900627
- The Council of State Governments Justice Center. (2021). *Advancing the Work of Peer Support Specialists in Behavioral Health - Criminal Justice Programming.* csgjusticecenter.org/publications/advancing-the-work-of-peer-support-specialists-in-behavioral-health-criminal-justice-programming/
- Substance Abuse and Mental Health Services Administration's GAINS Center. (2017). *Peer Support in Criminal Justice Settings*. www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2019/06/WebinarSupportingDocument_PeerRolesinCJSettings508.pdf
- Taylor, C., & Becker, P. (2015). Are Your Friends Crucial or Trivial? Peer Support's Effect on Recidivism. *Justice Policy Journal, 12*(1). www.cjcj.org/media/import/documents/jpj_taylor_and_becker_spring_2015.pdf

Expand access for Crisis Intervention Team (CIT) Training and Crisis Response Teams

Increasing access to CIT training opportunities was a unanimous priority across intercepts. In order to expand accessibility for CIT training, it was recommended that a formalized platform of resources on best practices and implementation strategies be offered for localities. The resources for technical assistance by jurisdiction may be requested. This platform can be utilized by correctional officers, emergency medical services (EMS), police, 9-1-1 operators, and other

[28] Substance Abuse and Mental Health Services Administration. *Intercept 4: Reentry*. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview/intercept-4

first responders. The following resources are examples of best practices that Maryland State Government and its partners may consider:

- Washington State Criminal Justice Training Commission. (2019). *CIT - Crisis Intervention Team 8hr - In-Service Fire/EMS - King County.* https://www.cjtc.wa.gov/training-education/crisis-intervention-training/cit-crisis-intervention-team-8-hr-in-service-king-county-fire-ems
- WBIR-TV. (2022). *25 police officers, first responders and medical staff graduate from training for crisis intervention team*. wbir.com/article/news/local/several-police-officers-first-responders-and-medical-staff-graduate-from-crisis-intervention-training/51-98361295-a7eb-49b6-8c6c-52f23b938b5d
- National Association of EMS Educators. (2021). *Crisis Intervention Training* [Video]. YouTube. youtube.com/watch?reload=9&v=sUliGCwQCXc
- U.S. Department of Justice, National Institute of Corrections. (2010). *Crisis Intervention Teams: A Frontline Response to Mental Illness in Corrections [Lesson Plans and Participant's Manual]* (Accession No. 024797). nicic.gov/crisis-intervention-teams-frontline-response-mental-illness-corrections-lesson-plans-and
- The Pew Charitable Trusts. (2021). *New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises*. pewtrusts.org/en/research-and-analysis/issue-briefs/2021/10/new-research-suggests-911-call-centers-lack-resources-to-handle-behavioral-health-crises

Another priority related to crisis response was to expand mobile crisis teams. The following resources share best practices in implementing mobile crisis teams:

- The Council of State Governments Justice Center. (2021). *How to Successfully Implement a Mobile Crisis Team*. csgjusticecenter.org/publications/how-to-successfully-implement-a-mobile-crisis-team/
- International Association of Chiefs and Police, UC Center for Police Research and Policy. (2020). *Assessing the Impact of Mobile Crisis Teams: A Review of Research*. theiacp.org/sites/default/files/IDD/Review%20of%20Mobile%20Crisis%20Team%20Evaluations.pdf

Cultivating the Behavioral Health Workforce

The intercept 0/1 focus group expressed a need to foster and grow the behavioral health workforce. Due to the COVID-19 pandemic, there has been significant burnout within this field. Because of this, participants discussed the lack of engagement and positive attitude amongst

the behavioral health workforce; and the dramatic decrease in individuals working in the behavioral health field (i.e., peer specialists, social workers, therapists, etc.) across the country. The group also discussed the need to focus on the health of individuals working in this field. Some ways to help cultivate the workforce include gathering anecdotal and quantitative data about those working in the field as well as focusing on trends, such as the decrease in individuals working the field, to determine the cause and potential solution moving forward. Below there are some resources relating to the behavioral health workforce in Maryland and across the country.

- Maryland Hospital Association. (2022). *2022 State of Maryland's Health Care Workforce Report*. mhaonline.org/docs/default-source/default-document-library/2022-state-of-maryland-s-health-care-workforce-report.pdf
- Substance Abuse and Mental Health Services Association. (2022). *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies* (Publication No. PEP22-06-02-005). store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf
- Health Management Associates. (2021). *Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States*. healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf
- Health Resources & Services Administration. (2022). *Behavioral Health Workforce Projections*. bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

Increase Mental Health Courts

The intercept 2/3 focus group emphasized how Maryland lacks a sufficient number of mental health courts to keep up with the high demand of behavioral health concerns. Additionally, these courts are necessary to increase court diversion for those who are suffering with serious or extreme mental illnesses. The group ranked this priority as the second most important (7 votes). The following resources provide insight on the implementation of mental health courts and the progress of these efforts in Maryland:

- Maryland Courts. (2023). *Mental Health Courts: Problem Solving Courts*. https://mdcourts.gov/opsc/mhc
- Zhou, H., & Ford, E. (2021). Analyzing the Relationship between Mental Health Courts and the Prison Industrial Complex. *Journal of the American Academy of Psychiatry and the Law Online, 49*(4), 590-596. doi:10.29158/JAAPL.210012-21

- Swartz, M.S., & Robertson, A.G. (2016). Mental Health Courts: Does Treatment Make a Difference?. *Psychiatric Services, 67*(4), 363. doi: 10.1176/appi.ps.670403
- Blandford, A. M., Fader-Towe, H., Ferreira, K., & Greene, N. (2015). *Developing a Mental Health Court: An Interdisciplinary Curriculum–Handbook for Facilitators*. The Council of State Governments Justice Center. https://csgjusticecenter.org/wp-content/uploads/2019/11/HandbookForFacilitators.pdf
- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. (2012). *Mental Health Courts Program*. https://bja.ojp.gov/program/mental-health-courts-program/overview

Creating a Shared Data System

The intercept 2/3 focus group discussed the desire for a centralized place to share data across the state. The group advocated for a shared data system that is able to track racial and ethnic disparities across the criminal justice and behavioral health system. Participants noted how specific entities, such as the Opioid Operational Command Center, the Local Behavioral Health Authority, and the Governor's Office of Crime Prevention, Youth, and Victim Services, could work together to create this system. The following examples include an existing resource in Maryland as well as a best practice:

- Governor's Office of Crime Prevention, Youth, and Victim Services. *Data Dashboards*. http://goccp.maryland.gov/data-dashboards/
- Miligram, A., Brenner, J., Wiest, D., Bersch, V., & Truchil, A. (2018). Integrated Health Care and Criminal Justice Data - Viewing the Intersection of Public Safety, Public Health, and Public Policy Through a New Lens: Lessons from Camden, New Jersey Harvard University. *Executive Session on Community Corrections*. hks.harvard.edu/sites/default/files/centers/wiener/programs/pcj/files/integrated_healthcare_criminaljustice_data.pdf

Conclusion

This *State Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model (SIM) Mapping Initiative* summarizes the information gathered at Maryland's 2022 State Summit on Behavioral Health and the Justice System, to include the utilization of the SIM tool. As noted in this report, the 2022 Summit was facilitated by SAMHSA's GAINS Center and the Centers of Excellence. It also served as the first in-person summit due to the COVID-19 pandemic; the 2020 Summit was virtually hosted with assistance from SAMHSA's GAINS Center.

In comparison to the 2020 Summit, the 2022 Summit participants represented multiple stakeholder systems from various counties across the state. Because some counties were not represented, the report only provides information for represented counties. Moving forward, the Centers of Excellence will expand these annual summits to ensure all counties are represented.

Through its mission, the Centers of Excellence strive to assist, support, facilitate conversation and program development related to behavioral health and criminal justice efforts across the state of Maryland. In this role, the Centers of Excellence will continue to work with local, state, and federal partners to organize and implement SIM Mappings, at the request of local jurisdictions, and conduct an annual report using this model. The Centers of Excellence are currently working with the University of Maryland to develop a multi-year strategic plan for the Maryland Behavioral Health and Public Safety Center of Excellence. This multi-year strategic plan is available on the Governor's Office of Crime Prevention, Youth, and Victim Services' website, at: http://goccp.maryland.gov/reports-and-publications/. The Centers of Excellence, in partnership with SAMHSA's GAINS Center, also co-hosted a second train-the-trainer facilitator workshop in March 2023, to certify stakeholders that are interested in learning how to facilitate local jurisdictional SIM Mappings. The Centers of Excellence are currently in the process of finalizing their first SIM re-mapping with Cecil County. Because the Centers of Excellence received additional requests for county mapping across the state, an official request will be made available on the Governor's Office of Crime Prevention, Youth, and Victim Services' website.

RESOURCES

Brain Injury

- Edmonston, A. (2021). *The Intersection of Brain Injury and Substance Use Disorders* [PowerPoint slides]. Maryland Department of Health. https://health.maryland.gov/bha/Documents/Brain%20Injury%20and%20Substance%20Use%20for%20Public%20Health%20Administrators.pdf
- Maryland Traumatic Brain Injury Advisory Board. (2022). *Health-General § 13-2105–State Traumatic Brain Injury Advisory Board Annual Report - 2021*. https://health.maryland.gov/bha/Documents/HG%2013-2105%20State%20Traumatic%20Brain%20Injury%20Advisory%20Board%202021%20Annual%20Report.pdf
- National Association of State Head Injury Administrators. (2020). *Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs*. https://static1.squarespace.com/static/5eb2bae2bb8af12ca7ab9f12/t/5f66af29885b214e6f2b34ef/1600565034533/Criminal+and+Juvenile+Justice+Best+Practice+Guide_Final+edits+9-9-20.pdf
- Seale, G. (2022). Substance Misuse and Acquired Brain Injury. *Psychiatric Times.* https://www.psychiatrictimes.com/view/substance-misuse-and-acquired-brain-injury

Collaboration Across Silos

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PARTICIPANT LIST

Name (First, Last)	Title	Organization
Akima Copper	Forensic Case Specialist	Mid Shore Behavioral Health
Alex Paucar	Law Enforcement Assisted Diversion Program Coordinator	Governor's Office of Crime Prevention, Youth, and Victim Services
Alexis Capestany	Former Policy and Advocacy Coordinator, Centers of Excellence	Governor's Office of Crime Prevention, Youth, and Victim Services
Alisha Saulsbury	Forensic Mental Health Program Manager	Mid Shore Behavioral Health
Amanda Cram	Director of Social Work	Department of Public Safety and Correctional Services
Amber Gundlach	Senior Policy Analyst	Department of Legislative Services
Anastasia Edmonston	Traumatic Brain Injury Project Coordinator	Behavioral Health Administration
Andrea McDonald-Fingland	Director for Local Behavioral Health Authority	Calvert County Health Department
Angel Simms	Social Work Supervisor	Department of Public Safety and Correctional Services
Bianca Bersani	Director, Maryland Crime Research and Innovation Center	University of Maryland, College Park
Candace Johnson	Therapist II	Baltimore County Department of Corrections
Chauna Brocht	Director of Greater Baltimore Regional Integrated Crisis System Implementation	Behavioral Health System Baltimore
Cheryl Rowe	Case Manager	Humanism
Christopher Shea	Health Hub Supervisor	St Mary's County Health Department

Cindy Johnson	Senior Assistant State's Attorney	Howard County State's Attorney's Office
Dan Abreu, MS CRC LMHC	Senior Project Associate, Criminal Justice Division	Policy Research Associates
Dan Martin	Senior Director of Public Policy	Mental Health Association of Maryland
Dan Rabbit	Policy Director of Greater Baltimore Regional Integrated Crisis Systems (GBRICS)	Behavioral Health System Baltimore
Danielle Johnson	Diversion Project Manager	Behavioral Health System Baltimore
Darren McGregor	Director, Crisis and Criminal Justice Services	Behavioral Health Associates
Ed Soffe	Clinical Social Worker	Maryland Department of Health
Eleanor (Erin) Artigiani	Senior Faculty Specialist BSOS-Ctr for Substance Use, Addiction & Health Research	University of Maryland, College Park
Erin Moyer	Clinical Director	Catholic Charities
Erin Shaffer, Psy.D	Director for Patuxent Institution	Department of Public Safety and Correctional Services
Francine Reap	Social Worker	Office of the Public Defender
Genevieve LaPorte	Crisis Intervention Team (CIT) Coordinator	Howard County Police Department
Gray Barton	Executive Director	Problem Solving Courts at State of Maryland
Henrietta Yekah Bazzie	Reentry Specialist	Maryland Correctional Enterprises
James Harrison	Problem Solving Court Case Manager	District Court of Maryland for Baltimore City: Mental Health Court
Jen Corbin	Director, Crisis Response System	Anne Arundel County Mental Health Agency

Jessica Ellis	Harm Reduction & Diversion Programs Manager	Frederick County Health Department
Jessica Marvel	Forensic Social Worker	Office of the Public Defender
Jessika Hall	Opioid Response Supervisor	St. Mary's County Health Department
Jim Rhoden	Assistant Director, Center of Excellence	Governor's Office of Crime Prevention, Youth, and Victim Services
Jocelyn Tillman	Child and Adolescent Services Coordinator	Howard County Health Department/Department of Mental Health
Joshua McCauley	Patrol Lieutenant	Washington County Sheriff's Office
Joy Dodge	Assistant State's Attorney	Office of the State's Attorney for Howard County
Judith Brown	Regional Social Work Supervisor	Department of Public Safety and Correctional Services
Justine Muyu	Law Enforcement Assisted Diversion Program Manager	Howard County Health Department
Katherine Parron	Manager of Domestic/Intimate Partner Violence, Division of Parole and Probation	Department of Public Safety and Correctional Services
Kathryn Dilley	Executive Director	Mid Shore Behavioral Health
Katie Hester	Maryland State Senator	9th District
Kevin Nock	Administrative Peer Professional	Maryland Office of the Public Defender
Kim Tan	Assistant State's Attorney	Office of the State's Attorney for Howard County
Kristy Blalock	Executive Director	Gaudenzia Inc.
Kunle Adeyemo	Former Executive Director	Governor's Office of Crime Prevention, Youth, and Victim Services
Lacie Melville	Director of Residential Services	Lower Shore Clinic

Lauren Porter	Associate Professor, Criminology & Criminal Justice	University of Maryland, College Park
Lisa Hovermale	Psychiatrist	Maryland Department of Health: Developmental Disabilities Administration
Lucy Bill	Program Director, Mobile Crisis and Law Enforcement Assisted Diversion	Sheppard Pratt
Lynda Bonieskie	Director of Mental Health	Department of Public Safety and Correctional Services
Maria Daniels	Programs Director	Mid Shore Behavioral Health
Marie Liddick, LCSW-C	Deputy Director, Local Behavioral Health Authority	Carroll County Health Department
Mark Slater	Director of Rehabilitation & Treatment	Behavioral Health System Baltimore
Martha Danner	Director of Division of Parole and Probation	Department of Public Safety and Correctional Services
Mary Ann Thompson	Deputy Warden	St. Mary's County
Mary Becraft	Intern for Alisha Saulsbury	Mid Shore Behavioral Health
Meghan Kozzera	Research Analyst	Baltimore Police Department
Melissa Greenwell	Clinical Supervisor	Frederick County Health Department
Michael Guilbault	Director of Juvenile Forensics	Maryland Department of Health
Michael Richards	Director of Substance Use Treatment Services	Department of Public Safety and Correctional Services
Michael Williams	Director	Prince George's County Returning Citizens Affairs Division
Morgan Mills	Director of Government Relations	National Alliance on Mental Illness

Reese Murphy	Assistant Public Defender	Maryland Office of the Public Defender
Richard Chambers	Division Director	Department of Public Safety and Correctional Services
Robert Weisengoff	Director, Pretrial Services	Department of Public Safety and Correctional Services
Sally Reed	Truancy Court Coordinator	Prince George's County Circuit Court
Scott Sheldon	Peer Recovery Specialist Supervisor	Howard County Health Department
Shannice Anderson	Community Engagement Coordinator	Office of the Public Defender
Shannon McDade	Assistant State's Attorney	Howard County State's Attorney's Office
Shylia Tingle	Case Management Supervisor	Maryland Department of Health
Tasha Byrd	Re-Entry Case Manager	Carroll County Health Department
Tatiana Reyes	Policy and Advocacy Coordinator, Centers of Excellence	Governor’s Office of Crime Prevention, Youth, and Victim Services
Terri Collins-Green	Peer Recovery Specialist Supervisor	Howard County Health Department
Tiffany Vaira	Attorney	Howard County State's Attorney's Office
Tija Jackson	Drug Court Case Manager	Baltimore City District Court
Timothy Vail, Psy. D	Deputy Director of Mental Health	Department of Public Safety and Correctional Services
Tonyah Johnson	Clinical/Forensic Social Worker	Maryland Office of the Public Defender