Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION AND POLICY

STATE SUMMIT ON BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM

Utilizing the Sequential Intercept Model (SIM) Mapping Initiative

September 2025

Prepared by:
Centers of Excellence

Governor's Office of Crime Prevention and Policy

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This report has been prepared by Rachel Ames and Tatiana Reyes on behalf of the Centers of Excellence.

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EXECUTIVE SUMMARY

Local and statewide sequential intercept model (SIM) workshops offer an opportunity to develop strategic plans, provide technical support, advance crisis intervention programming, and coordinate data and evaluation efforts. In September 2025, the Centers hosted the fourth annual State SIM Summit. Based on a voting process, focus groups identified priorities within and across intercepts; the top four priorities for each group and across groups are listed below.

Intercepts 0-1	**Intercepts 2-3**	**Intercepts 4-5**	**Across Intercepts**
Establish a statewide standard for basic crisis services and prioritize sustainable funding. (28)	Expand housing options to better serve both general and specialized populations. (26)	Enhance communication and collaboration with key stakeholders. (24)	Strengthen communication, coordination, and collaboration across sectors. (64)
Enhance care coordination between and among law enforcement and providers. (27)	Develop strategies to address lapses in insurance coverage during incarceration. (24)	Secure guidance from the Office of the Attorney General on information sharing. (24)	Secure sustainable funding for essential programming. (29)
Support the integration of 988 and 911 services. (24)	Explore and develop community-based outpatient competency restoration options. (20)	Improve accessibility and support for special populations in reentry. (18)	Develop processes to ensure timely access to benefits in spite of coverage lapses. (27)
Evaluate and improve the emergency petition process. (20)	Strengthen cross-sector collaboration by promoting the sharing of information and resources. (13)	Develop a statewide community of practice for reentry. (7)	Promote community-wide education to reduce stigma and enhance understanding of behavioral health and justice-related issues. (8)

The Centers of Excellence recommend advancing statewide systems change focused on collaboration, service standardization, and sustainability. Efforts should expand equitable access to crisis response, diversion, housing, and reentry supports across all jurisdictions, while prioritizing continuity of care across the SIM, reducing unnecessary justice system involvement, and improving outcomes for individuals with behavioral health needs. Emphasis should be placed on strengthening community-based, trauma-informed approaches that reflect local capacity, address rural access challenges, and support individuals with complex needs at every point of contact.

BACKGROUND

Section 13-4202 of the Health General Article established the Maryland Behavioral Health and Public Safety Center of Excellence in the Office to increase treatment, prevent harm, and reduce detention of people with behavioral health disorders; and to serve as a statewide repository for behavioral health treatment and diversion resources. Section 3-522 of the Public Safety Article established the Crisis Intervention Team Center of Excellence in the Office to provide technical assistance related to behavioral health crisis intervention to local agencies and to develop and implement a crisis intervention model program. Collectively known as the Centers of Excellence (Centers), they advise the Office on efforts that help Maryland communities improve the criminal legal system's response to adults with behavioral health needs, intellectual and developmental disabilities, and neurocognitive conditions. Their work focuses on appropriately redirecting these individuals to the health care system, thereby reducing unnecessary incarceration and enhancing public health and safety. In its role as the statewide clearinghouse for behavioral health-related treatment and diversion programs, the Centers develop strategic plans to increase treatment and reduce detention for those with behavioral health disorders in the judicial system, provide technical support for localities, advance crisis intervention programming, and coordinate with State agencies to measure program effectiveness.

To fulfill its charge, the Centers:

- Update the 2023 multi-year strategic plan, originally developed in partnership with the University of Maryland and informed by recommendations from the 2020 and 2022 *State Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model Mapping Initiative*, using ongoing guidance from future annual State Sequential Intercept Model Summits.
- Provide technical assistance to local governments for developing effective behavioral health systems of care that prevent and minimize involvement with the criminal legal system for individuals with behavioral health disorders.
- Facilitate local or regional planning workshops using the Sequential Intercept Model.
- Coordinate with the Maryland Department of Health and the Behavioral Health Administration to implement and track the progress of creating an effective behavioral health system of care in the State relating to individuals involved in the criminal legal system.
- Identify and inform any relevant stakeholders of any federal funding available to carry out the mission of the Centers.
- Develop and expand cross-agency partnerships.

- Seek to establish and strengthen partnerships to identify and obtain diversion-related outcome data to support better deployment of behavioral health care resources and advance public safety.
- Guide the development of a statewide model for community crisis intervention services.
- Provide best practices, including logic models, strategic plans, data statistics, crisis intervention team models, toolkits, training/conferences, and relevant academic entities.

INTRODUCTION

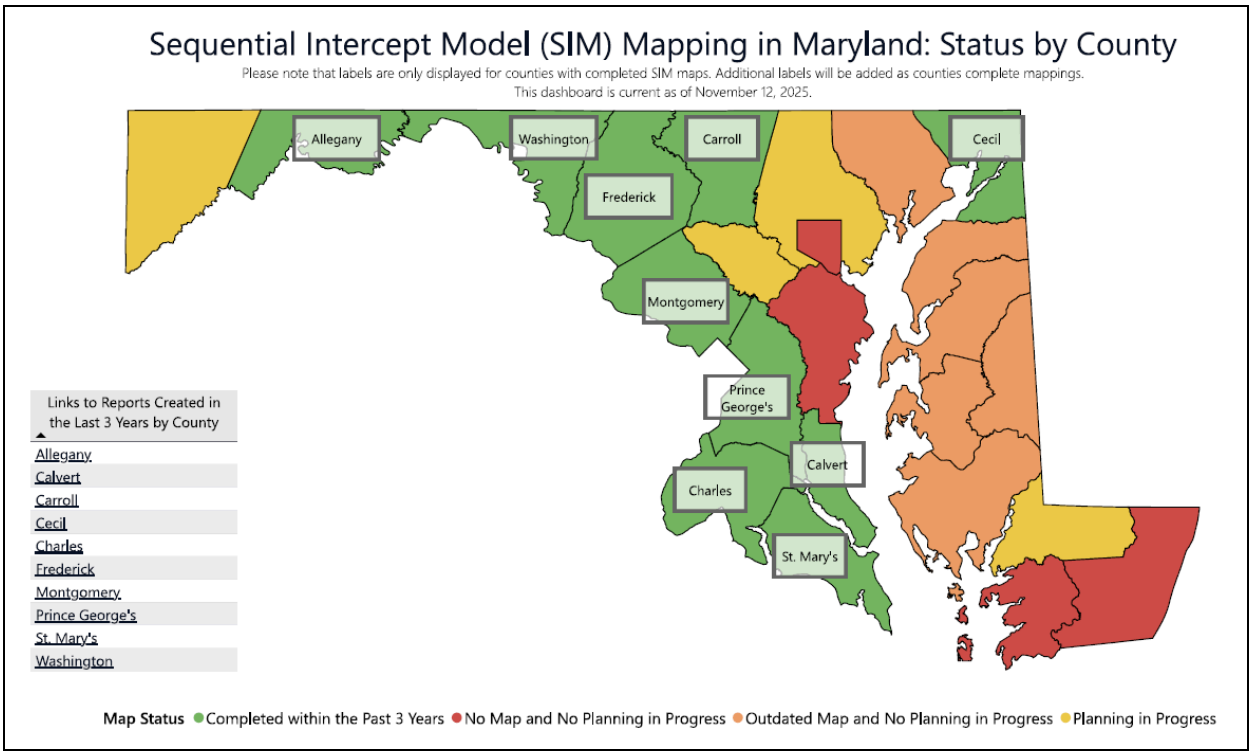
The Centers use SIM as a framework for organizing and achieving objectives, strategies, and tactics. The SIM helps communities understand how adults with behavioral health needs come in contact with and flow through the criminal legal system. Through SIM mapping workshops, facilitators and participants identify opportunities to connect individuals with behavioral health services and prevent further system involvement. Workshops also help individuals link to appropriate services as they transition out of the criminal legal system.

At SIM workshops, communities identify resources (e.g., substance use disorder treatment or transportation) accessible to adults with behavioral health needs at different points on their path through–or away from, in the best-case scenario–the criminal legal system. Participants discuss and catalog programs and services available at several intercepts: in the community, after an arrest, in jail, and as they prepare to return from periods of incarceration.

Conducted at both the State and local levels, SIM workshops serve as a foundation for developing strategic plans, advancing crisis response efforts, providing technical support, and coordinating data and evaluation systems.

In 2025, the Centers conducted four jurisdiction-specific SIM mapping workshops and scheduled four additional workshops to occur in 2026, along with one more planned for 2027.[1] To illustrate these efforts and support transparency, the Office maintains and regularly updates a data dashboard that highlights the completion and implementation of SIM mapping workshops and related reports (*as illustrated below*). To view the dashboard, please visit https://gocpp.maryland.gov/data-dashboards/centers-of-excellence.

[1] It is important to note that the Substance Abuse and Mental Health Services Administration (SAMHSA) completed additional SIM mapping workshops throughout the State.



Since November 2022, the Centers have hosted an annual *State Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model Initiative* (State SIM Summit) to advance strategic priorities. Each State SIM Summit has built upon the previous year's efforts, identifying key recommendations such as expanding access to housing, cultivating the behavioral health workforce, enhancing crisis intervention training, and developing shared data systems. These gatherings have also emphasized the need to expand interagency collaboration, increase peer involvement, and reduce siloed efforts.

In September 2025, the Centers hosted the fourth annual State SIM Summit, convening stakeholders from across Maryland to assess progress, share practices, and identify persistent service gaps across the SIM. This year's two-day, in-person event focused on the themes of cross-sector and regional collaboration, as well as the meaningful involvement of peers in program implementation and system reform.

Each presentation showcased an innovative program or initiative that involved partnerships either among multiple agencies within a jurisdiction or across county lines, with all programs integrating peer support as a core component. Day one began with a presentation on stigma to set the tone for open, respectful dialogue and concluded with updates on statewide initiatives to inform participants of current efforts led by statewide leaders working to strengthen behavioral health and public safety outcomes.

Day two facilitated guided, intercept-focused discussions to identify opportunities for improved linkage to services. These conversations help assess the current landscapes of Maryland's behavioral health and criminal legal systems to highlight policy, implementation, and funding needs. Both days offered valuable networking opportunities for stakeholders to forge new connections and explore ideas for future collaboration.

The discussions and outcomes from the 2025 State SIM Summit are documented in this *State Summit on Behavioral Health and the Justice System* report, which serves as a strategic reference for ongoing efforts throughout Maryland.

SUMMIT DAY ONE

Welcoming and Opening Remarks

Mr. James Rhoden, Director of the Centers of Excellence within the Governor's Office of Crime Prevention and Policy (Office), opened the State SIM Summit by welcoming attendees and setting the tone for a day focused on collaboration and progress. He then introduced Maryland Lieutenant Governor Aruna Miller.

Lieutenant Governor Miller delivered inspiring opening remarks, emphasizing the importance of the work being done across sectors to improve outcomes for individuals involved in the behavioral health and justice systems. She acknowledged the passion and dedication of those in attendance and celebrated the strides Maryland has made in advancing meaningful reform.

She was followed by Ms. June Chung, Director of Policy and Legislation at the GOCPP, who echoed this commitment, highlighting the importance of continued legislative and policy innovation to sustain momentum and drive change forward.

Chief Judge John Morrissey of the District Court of Maryland spoke next, reflecting on the collaborative efforts between the judiciary and community-based programs, underscoring the value of cross-sector partnerships in achieving lasting impact.

Closing the opening remarks, Sonia Chessen, Senior Advisor to the Secretary of Health, emphasized the role of public health in supporting justice-involved individuals and shared key program milestones. Among the highlights was the increasing coordination between the 988 crisis line and 911, with over 84,000 contacts to 988 recorded between January and July 2025. She also spotlighted the Community Forensic Aftercare Program, which currently monitors approximately 600 individuals found not criminally responsible (NCR), ensuring they receive appropriate support and resources to maintain stability in the community.

Collectively, the opening speakers underscored a shared message: hope, progress, and a call to continued action. They invited attendees to take pride in their contributions to this transformative work and encouraged the continued strengthening of the partnerships that make such progress possible.

Centers of Excellence Overview

Following the opening remarks, Ms. Rachel Ames and Ms. Tatiana Reyes outlined the purpose of the Summit and provided an overview of expectations for both days. They emphasized the goal of creating a space for collaboration across sectors to reduce siloed efforts, noting that fragmented approaches can leave individuals without critical support.

They highlighted several recent accomplishments of the Centers of Excellence, including the development and standardization of Crisis Intervention Team (CIT) training in partnership with the Maryland Police and Correctional Training Commissions, completion of a statewide CIT impact analysis, and collaboration with the University of Maryland School of Social Work on a CIT Landscape Analysis. In addition, the Centers are partnering with the Maryland Crime Research and Innovation Center to develop a measurable scorecard that tracks and visualizes statewide progress toward shared goals, all supporting the broader mission of improving criminal legal responses for adults with behavioral health needs.

Providing context for the Centers' establishment, Ms. Ames and Ms. Reyes explained their role in coordinating Maryland's systemwide response to behavioral health needs at the intersection of public safety. They described how the Sequential Intercept Model (SIM) tool guides this work through SIM mapping workshops by helping jurisdictions identify resources, pinpoint gaps, and develop targeted action plans that strengthen diversion and care pathways. Noting the number of workshops completed to date, they encouraged jurisdictions to request a local SIM mapping to enhance coordination and improve their community systems. They also introduced the SIM tool as a guiding framework for the Summit.

To conclude, Ms. Ames and Ms. Reyes previewed the day's agenda, which featured presentations aligned with all six SIM intercepts, demonstrating how collaboration, peer engagement, and innovation can drive systemic change. Before transitioning to the first session, they reminded participants that the programs highlighted were not endorsements but examples meant to inspire new ideas and strengthen Maryland's collective efforts to ensure individuals in crisis receive care, not confinement.

Morning Presentations

On Our Own of Maryland, Inc.

Ms. Jennifer Brown presented *Stigma: In Our Work, In Our Lives*, a flagship workshop developed from the Anti-Stigma Project. This session was designed to reduce stigmatizing behaviors, attitudes, and practices in mental health and addiction recovery settings. Attendees engaged in identifying stigma, understanding its personal and systemic impacts, and exploring actionable solutions to create more equitable and supportive environments.

The workshop emphasized how stigma affects credibility, relationships, opportunities, and overall recovery, and highlighted the importance of awareness, education, and meaningful contact with individuals with lived experience. Through discussion and reflective exercises, attendees were encouraged to reconsider preconceived notions, examine intersecting stigmas, and develop strategies to foster inclusivity within organizations and communities.

Carroll County

Ms. Veronica Dietz and Lt. Timothy Rife presented on Carroll County's pre-arrest diversion initiative, which leverages interdisciplinary Quick Response Teams (QRT) to engage overdose survivors, particularly those who decline hospital transport, and connect them to treatment during the critical post-overdose period.

The QRT initiative reflects a collaborative, data-driven response to the opioid crisis in a rural-suburban setting facing complex challenges, including a rising unhoused population and limited public transportation. Launched in 2022 through a partnership between the Carroll County Health Department and Westminster Police Department, the QRT is a co-responder model consisting of a case manager and peer recovery specialist. The team provides non-judgmental, community-based follow-up care, connecting individuals to treatment, harm reduction tools, and social services.

Built on strong cross-sector collaboration and community engagement, the program evolved from an idea sparked at last year's State SIM Summit. It is now embedded within law enforcement operations and supported through the Comprehensive Opioid, Stimulant, and Substance Use Site-Based Program (COSSUP), administered by the Office. The program's success is largely attributed to efforts that address stigma, strengthen collaboration and trust between law enforcement and behavioral health providers, and integrate case managers and peers into roll call briefings and ride-alongs.

Since its launch, the QRT has made measurable progress. When combining data from fiscal years 2023 and 2024, the team's efforts included responding to over 50 overdose cases, connecting 31 individuals to treatment services, and distributing 23 naloxone kits along with 27 community training sessions. To further expand access to harm reduction supplies, NaloxBoxes were installed in 20 public locations across the community.

Looking ahead, Carroll County aims to strengthen outreach efforts, refine best practices, and continue bridging gaps between behavioral health and law enforcement to reduce overdose deaths and improve community wellness.

Allegany County

Lt. Alexander Menges of the Cumberland Police Department presented *Project Connect*, Allegany County's expanded reentry and community support initiative. Originally launched in 2023 as a reentry-focused program to reduce recidivism among justice-involved individuals, the initiative quickly evolved into a broader community engagement and resource navigation effort.

In collaboration with a wide network of partners, including the Maryland Department of Labor, the Department of Transportation, the Division of Parole and Probation, and local service providers, Project Connect offers a welcoming, low-barrier entry point to vital services such as healthcare, housing, employment, legal aid, and specialized support. While still serving individuals involved in the justice system, the program now also supports any resident in need, helping to break down stigma and build trust between law enforcement and the community.

Project Connect hosts regular community engagement events, including the well-attended annual Summer Carnival at the Canal Place Festival Grounds, which brings together service providers, families, and law enforcement for an afternoon of activities, free meals, and resource access. Law enforcement plays a central role in organizing these events and inviting community providers to participate. The carnival features service provider booths, children's activities, raffles with bicycles and other giveaways, and a youth bike ride in partnership with the Department of Juvenile Services and the Bike Patrol.

In addition to the annual event, Project Connect helps coordinate partner events throughout the year, further strengthening community relationships and increasing awareness of available services. Early in the program, transportation was identified as a major barrier to treatment and resource access. To address this, the team secured funding for transportation vouchers, distributing approximately 100 to date. The program has also strengthened officers' understanding of local resources, allowing them to more effectively connect individuals to appropriate services and collaborate effectively with specialty courts and behavioral health partners.

The initiative has strengthened collaboration across sectors, improved law enforcement's familiarity with available resources, and helped increase participation in programs like specialty courts. Through efforts such as the PLAY Program, engaging officers and youth biweekly during the school year through recreational outings and educational sessions on topics such as vaping, bullying, and personal safety, Project Connect continues to foster stronger relationships and community resilience. Guided by a philosophy of meeting people where they are and moving forward together, Project Connect has become a model for community-centered, cross-sector collaboration in a rural setting.

Afternoon Presentations

St. Mary's County

Ms. Tammy Loewe, Mr. Christopher Shea, and Mr. Karl Webner presented the St. Mary's County Health Hub, a centralized access point for health and social services in Lexington Park. The initiative targets high-need areas in Lexington Park, Great Mills, and Park Hall, where residents face disproportionately high rates of poverty, unemployment, and health disparities.

Launched in late 2022, the Health Hub provides no-cost services to support residents' well-being, including behavioral health crisis walk-in, care coordination, harm reduction, wound care, rapid testing, primary care, jail diversion, youth mentoring, legal services, conflict resolution, housing support, education, literacy tutoring, financial coaching, job support, and a free library. Peer Recovery Specialists offer emotional and instrumental support. By co-locating critical services such as day reporting, expungement clinics, and crisis intervention, the Hub reduces transportation barriers and offers an accessible alternative to siloed systems.

Through a partnership with WellCheck, the Health Hub utilizes a digital referral platform and registration suite that works across devices with no downloads required. The platform features a directory of community services, supports prescribed or self-referrals, allows prescribers to note special needs, and sends automated reminders. WellCheck's "Social Wellness Assessment" identifies individual needs across key social determinants of health, including transportation, housing, food access, employment, education, violence, behavioral health, and financial security. Assessment responses generate referrals that care coordinators monitor and assist with, strengthening care coordination and outcomes.

In fiscal year 2025, the Health Hub has served over 560 unduplicated individuals through more than 1,450 clinical encounters. Despite rural health challenges such as provider shortages and limited resources, the Hub has become a model for integrated, low-barrier care that advances health equity and strengthens community well-being through cross-sector coordination and by meeting residents where they are.

Central Maryland

Ms. Valeree Tolios and Ms. Jamie Meyers of the United Way of Central Maryland presented on the Central Maryland Regional Veterans Treatment Court, a collaborative, multi-jurisdictional initiative serving Baltimore City and Baltimore, Carroll, Harford, and Howard counties. The program ensures consistent access to treatment, supervision, and recovery support for justice-involved veterans across the region, addressing a critical gap in coordinated services. Veterans treatment courts (VTC) are court-supervised, voluntary programs that connect participants to evidence-based treatment, peer mentorship, and community resources aimed at reducing recidivism and promoting successful reintegration.

First launched in Baltimore City in 2015 following a year of cross-sector planning, the VTC model has since expanded statewide, with the Central Maryland Regional Court established in November 2024 to coordinate operations across five jurisdictions. The regional model maximizes staffing and resources while maintaining local access to specialized care and legal oversight. United Way of Central Maryland serves as the program's fiscal agent and coordination hub, facilitating communication among judges, attorneys, probation officers, and a robust

network of service providers. United Way also employs case managers who maintain a 20:1 caseload and provide wraparound support through individualized goal plans, connecting participants to healthcare, education, employment, and housing. Each veteran is also matched with a veteran mentor, ensuring peer-based accountability and encouragement throughout the program.

Through partnerships with the U.S. Department of Veterans Affairs, the Maryland District Court, the Administrative Office of the Courts' Office of Problem-Solving Courts, the Maryland Department of Public Safety and Correctional Services, Parole and Probation, and numerous community organizations, the program delivers comprehensive, trauma-informed care that integrates legal, clinical, and peer-based supports. A hallmark of the program is its "Warrior Canine Connection," in which veterans train service dogs for fellow veterans participating in the program. VTC participants also have the opportunity to earn community service hours through their work with the service dogs. Since 2015, the program has engaged 212 participants, with 128 successful graduates and 43 active participants as of late 2024.[2] Following its regional expansion, caseloads have doubled, underscoring the demand for coordinated veteran-specific services.

By bridging the gap between justice, behavioral health, and veteran services and sustaining an active alumni network to support ongoing recovery and reintegration, the Central Maryland Regional Veterans Treatment Court stands as a model of cross-sector collaboration and lasting community impact.

Maryland Judiciary and The Leifman Group

Judge Marina Sabett, Ms. Maxine Curtis, and Ms. Patricia Tobias provided an update on statewide efforts to strengthen behavioral health and justice system integration in Maryland. As of January 2025, The Leifman Group, a consultancy dedicated to assisting jurisdictions in navigating behavioral health and justice solutions, began work under a multi-year State Justice Institute grant. At the core of these efforts is the recognition that effective diversion and treatment require coordination across all intercepts (0–5), with courts, law enforcement, and service providers functioning as an interconnected ecosystem. The Leifman Group helped inform the *Summit on Behavioral Health: An Opportunity for Collaborative Change*, held in May 2025.

The event brought together over 375 attendees representing all branches of the justice system, committing to reducing the overcriminalization of mental illness. Out of this event, the *Statewide Steering Committee on Behavioral Health and the Justice System* was established,

[2] Of the remaining participants, 17 had their cases dismissed, transferred to other courts, or administratively closed, and 24 were classified as unsuccessful graduates.

incorporating broad stakeholder representation and supported by the Governor's Office of Crime Prevention and Policy and the Maryland Department of Health. The Committee aims to foster cross-branch coordination, eliminate silos, align investments, promote transparency and accountability, and ensure inclusive stakeholder input.

To advance these goals, focused workgroups are being established to address key topics, including:

- Screening and assessment processes, case management, crisis stabilization, community provider engagement, and competency considerations;
- Data integration and coordination, including data sharing across systems, identifying existing data platforms, and determining what data is needed to measure program effectiveness and establish baselines;
- Interdisciplinary education and training to build consistency in terminology and understanding among judges, probation agents, law enforcement, and other stakeholders regarding their respective roles; and
- Local jurisdictional priorities, identifying common needs and strategies across individual jurisdictions and regions.

These workgroups will provide collaborative forums to translate the Committee's vision into actionable strategies and measurable outcomes across Maryland's behavioral health and justice systems.

These judiciary-led initiatives and The Leifman Group's efforts complement the ongoing work of the Centers of Excellence, which continue to advance statewide and local SIM mappings and related strategic initiatives. Together, these coordinated efforts strengthen Maryland's integration of behavioral health and justice systems.

Closing Remarks

Maryland Supreme Court Chief Justice Matthew Fader provided the closing remarks for Day One of the Summit, offering a thoughtful reflection on the progress made and the work still ahead. He emphasized the importance of sustained and deep collaboration in addressing the complex intersection of behavioral health and the justice system. Chief Justice Fader acknowledged the staggering prevalence of mental illness across the population, and especially within the detained population, underscoring the urgency of continued reform.

He noted that while the challenges are significant, meaningful progress is achievable through deliberate, cross-sector collaboration. He underscored that improving outcomes for individuals with behavioral health needs depends on shared responsibility rather than isolated efforts.

Collaborative partnerships drive the development of best practices, strengthen advocacy for resources, and inspire innovation even amid limited capacity. By working together, systems can deliver more coordinated, compassionate, and effective responses.

Chief Justice Fader closed by commending attendees for their dedication and partnership, encouraging them to carry the day's insights and energy into future efforts. The following section provides a brief overview of the layout of day two, outlining key sessions and topics covered.

SUMMIT DAY TWO

Welcoming Remarks and Workshop Overview

Building on the foundation set during Day One, Ms. Rachel Ames and Ms. Tatiana Reyes welcomed attendees and outlined the day's agenda, explaining that the purpose of Day Two was to move from information-sharing to collaborative problem-solving, creating space for cross-sector dialogue, identifying statewide patterns, and developing strategies to strengthen connections between systems.

The morning began with a review of recurring themes identified through local SIM mappings conducted over the past three years. Ms. Ames and Ms. Reyes highlighted that seven out of ten jurisdictions cited inpatient bed capacity and transportation as major barriers to treatment and service engagement, while nine out of ten identified housing shortages as a critical challenge. Acknowledging these persistent obstacles, they encouraged participants to think beyond the surface, to consider what underlying factors perpetuate these barriers and what steps might help dismantle them to create more equitable, coordinated systems of care.

Attendees were then introduced to the structure of the day's concurrent focus group sessions, organized by SIM intercepts. Each group was tasked with discussing statewide trends, pinpointing gaps in resources, and identifying innovative practices that could be scaled or replicated. While local examples were welcomed to illustrate key issues, Ms. Ames and Ms. Reyes emphasized that the ultimate goal was to identify statewide patterns that could inform Maryland's broader behavioral health and justice strategy.

Before transitioning to their assigned rooms, attendees were reminded of the shared values guiding values of person-first language, respect, hope, and inclusion, and encouraged to approach the day's conversations with the understanding that recovery is not just possible, it is achievable through compassion, understanding, and systemwide commitment.

Concurrent Focus Groups

Attendees were divided into one of three focus groups: intercepts 0-1, community services and first responders; intercepts 2-3, initial detention, initial court hearings, jails, and courts; and intercepts 4-5: reentry and community integration.

Each focus group was co-facilitated by two trained SIM facilitators, with a staff member from the Centers serving as both notetaker and moderator. Facilitators led discussions to identify statewide resources, gaps in planning or programs, and action items to address identified gaps.

To conclude the focus groups, attendees voted to establish a list of priorities for change. Following the voting process, summit participants were provided dedicated time to discuss strategies for addressing any priority of their choosing. In the intercepts 0-1 and 2-3 focus groups, participants initiated the discussion together but then divided into small, regionally-based groups to highlight local gaps and collaboratively develop strategies to address priorities. Participants in the intercepts 4-5 focus group remained together to discuss statewide approaches for addressing priorities. The strategies developed during these discussions are reflected within the corresponding opportunities outlined in this report.

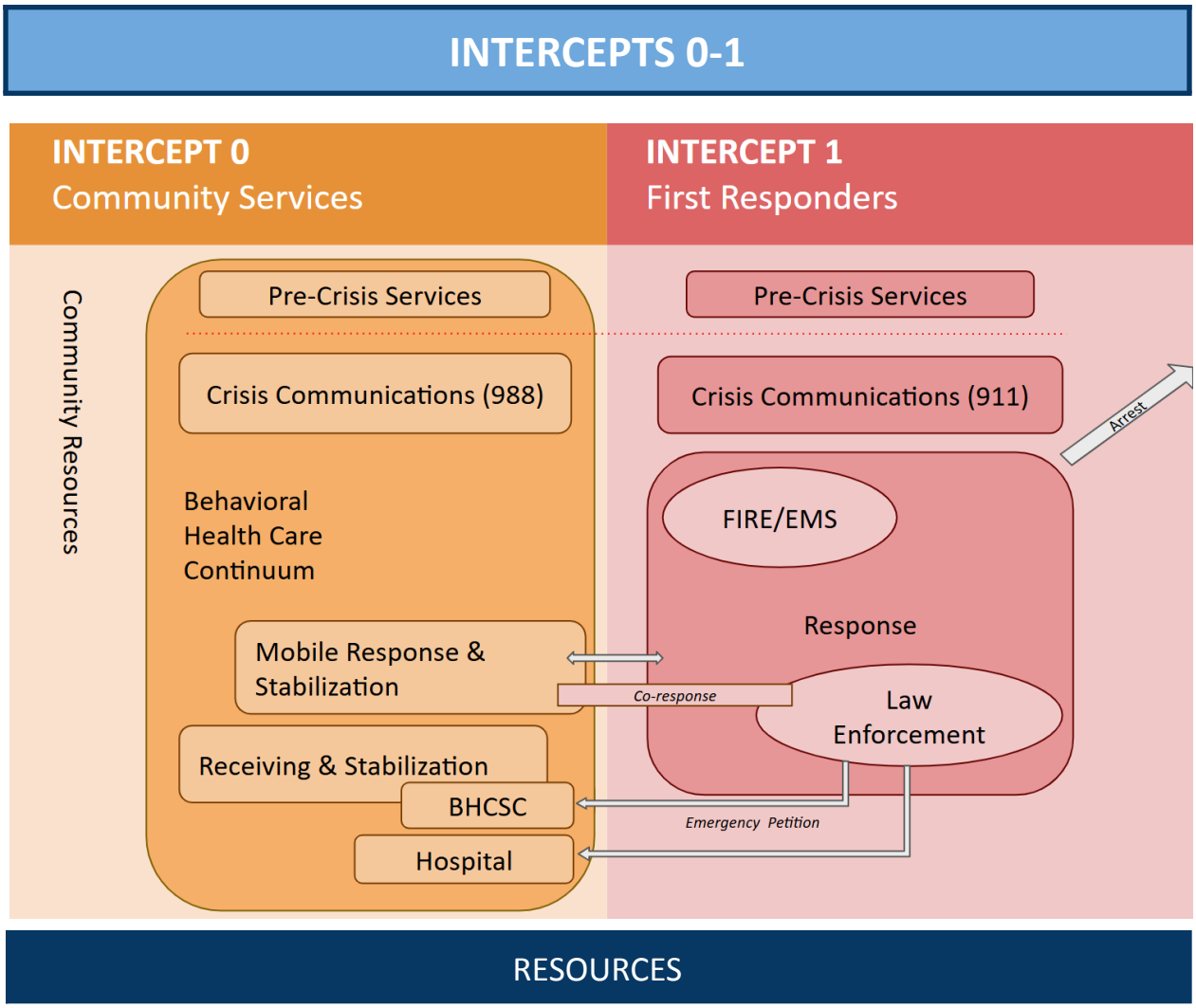
After these discussions, facilitators presented each list of priorities for change to all attendees. Detailed summaries of the focus group discussions and priorities begin on the following page. For a condensed overview of the priorities, please refer to Priorities Across Intercepts.

Next Steps

Ms. Rachel Ames presented the next steps following the concurrent focus group discussions, outlining how insights from the day will inform ongoing strategic planning. She explained that, in partnership with the University of Maryland's Maryland Crime Research Innovation Center, the Centers of Excellence developed a multi-year strategic plan in 2023, which includes seven priorities aligned with the 2020 and 2022 Summit topics. Over the past two years, this plan has served as a roadmap guiding the Centers' efforts, and it is updated annually with a report submitted to the General Assembly. Ms. Ames noted that Summit's discussions will drive updates to the plan, helping the Centers of Excellence direct resources and initiatives toward identified priorities. She closed by thanking attendees for their time and engagement and introduced Mr. James Rhoden to provide the Summit's closing remarks.

Closing Remarks

Mr. James Rhoden closed the Summit by thanking attendees for their engagement, collaboration, and commitment over the past two days. He emphasized that while the Sequential Intercept Model (SIM) provides the guiding framework, it is the dedication and innovation of attendees across law enforcement, courts, behavioral health, and community organizations that drive meaningful change. Mr. Rhoden recognized Ms. Tatiana Reyes and Ms. Rachel Ames for their leadership in planning the event, highlighting how insights from the Summit will inform the next statewide strategic plan, future SIM mappings, and ongoing improvements to Maryland's crisis response systems. He concluded by reminding attendees that every intercept is an opportunity to change a life and encouraged continued cross-sector collaboration moving forward.



Community Services

Livable communities are built on key elements that allow all residents to thrive, such as housing, transportation, and services for special populations.

- Local Continuums of Care, operating under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program, fund homeless service programs, coordinate rehousing strategies, and support initiatives that promote self-sufficiency.
- Supportive housing combines affordable housing with support services that help people who face the most complex challenges to live with stability, autonomy, and dignity.
    - Partnerships with real estate investors and supportive housing developers help expand housing options, particularly in urban areas; however, housing development capacity and availability remain highly variable across the state.

    - HUD funds the Supportive Housing for Persons with Disabilities Program ("Section 811") to develop and subsidize rental housing with the availability of supportive services for very low- and extremely low-income adults with disabilities, including chronic mental illness. Properties eligible for the Section 811 PRA Program may be owned by a nonprofit, public, or private entity and may include new construction, rehabilitation, or existing properties.
- Communities are developing innovative strategies to address transportation barriers.
    - The HOFFA Foundation, a family-based nonprofit, has expanded from its origins in Carroll County to provide transportation to substance use treatment statewide, though service remains limited for residents in most remote areas.
    - Through state/federal grant funding, jurisdictions provide limited transportation for Medicaid recipients who cannot travel to medical appointments.
    - In some jurisdictions, law enforcement provides essential transportation as part of local crisis intervention team (CIT) efforts.
    - Many residential treatment providers assist clients by offering transportation for intake appointments.
- Access to services for special populations varies by location, though certain resources are available statewide.
    - The Brain Injury Association of Maryland offers advocacy, education, and research initiatives that support individuals, families, and professionals across the state.
    - The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) oversees Maryland's Commitment to Veterans program, a statewide initiative that develops Veteran-focused behavioral health policies; offers peer support, referrals, and limited crisis funding; and delivers training and educational resources for providers, peers, first responders, and community organizations.
    - PFLAG (Parents, Families, and Friends of Lesbians and Gays), the nation's largest organization dedicated to supporting, educating, and advocating for LGBTQ+ people and their loved ones, operates eight chapters throughout Maryland. In addition, five LGBTQ+ support centers provide services statewide.

Behavioral Health Continuum of Care

Maryland's public health approach aims to deliver a comprehensive range of services for mental health and substance use conditions, encompassing prevention, early intervention, crisis response, and long-term recovery support. A strong, coordinated system ensures that individuals receive the appropriate level of care at the right time, reducing crises, minimizing emergency room use and legal system involvement, and supporting sustained recovery.

Prevention and Promotion

- Outpatient and early intervention services are available in primary care settings in every jurisdiction.
- All Maryland residents can register for a free grant-funded course in Mental Health First Aid, a curriculum developed by the National Council for Behavioral Health to effectively train individuals (including criminal justice professionals) to recognize behavior commonly associated with mental illness.
- Evidence-based harm reduction strategies such as naloxone training and distribution have reduced overdose fatalities across Maryland. Post-overdose response teams or programs operate in many jurisdictions to connect individuals to treatment and support following a nonfatal overdose.

Treatment and Recovery

- Mobile treatment programs provide recovery-focused, community-based treatment and support in non-office settings.
    - Access to assertive community treatment (ACT)[3] has expanded from 19 jurisdictions in December 2024 to 21 as of October 2025.
    - Maryland's opt-in naloxone leave-behind program has been active since 2018 and currently operates in 23 jurisdictions; Somerset County is exploring implementation.
    - Select jurisdictions have implemented EMS buprenorphine field induction protocols that allow trained paramedics to initiate medication for opioid use disorder (MOUD) in the pre-hospital setting for patients experiencing opioid withdrawal. These protocols are in place in Frederick and Baltimore counties and in the cities of Baltimore and Salisbury.
        - In Anne Arundel County, the Maryland Mobile Wellness Initiative operates a mobile health vehicle staffed by a certified registered nurse practitioner, registered nurse, and peer support specialist. The team provides low-threshold alcohol and buprenorphine induction, on-site wound care, and virtual services (410-U-BE-WELL).
- State Care Coordination is a recovery support service designed to improve recovery outcomes for individuals at risk of relapse and high-cost individuals who utilize publicly funded substance use treatment resources. State Care Coordination is available in every

[3] Assertive community treatment (ACT) is an intensive, client-centered, community-based mental health service that provides comprehensive case management and support to individuals with severe and persistent mental illness who have not benefited from traditional outpatient programs. Multidisciplinary ACT teams provide time-unlimited services in clients' homes and communities, including psychosocial rehabilitation, recovery support, and 24/7 on-call assistance.

jurisdiction, providing recovery assessment, care planning, ongoing monitoring, and follow-up.

- Many hospitals offer case management to help coordinate appropriate care.
- The Older Adult Behavioral Health PASRR[4] Project, a collaboration between the Maryland Department of Health (MDH) Behavioral Health Administration (BHA) and Maryland's Money Follows the Person (MFP) Project, aims to bridge the gap between behavioral health and aging services. Regional specialists support behavioral health providers working with aging clients, as well as aging services partners whose clients have behavioral health needs. These specialists offer resources and consultation to help older adults with behavioral health conditions avoid nursing facility placement or reduce the length of their stay.

Urgent and Acute Care

- All 988 call centers are providing warm hand-offs from 988 to 911 when transfer is warranted; some can send information directly to public safety answering points (PSAPs). The Behavioral Health Administration is working to streamline and standardize this process.
- In addition to promoting 988, several communities (e.g., Anne Arundel and Frederick counties, the Mid-Shore region, and the Southern Maryland tri-county region) continue to accept calls to local lines that are familiar to residents.
- Every jurisdiction strives to sustain and expand crisis services, although implementation varies.
    - Walk-in behavioral health care has expanded from five facilities to nine. Six facilities (including two virtual) offer same-day or next-day urgent behavioral health care appointments.
    - Sixteen jurisdictions maintain crisis beds.
    - Hospital diversion programs help redirect individuals from hospitals and emergency rooms to more appropriate community-based services, such as crisis stabilization centers or case management. By providing timely stabilization, treatment, and support in the community, these programs aim to reduce hospitalizations related to mental health or substance use crises.
    - Alternative destination programs transport patients with low acuity conditions to urgent care facilities instead of hospital emergency departments. Implementation of these programs requires approval from the Maryland Institute

[4] The Pre-Admission Screening and Resident Review (PASRR) Program is a federal program governed by the Centers for Medicare and Medicaid Services. This program screens people seeking nursing facility care for a history of mental illness and identifies the most appropriate and least restrictive services that will meet their needs.

for Emergency Medical Services Systems (MIEMSS) and is limited to jurisdictions with eligible receiving facilities.

- Mobile integrated health (MIH) is a national care-delivery model that uses patient-centered, mobile resources in out-of-hospital settings to prevent unnecessary ambulance transports, emergency department visits, and hospital admissions or readmissions. MIH aims to improve outcomes for highly vulnerable residents with chronic needs, including behavioral health conditions. Teams, typically composed of paramedics, nurses, and social workers, leverage existing interagency partnerships to connect high-need individuals with appropriate services, reducing emergency service use among frequent users. Participants are identified through repeated 911/EMS calls, high hospital utilization, or other referral sources. MIH or Mobile Integrated Community Health (MICH) programs are available in several jurisdictions.

Law Enforcement

- Community policing strategies, broadly mandated by Section 3-517 of the Public Safety Article, vary across communities and may include a range of programs and services that fulfill the two complementary core components of the framework, community partnership and problem-solving.
- In certain instances, law enforcement representatives serve as vital, collaborative members of problem-solving courts' interdisciplinary teams, moving beyond traditional roles to support rehabilitation and accountability.
- Diversion programs are designed to connect individuals to community-based treatment and support services as an alternative to formal prosecution or incarceration. These efforts intend to integrate a public health approach into public safety strategies, reduce over-incarceration, and mitigate the harmful effects of justice-system involvement. Diversion programs generally fall into three broad categories (early, pre-plea, and post-plea) based on the timing of intervention.
    - Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) programs provide early diversion opportunities for individuals who commit low-level offenses stemming from unmet behavioral health needs, redirecting them to case management and services rather than the criminal legal system.
        - The Governor's Office of Crime Prevention and Policy currently administers the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) fund to 13 of Maryland's 16 active LEAD sites. Many of these programs combine a community-first, public health approach with pre-arrest diversion.

- The Safe Station model provides individuals with substance use disorders a way to seek help from police without fear of arrest or prosecution, using designated stations as entry points to treatment.
    - Anne Arundel County operates the state's only 24/7/365 program, which now includes all fire stations as additional entry points. The program serves individuals from across Maryland and beyond, striving to connect them with support in their home communities. The program is supported by SOR and MOOR funding and relies on collaboration with mobile crisis teams, CIT officers, and contracted providers.
    - Other jurisdictions have expressed interest in securing funding to implement pilot programs.
- Focused support for first responder safety and wellness is a critical component of public safety, promoting the well-being of responders, their colleagues, agencies, families, and communities.
    - Facility K9s, such as agency therapy dogs, provide animal-assisted emotional support in several jurisdictions. The Frederick Police Department has expanded this approach: its K9 supports officers while also engaging the community through follow-ups from previous shifts, participating in community events, and responding to patrol requests for assistance.
    - Many agencies have created pipelines to connect first responders with resources familiar with public safety operations. In Frederick County, for example, local first responder agencies employ clinicians who are independent of the chain of command and embedded within the health department. This approach aims to reduce hesitancy driven by the well-documented career-advancement impacts of first responders accessing behavioral health care.

Peer Support Services

- Strategies supporting people living with or recovering from mental and/or substance use disorders have increasingly prioritized the addition and integration of peers into existing service spaces across the continuum of care.
- Peer-led, community-based organizations play a growing role in helping people find and sustain recovery. Through funding from the Maryland Behavioral Health Administration, a network of peer-led wellness and recovery centers (WRCs) operate statewide as part of the Maryland Public Behavioral Health System (PBHS) continuum of care. WRCs provide resources, socialization, and activities within a supportive peer community.

Family Support Services

- Maryland Coalition of Families (MCF) provides confidential, no-cost peer support for families of individuals with behavioral health challenges, regardless of income or insurance. The organization helps families understand their rights, navigate complex systems, and access resources.

GAPS AND OPPORTUNITIES

Community Services

- Gaps in transportation and housing limit employment opportunities and access to essential treatment and support services, vital components of long-term recovery.
- Maryland residents face a shortage of adequate and affordable housing, undermining efforts to prevent and end homelessness.
    - Long waiting lists for permanent housing, coupled with insufficient access to low-barrier public shelters and transitional housing, leave individuals waiting on the street. Strict HUD criteria exacerbate the issue.
        - Western Maryland is especially affected; Allegany County only has a single faith-based shelter, while Garret County has no shelters of any kind.
    - Development agreements are voluntary and subject to negotiation. In some areas, such as the Eastern Shore, the outcome of these agreements is skewed in favor of the developers who avoid making affordable housing contributions, infrastructure improvements, or community amenities.
    - Across the state, housing vouchers go unused due to a shortage of affordable housing units, landlord reluctance to participate, and intense competition in the rental market.

Opportunity: Repurposing existing buildings to provide shelter and housing offers a cost-effective, environmentally sustainable solution to housing shortages. This approach, known as adaptive reuse, reduces construction costs, accelerates project timelines, and revitalizes underutilized or abandoned properties. It also increases housing availability in areas with existing infrastructure, promoting neighborhood stability and renewal. To fully leverage adaptive reuse in addressing urgent housing and service gaps, planners and policymakers should adopt a multi-pronged strategy to overcome key barriers. Recommended actions include:

- Comprehensive rezoning: Evaluate land use and development patterns, allowing simultaneous rezoning of multiple properties at once
- Zoning and ordinance updates: Permit diverse land uses, adjust density requirements,

and eliminate exclusionary zoning practices
- Leveraging state-level initiatives: Utilize programs and policies such as the Housing Expansion and Affordability Act, the Just Communities Act, and the state requirements for developing local comprehensive plans.

- Public transportation and private ride services (e.g., Uber) are limited or non-existent in much of the state.
    - Reliance on public transportation restricts housing options for residents who need to stay near essential services.
    - Caregivers may face challenges arranging transportation to visit loved ones in inpatient facilities.
    - Individuals discharged from hospitals overnight, whether from the emergency room or other units, often wait until morning to access transportation, which can delay follow-up care and increase the risk of complications.

Behavioral Health Continuum of Care

Prevention and Promotion

- Stakeholders report a disconnect between evidence-based harm reduction principles and funding. While harm reduction is widely recognized as a standard level of care in many parts of the world, its adoption in the United States remains fragmented and inconsistent.
- Stakeholders express willingness to partner with academic institutions to expand the evidence base beyond naloxone administration; however, the gap lies not in research, which has already produced decades of robust local, state, and federal data, but rather in policy at every level.
    - Federal: Concerns centering on the federal funding landscape highlight the need for funding at the state and local levels to ensure sustainability.
    - State: While the Office of Harm Reduction within BHA oversees the Overdose Response Program, Syringe Services Program, naloxone distribution, harm reduction grants, and various workforce development, training, and technical assistance activities, harm reduction is recognized as an approach and set of strategies rather than a single, defined level of care with regulatory standards. This lack of formal definition leads to inconsistencies in procurement language, thereby reducing efficiency, transparency, and objectivity.
    - Local: The stigma surrounding behavioral health is driven by negative beliefs held by both the community and consumers; stigma can be directed (or self-directed) at consumers themselves or the system and its components, including first

responders and certain provider types. While data can demonstrate effectiveness, community buy-in remains essential for implementation and sustainability.

Opportunities:

- Community-based organizations and nonprofits are uniquely situated to provide harm reduction services, shielding local health departments from controversy.
- Given the need for support from local elected officials, some jurisdictions have adopted a public health model that specifically builds political will through initiatives such as public official ride-alongs.
- Current research suggests that education and awareness-raising activities are often insufficient to reduce stigma and discrimination. Current recommendations for anti-stigma initiatives move beyond behavioral health literacy, focusing instead on the principle of social contact, inclusive partnerships, and co-leadership by people with lived experience.[5]

Treatment and Recovery

- Provider shortages often lead to increased workloads and decreased morale, which accelerates professional burnout and hinders recruitment and retention efforts.
- Long wait times, especially in rural areas, limit timely access to evidence-based, culturally competent care. This worsens disparities in underserved communities and increases reliance on urgent and acute care services.

Opportunities:

- Artificial intelligence (AI) tools are transforming behavioral health by improving assessment speed and accuracy, aiding detection and triage, and reducing provider workload. Early data suggest consumers support AI enhancements as long as clinical decisions remain guided by human judgment. Health care systems considering AI implementation must carefully evaluate the factors that influence acceptance of AI-supported care.
- Colleges and universities offer a strategic opportunity to address the behavioral health workforce shortage. Local campuses can help build a stable pipeline of qualified professionals through internships, practicums, and early-career placements.

[5] World Health Organization. (2024). *Mosaic toolkit to end stigma and discrimination in mental health*.

- Emerging models (e.g., non-crisis-based parallel behavioral health systems) emphasize prevention and long-term wellness rather than acute intervention. These systems use community-based, peer-led support, integrate treatment for co-occurring disorders, and work to recognize and break cycles of trauma and stress.

- Although access to medication-assisted treatment (MAT) is improving, availability remains uneven across the state, particularly in under-resourced areas.

Opportunity: Low-threshold models, such as mobile services or telehealth, can expand access to MAT, increase referrals, and strengthen connections to care for individuals in under-resourced communities.

- Resources have shifted focus to addressing the opioid crisis, leaving limited treatment options for individuals with addictions to alcohol, cocaine, or other substances.
- Language barriers for non-English language preference (NELP) individuals can limit access to treatment, impede crisis service delivery, complicate assessments, and hinder efforts to address broader factors affecting behavioral health, such as housing instability and limited access to care.
- Medical complexity and patient history limit access to behavioral health care.
    - Medical complexity: Access is limited for aging adults with both behavioral and physical health conditions.
    - Patient history: Individuals with a history of aggressive behavior, frequent no-shows, or treatment non-adherence may find it difficult to set appointments with willing providers.
- Statewide, services designed to address both mental health and substance use conditions simultaneously, known as dual diagnosis or co-occurring disorders treatment, remain limited.
    - Treating one condition without addressing the other often leads to poorer outcomes, higher relapse rates, and increased recidivism.
- Limited options exist for individuals who are not ready to commit to abstinence, reducing access to treatment and housing.
- Insurance requirements and restrictions continue to impact access to health care.
    - Insurance coverage and patient costs of medications and services interfere with clinical care plans.
    - Medicaid coverage is state-specific; Maryland Medicaid does not apply in other states except for emergency care, limiting access for residents near state borders.

- Care coordination remains a challenge.
    - Individuals often receive treatment (especially urgent and acute services) outside of their "home" jurisdiction, complicating care coordination.
    - Local providers often struggle to coordinate care across settings, resulting in inappropriate referrals and overburdened urgent and acute services.
    - Without a centralized statewide resource, consumers and care teams must navigate program eligibility, insurance coverage, and service availability.

Opportunity: Patient navigators are a promising strategy for helping individuals navigate the complexities of the health care system. Depending on need and context, these roles can be filled by health professionals such as nurses, social workers, physicians, or physician assistants, or trained lay persons, including community workers and individuals with lived experience.

- Case management, including targeted case management, requires additional outreach and education to increase utilization.
- Strict eligibility requirements for assertive community treatment (ACT) services leave many individuals without access to equivalent 24/7 community-based services for individuals with serious mental illness who experience or are at particular risk for concurrent substance use, frequent hospitalization, homelessness, involvement with the criminal legal system, and psychiatric crises.
- Gaps in the continuum of care disrupt the progression of treatment across levels of care.
    - Insufficient capacity creates bottlenecks, delaying placements across levels of care.
    - Regulations and rigid level-of-care criteria can unintentionally limit access and strain staff and program availability.
    - Fragmented treatment resulting from these systemic barriers negatively impacts treatment outcomes.

Opportunity: Peer-led strategies such as non-service-based housing, peer-supported housing, and sober living may reduce strain on the behavioral health continuum by offering appropriate options for individuals who do not require daily support. These programs create step-down options that help prevent unnecessary placements and prolonged stays in higher levels of care. For example, counties may consider adapting the approach utilized by the peer-run nonprofit organization Main Street, Inc., which provides rental housing for low-income individuals and families living with psychiatric disabilities in 12 jurisdictions across Maryland.

- Resources are particularly limited for children, adolescents, and transition-aged youth, and services vary widely by location. Younger patients often travel significant distances to access care, including urgent and inpatient care.

Opportunities:
- Several states have launched initiatives targeting the juvenile population. Upstream mappings and focused summits convene stakeholders serving the juvenile population (including juveniles involved in the adult criminal legal system).
- More immediately, the SIM workshops underway in Maryland present an opportunity to assess existing resources and unmet needs for transition-aged youth and young adults (ages 16-25).

Urgent and Acute Care

- State efforts to provide one-size-fits-all solutions fail to recognize the unique landscapes of communities across the state.
- The state lacks a recognized standard for basic crisis services to include, at a minimum, regulation-compliant mobile crisis services.
    - When requests for proposal (RFPs) open for crisis funding, jurisdictions compete regardless of whether the proposal fills a void or expands an existing service.

Opportunity: While efforts are underway to build a comprehensive statewide crisis system, community education can help strengthen informal social safety nets that support individuals in crisis who do not require more restrictive care settings.

- Workforce shortages limit the availability and accessibility of urgent and acute care, leading to increased reliance on hospital emergency departments as individuals eventually present in crisis.
- Many local hospitals lack the adequate and appropriately-trained staff to provide long-term behavioral health care or comprehensive discharge planning, particularly when local resources for warm hand-offs are limited or unavailable.
- The state lacks professional standards recognizing crisis intervention as an evidence-based and evidence-informed specialty that equips practitioners to assess individuals in crisis, provide triage and stabilization, and develop intervention plans.
    - Crisis workers are not compensated competitively despite the high demand for these professionals. This issue is seen across settings; as one example, school-based clinicians are paid significantly higher salaries as opposed to similarly licensed clinicians within mobile crisis services, despite mobile crisis teams often responding to calls for service from schools.

- The reduced wages and unextended, unpredictable hours compared to other industry settings hinder the cultivation of a robust workforce of experienced crisis specialists.

Opportunities:

- Organizations such as the American Association of Suicidology offer national certifications that ensure competency in crisis response.
- Local stakeholders should consider leveraging internships to support expanded hours of operation for crisis services.

- The costs associated with certifying, staffing, tracking, and operating facilities to provide 24/7 crisis coverage remain a significant concern for local jurisdictions.
  - Jurisdictions face long windows for repayment and reimbursement.
  - Medicaid alone cannot sustain crisis programming.
  - Under- and undocumented individuals, as well as individuals not seeking services due to fear of personal or professional consequences, continue to require care that only becomes increasingly complex and costly when left unaddressed.
  - Braided funding is encouraged but entails demanding data collection and oversight requirements for staff.
- Systemic underinvestment in psychiatric infrastructure creates gaps by location and level of care, a concern that is especially apparent in relation to mobile crisis coverage, crisis beds, and inpatient capacity.

Opportunity: State leaders could address confusion about the broad decision-making process for determining need and allocation by transparently engaging with professionals and community members. Topics would include opportunities and limitations related to compelling or incentivizing the expansion of psychiatric services, including inpatient beds and follow-up behavioral health care.

- The current emergency petition process lacks a statewide evidence-based standard.
  - Variability in interpretation and execution across jurisdictions undermines consistent, compassionate care.
  - Improperly executed petitions may result in discharge without further evaluation or treatment.

Opportunity: Implementing comprehensive, standardized training for law enforcement officers, clinicians, and physicians can promote a shared understanding of the state's legal and procedural requirements for emergency petition.

- Petitioner characteristics may unduly influence decisions regarding the use of an emergency petition.
    - Individuals unfamiliar with inpatient admission requirements may submit unnecessary petitions.
    - Law enforcement faces burdens due to the prohibition of forced offload; officers may resort to arrest when hospitals are slow to accept evaluees, especially amid workforce shortages.
- The process for completing and transmitting the emergency petition form is inefficient and confusing.
    - Sections 10-601 and 10-624 of the Health General Article authorize electronic petitions; however, jurisdictions require a physical document while awaiting guidance on regulatory implementation.
    - The current form's instructions are unclear, as the requested "brief statement" is typically insufficient.

Opportunities:

- Anne Arundel County is piloting a protocol that may serve as a model for electronic emergency petitions.
- Worcester County has developed a proposed form that could serve as a template for the circuit court to update its existing emergency petition form.
- Law enforcement leadership should continue, or begin, directing officers to complete petition forms with a detailed probable cause statement rather than a brief description.

- Legal and procedural gaps complicate care for individuals who are unable or unwilling to seek care voluntarily.
    - The legal limits on treatment over objection create a gap between instability and the threshold for involuntary psychiatric intervention, contributing to a "revolving door" effect for emergency departments and jails.
    - Hospital security may be unable or unwilling to stop voluntary walkouts, leaving individuals without immediate or follow-up care.
    - The involvement of multiple agencies in regulating the use of force has fostered confusion and inconsistent implementation.
        - The Maryland Use of Force Statute[6] sets guidelines; the Police Training and Standards Commission provides recommendations; and each agency is responsible for developing and implementing policy.

[6] §3-524 of the Public Safety Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gps&section=3-524&enactments=false

- The emergency petition process lacks cross-sector communication channels.
    - No formal process exists for law enforcement or the local crisis system to provide situational updates to the court during hearings on petitions for emergency evaluation.
    - Courts may unknowingly grant a petition filed by a concerned third party when a voluntary placement has already been secured following a welfare check or mobile crisis team response. The emergency petition then overrides the existing care plan, necessitating an involuntary transport to the emergency department that needlessly taxes resources, delays treatment, undermines client autonomy, and erodes client trust.

Opportunity: Statewide initiatives ensure that professionals across sectors share an understanding of the legal and clinical considerations for involuntary evaluation and treatment of individuals who, due to mental health disorders, are considered a risk to themselves or others. Coordinated efforts align policies and procedures across sectors to ensure that individuals in crisis receive appropriate services. Local partnerships with the judiciary support coordinated jurisdictional efforts to connect individuals in crisis to appropriate treatment, including crisis intervention team (CIT) programs and mobile crisis teams. Coordination of the courts, law enforcement, and peer support offers a more holistic approach to supporting individuals in need of support and services.

- **Example**: Anne Arundel County is piloting an initiative in which district court judges may issue bench warrants stamped with a large red “988” designation to signal that the defendant has known mental health issues. The stamp provides advanced knowledge to enhance officer, consumer, and community safety, but does not change the procedure for serving the warrant. The effort intends to help law enforcement recognize and prepare to assist individuals who may need psychiatric care. As these individuals may already be familiar with the crisis intervention team (CIT), CIT can be contacted to assist or be on scene if the situation warrants and time permits.

Law Enforcement

- Structured scripts for emergency dispatch ensure consistency but limit opportunities for implementation of deescalation skills learned in CIT training. Standard prompts also limit 988 diversion efforts.
- Officers in border areas face additional hurdles when transferring and directing people to behavioral health services.
- In some jurisdictions, local law enforcement leadership remains hesitant to permit bidirectional transfer between 988 and 911 due to liability concerns.

Opportunities:

- By deploying a 911 diversion strategy, certain types of calls (e.g., mental health crises) can be routed directly to a mobile crisis team or civilian response unit before police are dispatched, rather than after.
- Necessary trust-building should begin with the region's designated 911/988 champion within the local behavioral health authorities and/or core service agencies.
- To address concerns among stakeholders regarding 911 diversion, champions can emphasize the reduced liability associated with deploying behavioral health professionals to resolve nonviolent, low-public-safety-risk situations.
- Realistic conversations ensure that public safety answering points (PSAPs) and law enforcement leadership are comfortable with the protocol. These conversations must necessarily address any unique jurisdictional factors pertaining to existing crisis system services and procedures.
- Counties may consider piloting a model similar to Baltimore City's 911 diversion program, which allows 911 calls to be transferred to 988 for telephonic resolution or civilian mobile crisis team dispatch.

- Jurisdictions across the state express the need for additional guidance regarding the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) to facilitate effective coordination among agencies at the intersection of behavioral health and the criminal legal system.

Opportunity: While awaiting guidance at the county and state levels, jurisdictions can develop location-specific infographics to educate and highlight law enforcement's role in the continuum of care. Counties may reference the Primary Care Coalition in Montgomery County as a model, which collaborated with hospital legal departments to create hospital-specific HIPAA infographics.

- Officer wellness remains a key concern for stakeholders. At the same time, workforce shortages contribute to burnout among current professionals, creating a feedback loop that reduces the wellbeing and safety of first responders, their families, and the communities at large.

Opportunity: Investments in education, training, recruitment, and retention are the keys to building a sustainable workforce. Expanded access to officer wellness programs, peer support, and universal trauma-informed care training benefits law enforcement and the communities they serve.

Peer Support Services

- Jurisdictions struggle to develop the strong peer workforce needed to sustain and expand outreach and harm-reduction strategies.
- Pressure to recruit peers leads to rushed certification and less thorough selection and training.
- Difficulty accessing refresher training often results in the decertification of otherwise willing peer professionals.
- Unrealistic expectations of peer support specialists and inconsistent training for peer specialist supervisors often result in assigned responsibilities that do not align with their job descriptions. This can leave peers underutilized or overburdened by providers who are unfamiliar with their proper scope of practice. These misunderstandings may inadvertently create barriers to peer involvement and ultimately reduce their effectiveness.
- While peers are increasingly integrated into service settings across the continuum of care, non-clinical public spaces, such as shelters, schools, and libraries, are often overlooked. This is a missed outreach opportunity, as many individuals first seek assistance in these settings.
- Heavy demands coupled with limits on career advancement and salary inequities hinder recruitment and retention efforts.

Opportunities:

- Several organizations, including On Our Own of Maryland, Inc., offer free and low-cost training for peers and administrators.
- The Rural Advancement for Maryland Peers (RAMP) program intends to expand and strengthen Maryland's certified peer recovery specialist workforce serving rural communities. Administered through a partnership between the Maryland Department of Labor and the Maryland Department of Health, funds support training, certification, and career advancement for certified peer recovery specialists, offered at no cost to program participants. In addition to providing free training for new peer recovery specialists, RAMP will support current behavioral health professionals with opportunities for career growth and retention in the field.
- Recent COMAR updates expand family and youth peer support and increase Medicaid coverage for certified peer recovery specialists. These changes create opportunities for partners to help peers advance into higher-level behavioral health roles.
- Peer specialist supervisor certification is available for professionals providing direct oversight of peer specialists, a necessary qualification for organizations planning to bill Medicaid using the newly established "peer services" billing code.

- Local agencies are working to ensure competitive compensation for peers. For example, as one of the first counties nationally to secure SAMHSA funding for peers, Frederick County taps multiple funding sources to ensure its peers are all state merit employees.

- The peer workforce lacks diversity in recovery pathways, which can limit the sense of shared experience for individuals whose recovery journeys differ. Providers also note the challenge of engaging people who are not actively seeking help.

Family Support Services

- Caregiver wellbeing initiatives require additional caregiver training, wraparound services, and family respite to provide effective support. However, high costs and workforce issues result in low response rates to requests for proposals.

Data Systems & Interagency Collaboration

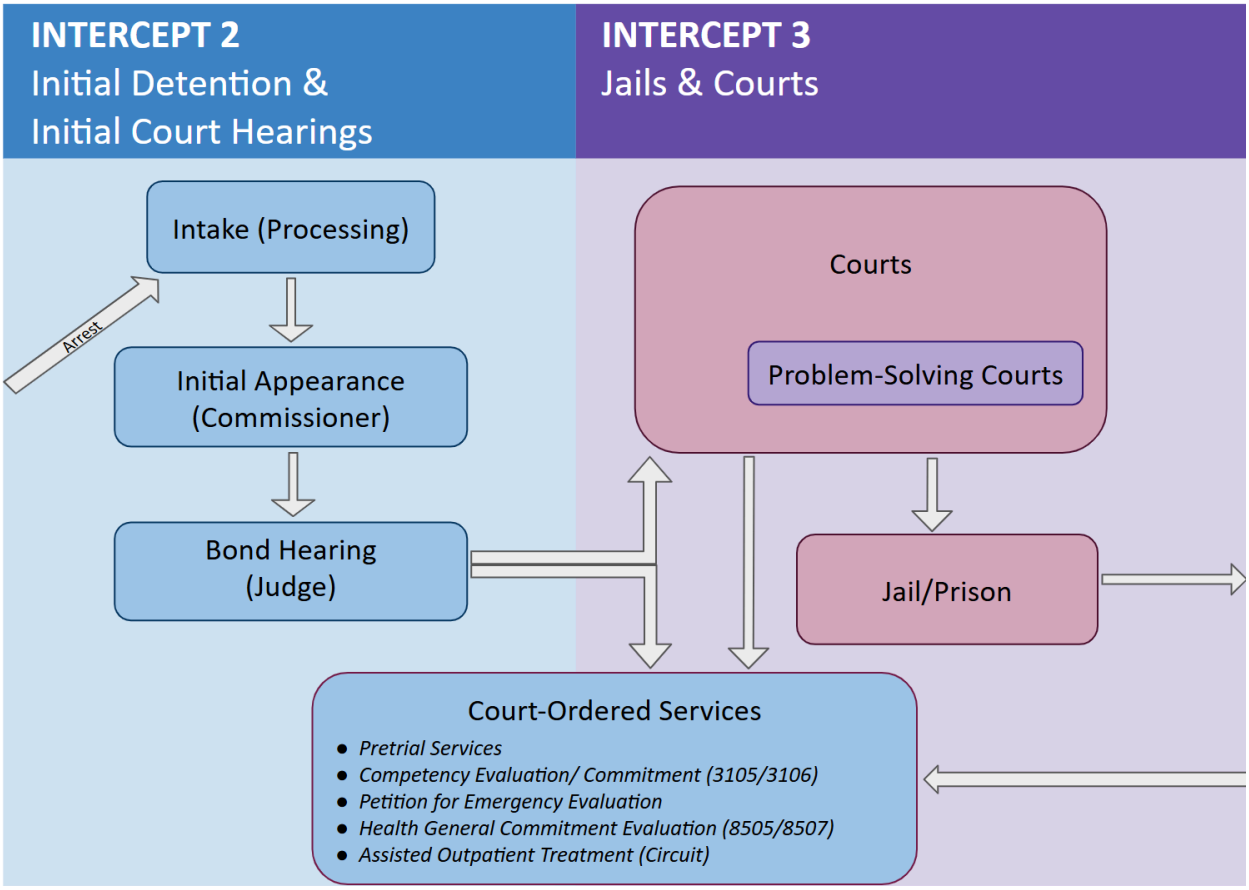
- Insufficient coordination at the state and local levels leads to duplicative programs and services.
- Widely recognized regional divisions overgeneralize uniformity and mask the diversity within regions.
    - Emphasis on regional approaches fails to acknowledge that a greater scale introduces greater complexity.
    - Western Maryland, Southern Maryland, and the Eastern Shore are often treated as singular regions, which can obscure important differences between jurisdictions within each region. Recognizing distinctions between sub-regions or counties (e.g., the Mid-Shore versus the Lower Shore within the Eastern Shore) could improve communication and decision-making while highlighting the need for cross-agency coordination.
- Data sharing refusals driven by a mix of legal, technical, social, and economic barriers prevent cohesive data collection and analysis strategies and reinforce data siloes.
- The funding landscape often fosters a competitive rather than collaborative stance.

Opportunities:

- Stakeholders must work across sectors and jurisdictions to align policies, reduce competition for limited resources, and establish shared priorities that support strategic, long-term planning for effective community development.
- State grant-funding agencies should encourage partnerships by incentivizing collaborative efforts.

PRIORITIES		
1.	Establish a statewide standard for basic crisis services and prioritize sustainable funding to develop, maintain, and expand crisis services.	28 votes
2.	Enhance care coordination between and among law enforcement and providers through statewide HIPAA guidance, cross-sector education, and cooperative data-sharing practices.	27 votes
3.	Support the integration of 988 and 911 services by promoting coordination through shared protocols, enhanced technology, and cooperative care models at the state and local levels.	24 votes
4.	Evaluate and improve the emergency petition process through updated legal forms, standardized practices, cross-sector coordination, and methodical examination of legal and clinical standards.	20 votes
5.	Conduct a review of all regulatory bodies involved in addressing state workforce shortages to enhance transparency and clarify governance of the workforce and regulatory requirements while examining certification delays and how reliance on grant funding and the creation of temporary positions relate to workforce challenges.	7 votes
6.	Assess core funding for crisis services through a transparent review of the state's Core Funding program and the state-driven formula for core funding distribution.	6 votes
7.	Expand community health education and outreach to increase service utilization using evidence-based strategies, including credible messengers and targeted communication channels.	6 votes
8.	Enhance service accessibility across the lifespan by conducting a thorough gaps analysis of the behavioral health care system's responsiveness and availability for different age groups, considering factors such as pregnancy, parenting status, and somatic health care needs.	4 votes
9.	Revise the criteria for involuntary treatment by clearly defining the dangerousness standard to address factors such as grave disability and psychiatric deterioration.	2 votes

INTERCEPTS 2-3



RESOURCES

Initial Booking Process

The initial booking process is the first step in the criminal legal system after an individual is arrested. It involves recording personal information, photographing and fingerprinting, and conducting basic health screenings to assess immediate needs such as mental health, substance use, and medical concerns.

- In many jurisdictions, this process takes place within the local detention center's central booking unit, allowing for streamlined coordination and processing of arrestees.
- The nature and scope of these screenings vary by jurisdiction:
    - Some jurisdictions' focus on identifying substance use issues
    - Others limit the screening to immediate or urgent medical concerns only.

- Mental health and substance use screenings are available at booking in select jurisdictions:
    - These screenings are often conducted separately from each other.
    - In many cases, they consist of only a few brief questions about current mood or well-being, rather than a comprehensive assessment of psychiatric conditions or behavioral health risks.
- In some jurisdictions, specialized teams and/or detention center medical staff assist with immediate health needs and diversion referrals during the booking process. The following examples highlight how different jurisdictions implement these supports:
    - In Washington and St. Mary's counties, medical departments may conduct in-depth evaluations at central booking upon request.
    - In Carroll County, contracted medical staff can be utilized during booking if a detainee requires medication.
    - In Montgomery County, the Clinical Assessment and Triage Services (CATS) team, housed within the detention center, supports diversion and triage efforts. CATS may refer individuals to services as Avery Road, the drug court, mental health court services, or pretrial services. The team also alerts detention center staff if a detainee is considered unsafe for placement in the general population.
    - In Allegany County, the detention centers' medical staff can initiate medication-assisted treatment (MAT) at booking for individuals who report or exhibit signs of opioid use disorder.
    - In Anne Arundel County, a pilot program deploys crisis response teams during the booking process (after arrest, but before the commissioner hearing) to assess whether an emergency petition (EP) should have been initiated. Early results indicate the intervention has been effective, with crisis teams not only completing the emergency petition (EP) process but also ensuring appropriate follow-up care.

Initial Appearance

An initial appearance before a commissioner is a brief court proceeding that typically occurs shortly after a person is arrested and booked. During this hearing, the commissioner informs the detainee of the charges against them and determines whether the individual will be held or released pending further court proceedings.

- Commissioners conduct initial appearance hearings in all jurisdictions.
- In some cases, if a detainee is held and exhibits signs of mental health concerns, commissioners may document these concerns for the judge's consideration.
- In select jurisdictions, Veteran status screening is also initiated at initial appearance.

    - For example, in Frederick County, detainees are screened for Veteran status to support future service coordination or diversion opportunities, such as referral to the Regional Veterans Treatment Court.

Pretrial Services

Pretrial services include programs or agencies that support the criminal legal system by providing supervision, support, and resources to individuals released from custody while they await their trial. Their goals are to promote public safety, ensure that individuals return to court for their scheduled appearances, and reduce unnecessary detention of individuals who may be safely managed in the community.

- All jurisdictions offer some form of pretrial services, except for Charles County.
    - The Charles County Criminal Justice Coordinating Council's Pretrial Services Committee has been advancing ongoing efforts to implement pretrial services, including meeting with other jurisdictions, such as St. Mary's County and Carroll County, to discuss program practices and structural models.
- Formalized pretrial services units, however, exist only in select jurisdictions.
- Demand for pretrial services differs significantly across jurisdictions.
- Risk and Need Triage (RANT) is an evidence-based assessment tool that provides supervision and clinical service recommendations. It is an effective triage tool for drug-involved individuals at or near the point of arrest to determine disposition, meaning the most appropriate course of action or outcome, such as diversion to treatment, further legal processing, or other interventions.
- Local jurisdictions are responsible for ensuring that screening and assessment tools (e.g., RANT) are appropriately validated to reflect the characteristics and needs of the individuals they serve.
    - St. Mary's County's Pretrial Program has revalidated its Pre-trial Release Risk and Needs Assessment and administers it before a bail review hearing.
- Pilot programs currently operating in Harford, Cecil, and Caroline counties focus on individuals charged with non-violent offenses, aiming to identify substance use and mental health risks before hearings. These efforts seek to increase referrals to community-based services and reduce the time between arrest and access to needed treatment.

Judicial Hearings and Proceedings

Hearings before a judge are a critical part of the judicial process in which legal determinations are made regarding a defendant's case. These hearings may include bail reviews, competency evaluations, mental health court proceedings, and other matters related to custody, release, or treatment planning.

- The Maryland Office of the Public Defender receives referral requests from prosecutors for diversion at bond review hearings.
- Since the COVID-19 pandemic, many jurisdictions have continued to offer remote hearings via platforms such as Zoom. However, in-person hearings are generally encouraged and preferred when circumstances allow, depending on the individual case and logistical factors.
    - For example, Anne Arundel County conducts its Emergency Relief Docket for the District Court directly at the detention center within the central booking facility, in partnership with the Commissioners' Office. This docket primarily serves individuals ordered to undergo evaluation by the Health Department to assess competency to stand trial or designated for treatment in a health care facility. Holding these proceedings on-site eliminates the need for transportation to and from the courthouse and improves efficiency, staffing coordination, and security, particularly for individuals with behavioral health needs.

Competency Evaluations

The Maryland Department of Health (MDH) conducts competency evaluations either in person or virtually, depending on the defendant's bond status. After a hearing, if the court finds that the defendant is incompetent to stand trial[7] but is not dangerous (i.e., a danger to self, others, or the property of others), the court may set bond conditions or authorize the release of the defendant on recognizance. If, however, the court finds that the defendant is incompetent to stand trial and dangerous, the court must order the defendant committed to a facility designated by the MDH until the court determines that the defendant is no longer incompetent to stand trial, no longer meets the standard for dangerousness, or there is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future.

[7] Incompetency to stand trial refers to a defendant's lack of capacity to understand the nature and purpose objective of the legal proceedings, to consult meaningfully with counsel, and to assist in preparation of a defense; such incompetency determinations require the presence of a mental disorder or intellectual disability.

Petitions for Emergency Evaluation

Sections 10-620 through 10-627 of the Health General Article define the legal process to obtain an emergency evaluation for possible involuntary hospitalization of individuals experiencing a psychiatric crisis.[8]

- Certain mental health professionals (e.g., physicians, psychologists, clinical social workers) and law enforcement may file an emergency petition without the courts' approval. However, the courts must grant petitions filed by anyone else interested in an individual's mental well-being.
- Law enforcement transports petitioned individuals to the closest emergency facility for rapid evaluation. However, emergency facilities may only keep an individual who is emergency petitioned for up to 30 hours unless a physician or a psychologist completes certificates for involuntary admission.[9]
- Involuntary admission may only be deemed when an individual has a mental disorder, is a danger to themselves or others, is unable or unwilling to be admitted voluntarily, and there is no less restrictive form of care or treatment to meet the individual's needs.
- Considerations related to current policy and procedure are noted in Intercepts 0 and 1.

Assisted Outpatient Treatment

Sections 10-6A-01 through 10-6A-12 of the Health General Article authorize counties to establish assisted outpatient treatment (AOT) programs, and require the Maryland Department of Health to establish AOT programs in counties that choose not to do so.[10] These programs provide court-ordered treatment for individuals with severe mental illness who meet specific criteria, such as a history of non-adherence to treatment that has led to hospitalization or incarceration. The AOT process may only be initiated through the circuit court.

- To support a consistent and coordinated approach, and to address feedback from jurisdictions on the best pathway for developing AOT programs with shared standards or infrastructure, the Maryland Department of Health's Behavioral Health Administration (BHA) is implementing a structured, statewide AOT initiative in three phases (see Table 1). The phased rollout emphasizes jurisdictional readiness, geographic equity, and projected referral volume to guide implementation across the state.

[8] §10–620 of the Health-General Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=10-620&enactments=False&archived=False

[9] §10–624(b) of the Health-General Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=10-624&enactments=False&archived=False

[10] The law outlines the eligibility criteria for AOT and details the procedure for initiating AOT, including court hearings and legal representation for the individuals involved.

Table 1 *BHA's Assisted Outpatient Treatment (AOT) Statewide Implementation Plan*	
Phase	Objectives
Launch & Site Selection	● Establish a state-led implementation model ● Identify three priority regions based on: ○ Projected AOT referral volume ○ Jurisdictional readiness ○ Geographic balance (central vs. outlying regions) ● Prepare core infrastructure, including: ○ MDH to finalize COMAR regulations and clinical/operational guidance ○ MDH to collaborate with the circuit court judiciary on matters of judicial best practices and judicial rulemaking
Regional Implementation & Expansion	● Launch AOT programs in the three selected priority regions ● Monitor operations, workforce capacity, and funding mechanisms ● Capture lessons learned to refine the statewide model ● Engage local jurisdictions through stakeholder forums and advisory groups
Full Statewide Implementation	● Expand AOT programming to all remaining regions ● Standardize operations across jurisdictions ● Strengthen quality monitoring and outcome evaluation ● Maintain ongoing engagement with clinical, judicial, and consumer advisory groups and provide regular updates to LBHAs, local health departments, and community partners

Health General Commitment Evaluation and Treatment

Court-ordered evaluations[11] and treatment[12] for drug or alcohol use are available to address substance use and co-occurring diagnoses. These orders provide valuable resources, offering specialized support and integrated care for individuals with multiple conditions. Evaluations can be ordered at any stage of criminal proceedings.

Problem-Solving Courts

Problem-solving courts are specialized courts within the criminal legal system designed to address the underlying issues, such as mental health disorders, substance use, homelessness, or

[11] §8-505 of the Health General Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=8-505&enactments=false
[12] §8-507 of the Health General Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=8-507&enactments=False&archived=False

trauma, that contribute to criminal behavior. These courts aim to reduce recidivism and improve individual outcomes through a collaborative, treatment-focused approach rather than traditional punitive measures.

- There are 74 problem-solving courts in 23 of the 24 jurisdictions in Maryland.
- Types of problem-solving courts include Adult Drug Courts, Mental Health Courts, Veterans Treatment Courts, Reentry Courts, Truancy Courts, Family Recovery Courts, Juvenile Drug Courts, and Back-on-Track Courts. A map of operational courts, current as of January 30, 2025, can be found at: https://www.courts.state.md.us/sites/default/files/import/opsc/pdfs/problemsolvingmap.pdf.
- Key characteristics of problem-solving courts include an emphasis on therapeutic interventions, regular court appearances and monitoring tailored to each participant's progress and needs, a collaborative team approach, and accountability.
- Criteria for participation in problem-solving courts vary based on the specific focus of each court, addressing distinct needs and often considering factors such as offense type, criminal history, risk level, and willingness to engage in treatment.
    - The time between identifying potential participants for drug courts and their entry into the program varies, but the statewide goal is 7-14 days.
- The *Problem-Solving Court Coordinator Directory*, current as of December 4, 2025, is available at: https://www.mdcourts.gov/sites/default/files/import/opsc/pdfs/coordinatorslist.pdf.[13]
- Some jurisdictions without formalized courts have established informal specialty dockets to manage specific cases (e.g., a Mental Health Docket). These dockets often comprise a team committed to working on specialty cases in addition to regularly scheduled cases.
- Problem-solving court teams typically include a range of key stakeholders, such as the judge, public defender, state's attorney, court coordinator, and representatives from parole and probation.
    - In select jurisdictions, additional members contribute to more holistic support and service coordination. These may include pretrial services representatives (where available), case managers, treatment providers, peer support specialists, and law enforcement officers.
    - Two examples highlighted in the breakout session include St. Mary's County, where a Law Enforcement Assisted Diversion (LEAD) peer support specialist participates in mental health dockets and supports transitions from the detention center, and Frederick County, where law enforcement has recently

[13] Please note that some coordinators staff multiple courts; therefore, while all courts have a coordinator, the total number of listed coordinators does not reflect the total number of courts.

been added to regularly scheduled mental health court dockets to enhance collaboration and case planning.

Health Services in Detention

Health care and rehabilitation services within local detention facilities are crucial for addressing the physical and mental health needs of individuals who are incarcerated, as they provide essential support and treatment that can significantly improve outcomes.

- Upon intake at local detention centers, individuals undergo a range of screenings and assessments to identify immediate needs and inform appropriate treatment and care. Initial screenings typically include medical evaluations to detect urgent physical health issues; mental health screenings to identify signs of mental illness, suicidal ideation, or cognitive impairments; and substance use screenings to assess for a history of substance use. Additional screenings may cover classification to determine custody level and housing placement.
- Following initial screenings, more in-depth assessments are conducted to further inform care and placement. These may include comprehensive medical evaluations, psychiatric assessments, and substance use assessments to determine the severity of use and need for detoxification or treatment. Risk and needs assessments are also used to evaluate an individual's likelihood of violence, victimization, or self-harm, helping to guide case planning and service delivery. Some facilities may also conduct behavioral and social assessments to support rehabilitation and inform reentry planning.
- WellPath and PrimeCare Medical are commonly contracted providers for medical and behavioral health services across a wide range of local detention centers.
    - In addition to these primary vendors, other service providers are also utilized depending on the specific needs of the jurisdiction. For example, YesCare and Pyramid Healthcare have been highlighted as additional contracted vendors in some counties, either supplementing or supporting services alongside the primary providers.
    - Prescription medication services are not standardized across the state and typically vary by jurisdiction. Some jurisdictions partner with local health departments and community pharmacies, depending on specific needs and contractual agreements.
    - A specific example of how these partnerships operate can be seen in St. Mary's County, where PrimeCare Medical is the contracted provider for delivering physical and behavioral health care within the detention facility. Additionally, the county maintains a Memorandum of Understanding (MOU) with Pyramid Healthcare to support the medications for opioid use disorder program and other

clinical services. This arrangement promotes continuity of care and smoother transitions from incarceration to community-based services.

- Mental health services vary by facility but may include crisis intervention, psychiatric care, medication management, and individual or group therapy for mental health conditions.
    - Some jurisdictions have established dedicated mental health units within their detention centers to address the behavioral health needs of incarcerated individuals more effectively.
        - For example, the Montgomery County Detention Center includes dedicated mental health services staff, a crisis intervention unit, and a step-down unit[14] to respond to urgent behavioral health needs.
        - Similarly, Frederick County Adult Detention operates a designated mental health unit within its detention center to provide targeted support for individuals with behavioral health conditions.
        - Prince George's County Department of Corrections offers a range of behavioral health services, including a behavioral health unit, a substance use treatment unit, which includes a calming-room designed to support de-escalation and emotional regulation, and a medication-assisted treatment (MAT) unit.
- As of October 2025, all 24 jurisdictions in Maryland offer some form of medication for opioid use disorder.[15] To support transparency and oversight, the Research, Analysis, and Evaluation division within the Governor's Office of Crime Prevention and Policy regularly updates the publicly accessible Opioid Use Disorder Examinations and Treatment Dashboard[16] on the Office's website.
    - Additionally, the Justice Reinvestment Act team within GOCPP provides an Opioid Use Disorder Examinations Treatment Reporting Guide[17] and Reporting

[14] A step-down unit in a detention center provides a structured, phased transition for individuals moving from highly restrictive conditions, like solitary confinement, to less restrictive environments or general population.
[15] In accordance with §9-603 of the Correctional Services Article, correctional facilities are required to assess the mental health and substance use status of each incarcerated individual using evidence-based screening and assessment tools. Facilities must provide at least one of the three FDA-approved medications for opioid use disorder, alongside counseling services and reentry planning, during incarceration.
[16] Opioid Use Disorder Examinations and Treatment Dashboard. https://gocpp.maryland.gov/data-dashboards/opioid-use-disorder-examinations-and-treatment-dashboard/
[17] Opioid Use Disorder Examinations and Treatment Reporting Guide. https://gocpp.maryland.gov/wp-content/uploads/Opioid-Use-Disorder-Examinations-and-Treatment_-Data-Definitions-and-Reporting-Guide-Revised.pdf

Template[18] on the Office's website to assist jurisdictions with consistent data reporting and compliance.

- Many jurisdictions offer additional substance use treatment programs. Common examples include the Jail Substance Abuse Program (JASP), Addicts Changing Together – Substance Abuse Program (ACT-SAP), and Jail Addiction Services (JAS).
    - Resources vary by facility but generally include GED courses, counseling, professional development, drug and alcohol classes, and faith-based services. Some facilities also offer parenting and anger management courses, full-service libraries, and access to tablets or other technology.

Peer Support Services

In the criminal legal system, peer support involves individuals with lived experience providing guidance and assistance to those currently navigating legal challenges. This support fosters trust, builds meaningful connections, and empowers individuals to make informed decisions, ultimately aiding in their reintegration into the community after incarceration.

- Access to peer support, including certified peer support specialists, varies at different points of the system and throughout the State. However, many jurisdictions do offer access to peer support services.

Family Support Services

Family support services provide guidance, resources, and emotional support to families impacted by a loved one's involvement in the criminal legal system. These services help families navigate complex legal processes, maintain connections during incarceration, and prepare for successful reentry and reunification.

- Access to family support services varies widely across jurisdictions.
- Maryland Coalition of Families is a nonprofit organization providing family peer support to individuals and families with loved ones facing mental health challenges, substance use disorders, or problem gambling. Their embedded Family Peer Support Specialists deliver emotional support, connect families to resources, and assist with navigating complex systems.
- Southern Maryland Center for Family Advocacy serves St. Mary's, Calvert, and Charles counties by offering personalized legal advocacy and representation, case management, crisis management, and emergency shelter services, all at no cost to survivors of domestic and sexual violence.

[18] Opioid Use Disorder Examinations and Treatment Reporting Template. https://gocpp.maryland.gov/wp-content/uploads/Opioid-Use-Disorder-Examinations-and-Treatment-Reporting-Template-Updated-5_24.xlsx

Training & Workforce

Comprehensive and accessible training opportunities are essential for professionals working in initial detention, jails, and courts. Ongoing training ensures staff are equipped to identify behavioral health needs early on and make informed decisions that support diversion to appropriate treatment. Training also plays a key role in maintaining consistency in responses across systems, especially in the face of staff turnover and transitions.

- Personnel can receive crisis intervention team (CIT) training, mental health first aid (MHFA) training, and trauma-informed training.
    - Correctional officers may receive the 40-hour CIT training and MHFA, but percentages vary in every jurisdiction.
    - Most providers and parole and probation agents participate in MHFA training.
    - Trauma-informed care training is offered to problem-solving court staff.
- Ongoing training for judges and court staff includes:
    - The New Trial Judge Orientation Program in Maryland is a three-phase program for newly appointed judges, including courses covering implicit bias and communication skills training.
    - The Judicial College of Maryland and the Maryland Department of Public Safety and Correctional Services offer opportunities for continuing education.

Data Systems & Interagency Collaboration

Effective data sharing and strong interagency collaboration are essential for coordinating care, improving service delivery, and supporting informed decision-making across the criminal legal and behavioral health systems.

- The Chesapeake Regional Information System for our Patients (CRISP) is Maryland's designated Health Information Exchange (HIE), designed to securely share health information among hospitals, providers, labs, and other health care organizations. It supports safer, more efficient, patient-centered care for individuals who do not opt out and whose providers participate in the system.
    - The MidShore regularly uses CRISP to track prescribed medications, prevent medication duplication, and reduce the risk of medication diversion.
- Datalink is a tool that enables the secure exchange of information between correctional facilities and behavioral health providers. This integration allows authorized providers to access information about individuals entering or exiting local detention centers.
    - Some jurisdictions are now reimplementing this platform, which was previously utilized, following encouragement from the Behavioral Health Administration to support coordination between the criminal legal and behavioral health systems.

Advisory Bodies & Governance

Advisory bodies are a key component of governance in the behavioral health and public safety system. They bring together experts, stakeholders, and community representatives to guide decision-making, evaluate policies, address service gaps, and recommend best practices. Through structured governance, these bodies promote accountability, foster coordinated responses, enhance access to treatment, and help ensure that policies remain responsive to the evolving needs of the community.

- Statewide task forces and commissions include:
    - Commission on Behavioral Health Care, Treatment, and Access (MDH)
    - Commission on Correctional Standards (DPSCS)
    - Maryland Police and Correctional Training Commissions
    - Prison Education Delivery Reform Commission (GOCPP)
    - Statewide Steering Committee (Maryland Judiciary)
- Statewide councils and boards include:
    - Behavioral Health Advisory Council (MDH)
    - Baltimore City Criminal Justice Coordinating Council (GOCPP)
    - Correctional Education Council (DL)
    - Inter-agency Opioid Coordinating Council (Office of Overdose Response)
    - Justice Reinvestment Oversight Board (GOCPP)
    - Maryland Task Force on In-Custody Restraint-Related Death Investigations (GOCPP)
- Many jurisdictions have advisory bodies that advance initiatives, and it is essential for these entities to facilitate collaboration, minimize duplication of efforts, and build upon positive outcomes.

GAPS AND OPPORTUNITIES

Initial Booking Process

- There is no statewide standard for screening tools or protocols used at central booking, leading to significant variations across jurisdictions. This inconsistency may result in inequities in care and missed opportunities for diversion, depending on where an individual is booked.
- Information on the specific screening instruments used and the level of staff training is limited, making it difficult to assess the effectiveness or consistency of screening practices.

- Some detention centers report receiving minimal or incomplete mental health information at the time of booking, which can delay the identification of needs and hinder appropriate referrals to services.
- Concerns about the potential legal implications of sharing detailed mental health histories, such as triggering unwanted competency evaluations, may lead defense counsel to resist broad data sharing. This hesitancy can limit collaboration between legal and clinical teams during a critical intervention point.

Opportunities:

- Validated risk assessment tools exist that can be adopted across all jurisdictions during booking to improve screening accuracy and consistency.
- Jurisdictions with central booking located within the detention center can leverage existing clinical and support teams onsite to enhance screenings and promptly address detainees' health needs.

Initial Appearance

- At the initial appearance before the commissioner, diversion is not an option; the detainee is held or released. Commissioners may occasionally note concerns related to mental health or substance use, but such instances are rare.

Opportunity: Expand the implementation of pre-booking mental health screening programs. Pilot programs currently operating in Harford, Cecil, and Caroline counties target individuals charged with non-violent offenses, aiming to identify substance use and mental health risks before hearings. Leveraging insights from these pilots can support broader implementation, increasing referrals to community-based services and reducing the time between arrest and access to necessary treatment, thereby improving outcomes.

Pretrial Services

- There is no single state entity that oversees pretrial services and units in Maryland; each jurisdiction manages its own pretrial operations.
- As a result, pretrial screening tools and processes vary significantly across jurisdictions, leading to inconsistent practices and outcomes.
- Many jurisdictions are not using validated tools or are using tools validated in other jurisdictions and mistakenly assume they are valid for their own population.
- Tools must be validated specifically for the populations they serve, but the validation process is often prohibitively expensive, creating a barrier to proper validation.

- Pretrial decision-making can result in significant delays due to differing practices across jurisdictions.
- These delays can hinder timely referrals to substance use treatment, as individuals often become ineligible by the time the referral is received. This highlights the need to initiate referrals earlier in the process to preserve treatment access.
- In jurisdictions without formal pretrial service units, public defenders and parole and probation agents often assume pretrial responsibilities. However, they are unable to provide supervision, limiting their support.

Opportunities:

- Promote the use of consistent screening tools and timelines to reduce variability in pretrial decision-making and ensure equitable access to services statewide.
- Establish clear protocols and shared communication systems between pretrial services, courts, treatment providers, and other stakeholders to reduce delays and streamline access to care.
- Leverage case managers to support timely and effective referrals.

Ongoing Efforts to Improve Maryland's Pretrial System:

- The Justice Reinvestment team within the Governor's Office of Crime Prevention and Policy, in collaboration with the Maryland Judiciary, is leading efforts to improve Maryland's pretrial system.
- The Justice Reinvestment Oversight Board is helping oversee these efforts to ensure accountability and progress.
- Six workgroups have been created to address various aspects of the pretrial process, including (1) standardization of pretrial terms and levels of supervision, (2) legalization and local rules, (3) detainers and information sharing, (4) private home detention and electronic monitoring, (5) risk assessments and validation, and (6) data collection and analysis.
- Workgroup chairs provide bimonthly updates to the Assistant Director of Justice Reinvestment.

Judicial Hearings and Proceedings

- Limited awareness of local resources among visiting judges can impact the connection of individuals to appropriate services.
- For court diversion programs to be effective, the behavioral health system infrastructure must be adequately prepared to receive and support individuals who are diverted from the court process.

- Transportation to treatment is needed for individuals who are not under an HG §8-507 court-ordered commitment.

Competency Evaluations

Individuals who are deemed incompetent to stand trial and found to pose a danger to themselves or others are court-ordered to the Maryland Department of Health (MDH) for competency restoration services. MDH is legally required to admit these individuals within 10 days of the court order; however, this standard is rarely met. As a result, individuals often remain in local detention facilities far beyond this period without appropriate treatment, leading to worsening mental health and delays in the legal process. This delay is largely driven by gaps in the continuum of care that create system bottlenecks, resulting in a lengthy waiting list for state hospital beds that exceeds current capacity to meet demand.

Assisted Outpatient Treatment

Final regulations for AOT have not yet been established, creating uncertainty regarding program parameters, eligibility criteria, and implementation processes. Key stakeholders have expressed a need to be well-informed about the goals of AOT in Maryland and the ongoing implementation efforts. They also emphasize the importance of receiving clear guidance on AOT provisions and their specific roles in executing the programs.

Opportunities:

- Develop and implement a strategy to increase visiting judges' awareness of local resources. This could include maintaining an up-to-date resource list, creating a "bend card" or quick-reference guide, and providing briefings prior to visits.
- **Competency Evaluations**: Expand inpatient treatment resources and streamline processes within the MDH to ensure timely admission for court-ordered competency restoration services. Improving coordination between MDH and local detention facilities can help reduce delays, prevent deterioration, and uphold individuals' legal and health rights.
    - Stakeholders have also highlighted the importance of exploring alternative tracks to traditional competency restoration, such as providing supportive services while individuals await placement or diverting appropriate cases to community-based systems of care.
    - Invest in comprehensive wraparound supports, such as case management, housing, and behavioral health care, to ensure community-based alternatives are effective, sustainable, and capable of meeting the complex needs of individuals found incompetent to stand trial.

- **<u>Assisted Outpatient Treatment</u>**: Local Behavioral Health Authorities (LBHAs) across the state maintain regular communication with the Behavioral Health Administration and are actively involved in the phased rollout of AOT. Stakeholders can connect with their LBHAs to access up-to-date information on AOT planning and regulatory developments and support local coordination and collaborative planning efforts.

Problem-Solving Courts

- While drug courts are more commonly established across jurisdictions, mental health courts and mental health-focused specialty dockets remain less prevalent. This limits options for individuals whose primary needs relate to mental health.
- Many individuals involved in the justice system present with co-occurring mental health and substance use disorders.
    - However, existing problem-solving courts are not always equipped to address dual conditions through integrated treatment approaches.
    - In addition, eligibility criteria for many problem-solving courts often exclude individuals with complex needs or those assessed as “high risk”, even though these populations may benefit most from treatment-based interventions.
- Individuals are generally not permitted to participate in problem-solving courts outside of the jurisdiction where their charges originate, restricting opportunities for those whose home jurisdictions lack such programs.
- The time dedicated to each participant in a problem-solving court is significant, making the process resource- and time-intensive for both the court and treatment providers.

Opportunity: Utilize existing regional problem-solving courts as models to explore and expand cross-jurisdictional participation. Examples such as Frederick and Washington and Frederick County Regional Veterans Treatment Court and Central Maryland Regional Veterans Treatment Court offer valuable insights into collaborative approaches that enhance access and resource sharing across jurisdictions.

Health Services in Detention

- Dedicated mental health units are not available in all detention facilities, limiting access to appropriate care for individuals with behavioral health needs.
- In the absence of appropriate mental health resources, some jurisdictions place individuals with behavioral health needs in segregation or solitary confinement. This practice can exacerbate mental health symptoms and does not provide appropriate therapeutic support.

- Stakeholders report the need for establishing dedicated specialty units across all jurisdictions to ensure that individuals with serious mental illness or co-occurring substance use disorders receive timely, specialized, and evidence-based care.
- There is significant variability in the consistent administration of prescribed medications, particularly when individuals are transferred between hospitals and detention facilities. These transitions often result in delays, changes, or discontinuation of critical medications, leading to worsening symptoms and increased risks to both the individual and facility safety.
- Section 9-603 of the Correctional Services Article was enacted without a designated appropriation in the State budget, requiring local jurisdictions to absorb the costs associated with implementation.
    - Many detention facilities face ongoing significant fiscal constraints that make it difficult to establish and maintain comprehensive medication-assisted treatment programs.
    - These financial limitations hinder facilities' ability to expand services, particularly for certain medications for opioid use disorder that are more costly, resulting in inconsistent access to care and inequitable treatment outcomes across facilities.
    - Several detention facilities have significant numbers of individuals receiving medications for opioid use disorder, but do not offer accompanying therapeutic or group counseling programs.
- Diversion of medications remains a widespread concern across the state, and stakeholders highlighted that the delivery of medications for opioid use disorder within detention facilities presents significant logistical and security challenges.
- Lengthy waitlists for programs (e.g., substance use treatment) in some jurisdictions create significant delays in accessing necessary care. Limited staffing capacity and reliance on contractual staff, along with other resource constraints, contribute to wait times and restrict timely program entry.
- Stakeholders report a need to expand access to individual therapy in detention facilities, as current programming relies heavily on group-based treatment.
- Maryland law currently does not permit competency restoration programs to be provided within jail settings. Individuals found incompetent to stand trial must therefore be transferred to a facility designated by MDH to receive restoration treatment. This statutory structure places full reliance on the availability of competency placements and limits alternative pathways for timely access to care. As a result, individuals may remain in jail settings that are not designed to provide therapeutic psychiatric treatment, which can negatively affect mental health stability and impede progress toward competency restoration.

- Juveniles transferred to adult detention facilities receive minimal behavioral health and rehabilitative support. This lack of specialized services places these vulnerable youth at increased risk for adverse outcomes and does not address their developmental needs.
- When an individual is incarcerated, their benefits, such as health insurance and public assistance, are typically suspended or deactivated, creating significant barriers to accessing care and services upon release; these challenges will be discussed further in the Gaps and Opportunities section of Intercepts 4-5.

Opportunities:

- Expand the use of peer support services to complement medication-based treatments.
- Connect with local behavioral health authorities to explore funding options for areas of need, such as support for MAT programs.
- Create cross-system care coordination procedures between hospitals, detention facilities, and community providers to ensure continuity of care during transitions.
- Utilize dedicated reentry coordinators to assist with pre-release mental health and substance use treatment planning.
- Develop and implement specialized behavioral health and rehabilitative programs tailored specifically for juveniles housed in adult detention facilities.

Peer Support Services

- Peer support specialists and peer professionals are not integrated into behavioral health and rehabilitative services within detention facilities and court-related settings across all jurisdictions. This limits the availability of lived-experience support that can enhance engagement, improve treatment outcomes, and facilitate smoother transitions through the justice system.

Opportunities:

- Integrate peer support specialists throughout the justice system to enhance behavioral health services by improving engagement, providing essential advocacy, and supporting individuals at each stage of their justice involvement.
- Partner with organizations such as the National Alliance on Mental Illness (NAMI) Maryland to expand access to trained mental health peers, enhancing and complementing existing SUD-focused services.
- Leverage local behavioral health authorities to expand peer support services within detention and justice system settings, enhancing holistic care and community reintegration.

Family Support Services

- Families are frequently left out of the incarceration process and not considered in system planning or communication. As a result, they are often without the resources, support, and guidance needed to navigate their loved one's incarceration.

Opportunity: Jurisdictions can enhance family support services by partnering with organizations such as the Maryland Coalition of Families, NAMI Maryland, and Family Justice Centers to identify strategic opportunities for embedding these supports at key points within the system.

Training & Workforce

- Some jurisdictions lack the funding or capacity to provide regular in-service Crisis Intervention Team (CIT) training for correctional officers.
- Mental Health First Aid (MHFA) is often offered without refresher training, limiting its long-term effectiveness.
- High staff turnover disrupts continuity in behavioral health practices.
- Lack of coordination in onboarding and ongoing training contributes to inconsistent responses across systems.

Opportunities:

- Facilitate access to local training programs for correctional officers and staff from neighboring jurisdictions to maximize resource efficiency.
- Promote participation in refresher training for programs such as Mental Health First Aid (MHFA) and Crisis Intervention Team (CIT) training to ensure skills remain current and effective.
- Develop collaborative training programs that bring together law enforcement, correctional personnel, and behavioral health providers to foster shared understanding, improve communication, and enhance coordinated responses to individuals with behavioral health needs.
    - Leverage the newly-formed Interdisciplinary Education Workgroup within the Statewide Steering Committee on Behavioral Health and the Justice System.
- Consider longevity and staff turnover throughout implementation and process development to ensure sustained effectiveness and continuity of programs.

Data Systems & Interagency Collaboration

- Data sharing limitations impact early coordination between behavioral health and criminal legal systems.
- Stakeholders report that DataLink functions as a flat platform, primarily indicating whether individuals were seen or not, and is not user-friendly. In contrast, CRISP was viewed as more clinically oriented and user-friendly, leading some to suggest that its use be revisited statewide, though with the important consideration that its effectiveness depends on consistent use by all relevant parties.
- Using both CRISP and DataLink can result in duplicated efforts, causing inefficiencies and confusion among providers and system partners.
- Silos between behavioral health, public safety, and the courts limit coordination and reduce the overall effectiveness of cross-system responses.
- HIPAA compliance concerns, misidentification, and inconsistent naming conventions create significant barriers to accurate and timely information sharing.
- Challenges in tracking individuals post-release hinder continuity of care and follow-up support, particularly for those with behavioral health needs.
- Limited collaboration with the judicial system hinders the development of coordinated care plans, delays case resolution, and reduces the effectiveness of cross-system interventions for individuals with behavioral health needs.

Opportunities:

- Reevaluate data-sharing platforms, such as DataLinka and CRISP, to determine which best meets the needs of all stakeholders, ensuring the selected tool effectively supports behavioral health and justice system goals.
- Standardize the use of a single data-sharing platform across agencies and systems to streamline communication, reduce duplication of efforts, and enhance coordination of care for individuals involved in the justice system.
- Formalize cooperative data-sharing practices across agencies.
- Develop comprehensive, jurisdiction-specific cross-system resource guides for distribution to providers, system partners, and courts.
- Leverage the Statewide Steering Committee on Behavioral Health and the Justice System and forthcoming workgroups emerging from the Maryland Judiciary's State Summit on Behavioral Health (May 2025) to strengthen collaboration with the judiciary and promote consistent access to information statewide.

Advisory Bodies & Governance

- Redundancy among advisory bodies and duplication of efforts across the state contribute to inefficiencies, fragmented communication, and a lack of coordinated strategy in addressing behavioral health and criminal legal system challenges.

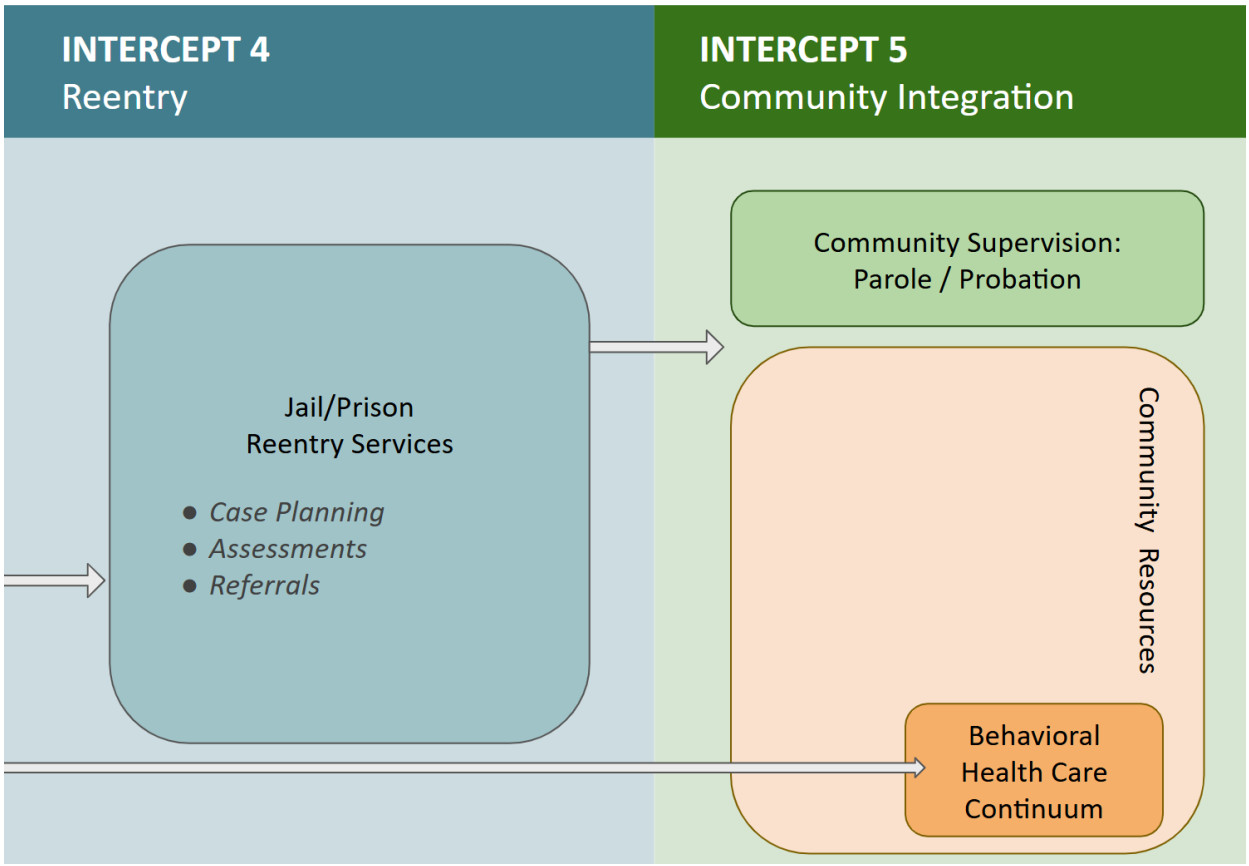
Opportunities:

- Evaluate the purposes, goals, and membership of existing advisory bodies to identify areas of overlap, streamline efforts, and promote coordinated strategy development;
- Consolidate groups with similar objectives and expand participation to include all relevant stakeholders, ensuring inclusive representation and consistent information-sharing across systems.
- Collaborate with the Maryland Equitable Justice Collaborative to expand advocacy efforts and align local initiatives with statewide priorities.
- Leverage local workgroups, such as Criminal Justice Coordinating Councils, for information sharing, coordination, and the exchange of best practices across jurisdictions.

PRIORITIES		
1.	Expand housing options to better serve both general and specialized populations, including residential rehabilitation programs, housing for individuals with mental health diagnoses and/or intellectual and developmental disabilities, and services specifically tailored for females with substance use disorders.	26 votes
2.	Develop strategies to address lapses in insurance coverage during incarceration, ensuring continuous access to healthcare and treatment services upon release.	24 votes
3.	Explore and develop community-based outpatient competency restoration options to address the growing number of individuals awaiting competency restoration in local detention centers.	20 votes
4.	Strengthen cross-sector collaboration by promoting the sharing of information and resources to enhance coordination and improve service delivery.	13 votes
5.	Increase funding dedicated to rural areas to enhance access to services, improve infrastructure, and address the unique challenges faced by these communities.	10 votes

6.	Enhance pretrial services statewide by improving assessment tools, streamlining referral processes, and strengthening enforceability.	10 votes
7.	Identify and implement robust screening and assessment tools that accurately evaluate individual needs and match individuals with appropriate treatment services.	7 votes
8.	Offer more training for correctional officers, including ongoing refresher courses, to enhance their skills in managing behavioral health issues and improving interactions with individuals in custody.	4 votes
9.	Standardize data collection and sharing tools to better serve both providers and users by improving user-friendliness and ensuring that platforms offer the level of detail and functionality for effective use.	3 votes
10.	Increase education and awareness initiatives aimed at reducing stigma, promoting understanding, and fostering compassion toward individuals affected by behavioral health challenges and involvement in the criminal legal system.	2 votes

INTERCEPTS 4-5

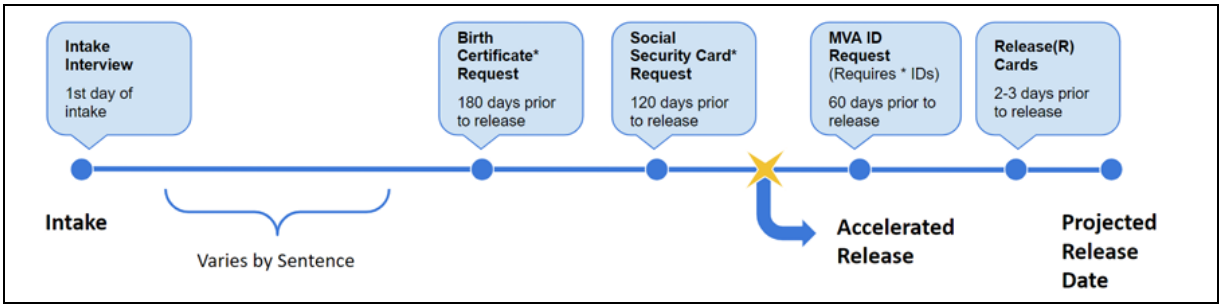


RESOURCES

Corrections Reentry Services

Services and Referrals

- Statewide, reentry coordination begins several months before scheduled release when possible, aiming to prepare individuals for successful reintegration.
- Partnerships between state agencies have improved the processes for obtaining vital documents for incarcerated individuals.
    - Chapter 514 of the Acts of the 2020 Maryland General Assembly enacted Senate Bill 77, which revised several statutes concerning the provision of identification documents by the Department of Public Safety and Correctional Services (DPSCS) upon release.
    - The timeline for obtaining release documents as illustrated by DPSCS is outlined on the following page:



- Release envelopes serve as an incarcerated person's consolidated repository for release documents, personal identification, informational bulletins, and applications for social services, voter registration, and re-entry resources.
- Release cards ("R-cards"), official DOC-issued photographic identification (ID) cards, are provided shortly before release; R-cards are valid for 45 days, and are considered an acceptable secondary form of ID per the Maryland Motor Vehicle Administration.
- Certified copies of birth certificates are issued by the Maryland Division of Vital Records or the relevant local jurisdictions for individuals born out of state. Since 2008, DPSCS has submitted batch requests for all incarcerated individuals intending to reside in Maryland, absorbing the application fee and assisting with the process.
- Social Security number (SSN) cards are not considered a primary form of ID; however, SSN cards assist in preparing employment documents. DPSCS can request replacement SSN cards, with individuals' permission, when they are within 120 days of release or participating in pre-release programs.
- Maryland Motor Vehicle (MVA) ID cards may be collected at intake or secured by family members. In 2021, DPSCS formalized an agreement with the MVA to streamline document transfers and ensure DPSCS-issued documentation meets MVA standards. Incarcerated individuals with an official birth certificate and SSN card are eligible to request an MVA ID card within 60 days of release. Those who are released earlier or are unable to obtain an ID before their release may present an R-card along with other identifying information to receive a waived fee for an MVA ID card within 60 days of release.
- Reentry specialists conduct assessments to create personalized reentry service plans, identifying immediate post-release needs such as services, referrals, and support.
    - Services include assistance with obtaining vital documents, reactivating health insurance, accessing public benefits (e.g., Supplemental Security Income, Veterans Affairs services), and coordinating referrals for health care and other basic needs.

- Reentry needs vary across settings, and partners share a commitment to identifying local reentry services throughout Maryland. Reportedly, clear lines of communication exist between state-level partners to improve service delivery.

Supervision

- The Division of Parole and Probation (DPP) within DPSCS has launched initiatives to improve supervision of individuals with behavioral health needs.
    - While the Maryland Correctional Training Commission requires that mandated parole and probation staff complete 18 hours of annual in-service training to maintain certification, DPP leadership requires mandated staff to complete 40 hours of Commission-approved in-service training annually, which includes modules on de-escalation and behavioral health.
    - Social workers are now embedded within DPP operations to assist agents in connecting individuals with necessary services and resources.
    - Agents provide referrals to community resources and apply graduated sanctions when permitted by the court, aiming for successful termination of supervision.
- Institutional staff and parole/probation officers may use the Interstate Compact Offender Tracking System (ICOTS) to transfer supervised individuals between states.
- Maryland operates successful work release programs, which have shown evidence of improving post-release employment outcomes and reducing recidivism.
- In Maryland, agents supervise both parolees and probationers, ensuring consistent resource allocation across both groups.
- Specialized caseloads allow for tailored supervision to address the specific needs of different populations. These caseloads include COMET (Collaborative Offender Management/Enforced Treatment for sexual offenders), domestic violence, DDMP (Drinking Driver Monitor Program), interstate, drug-related offenses, pretrial services investigation, and individuals under 30 assigned to the violence prevention initiative.

Community Reentry Services

- Community growth requires a dynamic network of resources. New partnerships have supported reentry services, but ongoing adaptability is necessary to meet evolving local needs.
- The one-stop shop model streamlines access to essential services, offering individuals under supervision direct access to care coordinators, peer support specialists, and representatives from key agencies (e.g., employment, housing, health care, and legal services).
    - Counties such as Prince George's, St. Mary's, and Anne Arundel operate one-stop shops to serve the reentry population.

Behavioral Health Services

- Various providers offer case management for reentry and recovery, assisting individuals with reintegration challenges.
- Some services identified within intercept 0 have the capacity to serve reentering individuals. Notably, certain providers are uniquely qualified depending on complexity, offense type, or history of trauma.

Professional Development

- The Maryland Department of Education Division of Rehabilitation Services (DORS) and the Maryland Department of Labor provide job training, coaching, resume writing assistance, job placement support, and education services (e.g., GED preparation) at several locations statewide.
- The Maryland Department of Labor launched the Maryland Reentry Navigator program, which relies on regional navigators to connect returning residents to employment opportunities, skill-building programs, credentialing resources, and other local reentry support services.
- Locally, nonprofit organizations (e.g., Justice Jobs, which has expanded its services from Frederick County to a statewide reach) and county workforce service entities play a key role in removing barriers to securing and sustaining employment.

Data Systems & Interagency Collaboration

- Local reentry advisory groups serve as collaborative forums that bring together stakeholders across multiple disciplines to develop shared strategies and recommendations that support justice-impacted individuals returning to the community.

GAPS AND OPPORTUNITIES

Corrections Reentry Services

Services and Referrals

- Reentry planning is often time-consuming and complex. The process of connecting individuals to essential services, such as benefits and housing, frequently involves lengthy and complicated application procedures.

Opportunity: Reentry practices vary across local correctional facilities, depending on factors such as staff structures, data management systems, and local partnerships. Rather than employing a one-size-fits-all approach, reentry efforts should leverage local strengths and

resources to address gaps effectively, tailoring strategies to the unique needs of each community.

- Dedicated reentry service staffing levels within detention centers are often limited, which hampers the effectiveness of these services.
- Although state-level partners have developed clear communication strategies, less efficient communication between state and local facilities impedes the implementation of reentry programs and strategies.
- Securing necessary documentation, such as a Social Security number (SSN) card, birth certificate, and state-issued photo ID, is a significant barrier for formerly incarcerated individuals, limiting their ability to access housing, employment, and government services.
    - The process of obtaining an SSN card is often delayed, complicating the ability to obtain other forms of ID, such as MVA-issued state ID, which requires both an official birth certificate and an SSN card.
    - DPSCS cannot initiate the SSN application process for individuals requiring corrections to their Social Security records, those needing a new SSN, non-citizens, or individuals who have used multiple SSNs. In these cases, the individual must handle the application after release.
    - Unplanned releases create additional challenges for ensuring that individuals have the necessary documentation upon release. Those released according to their scheduled release dates (e.g., parole, mandatory supervision) are more likely to have the required documents, compared to those released unexpectedly (e.g., court orders, administrative release, or after a revocation hearing).

Opportunity: States across the U.S. have implemented innovative strategies to improve access to state-issued IDs for formerly incarcerated individuals. The U.S. Department of Transportation's *Leading Practices Toolkit Concerning Government-Issued Identification for Formerly Incarcerated Individuals* offers examples of successful interagency collaborations, including DMV services offered within correctional facilities and mobile DMV units. Some of these models are locally run and even self-funded.

- Suspensions or terminations of health insurance during incarceration limit access to necessary health services both during confinement and post-release. The rules governing health coverage differ depending on the insurance type (e.g., private,[19] Health

[19] Incarcerated consumers may maintain their enrollment in private health insurance through the individual (non-group) market, outside of the Marketplace.

Insurance Marketplace ("Marketplace"[20]), Medicaid,[21] Children's Health Insurance Program (CHIP), Medicare[22]) and the individual's involvement within the criminal legal system. For more information, please refer to the Centers for Medicare and Medicaid Services' *Assisting Incarcerated and Recently Released Consumers* presentation at https://www.cms.gov/marketplace/technical-assistance-resources/assisting-incarcerated-and-recently-released-consumers.pdf.

Opportunities:

- Partnerships with local health departments can help ensure incarcerated individuals have access to necessary care and prevent gaps in health coverage during and after incarceration.
- Select jurisdictions have established programs that provide no-cost bridge medications, allowing individuals to maintain access to prescriptions immediately following their release, regardless of insurance status.
- Individuals are eligible to apply for Medicaid coverage at any time before, during, or after incarceration.

Ongoing Efforts to Improve Access to Benefits:

- The Maryland Department of Health has received approval from the Centers for Medicare and Medicaid Services (CMS) to offer targeted Medicaid services to incarcerated individuals with substance use disorders or serious mental illnesses up to 90 days before their release, starting July 1, 2025. Under an approved amendment to

[20] Incarcerated individuals are not eligible to enroll in a qualified health plan (QHP) through the Marketplace. However, individuals who are pre-conviction, post-conviction but under limited supervision or confinement, or on parole or probation, are not considered incarcerated and are eligible to enroll or remain enrolled in Marketplace coverage. Generally, individuals released from incarceration who meet other eligibility criteria for Marketplace coverage have up to 60 days from the date of their release to select a plan under a Special Enrollment Period (SEP).

[21] Generally, an individual detained in a local jail, state or federal prison, detention facility, or other involuntary confinement setting is considered an "inmate of a public institution" under Medicaid guidelines. This classification applies regardless of whether the individual is detained pending the disposition of charges or incarcerated following sentencing. Individuals who retain some degree of "freedom of movement," such as those on probation or parole, under home confinement, or residing in halfway houses under state or local government jurisdiction, are typically not considered inmates. Being an inmate does not automatically terminate Medicaid eligibility. Starting January 1, 2026, the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42) will prohibit states from terminating Medicaid eligibility for individuals classified as inmates of a public institution. However, states may continue to suspend Medicaid coverage for these individuals during their incarceration.

[22] Although Medicare generally does not reimburse costs during incarceration, consumers with Medicare Part A and Part B coverage should consider maintaining their coverage to ensure it remains active upon their release. For most consumers, Part A (hospital) coverage is free with no monthly premium. However, consumers will need to pay the monthly premium for Part B (outpatient) coverage to maintain it. If consumers lose their Part B coverage, they may face a coverage gap and will have to wait for the General Enrollment Period (January 1 -March 31) to re-enroll, with coverage taking effect on July 1. Additionally, individuals who experience a delay or lapse in enrolling Part B while eligible may incur premium penalties, which can increase their future Medicare costs.

the HealthChoice §1115 waiver, Medicaid will provide pre-release services in state prisons and state-run detention facilities in Baltimore. These services will include comprehensive case management and medication-assisted treatment for substance use disorders (when appropriate); counseling and prescribed medications are also offered for up to 30 days post-release.

- Unplanned releases disrupt the coordination of somatic and behavioral health care services, making it difficult to ensure continuity of care. This interruption increases the risk of relapse and raises the likelihood of reincarceration.

Opportunities:

- Initiating reentry planning at intake can help prepare individuals for release at the earliest possible opportunity, ensuring smoother transitions and reducing the impact of unplanned releases.
- Targeted case management (TCM) can address many of the challenges posed by unplanned releases, particularly given its broad eligibility criteria. Individuals can self-refer or be referred by non-professionals, such as family members, and TCM services can follow participants for several years, providing ongoing support and continuity.

Supervision

- Although there is some enhanced training for mandated staff within the Division of Parole and Probation (DPP), there is a need for broader, trauma-informed education for both DPP staff and community-based reentry service providers.

Opportunity: The GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA), annually solicits applications from communities, agencies, and organizations interested in developing a cadre of trauma-informed professionals who support adults involved in the criminal or civil legal systems. These free events teach local trainers to deliver the GAINS Center's "How Being Trauma-Informed Improves Criminal Justice System Responses" curriculum.

- Specialized supervision caseloads fail to account for the unique needs of vulnerable populations, such as emerging adults (ages 18-24), who face higher recidivism risks and require targeted interventions. Additionally, youth charged as adults face even more complex and specialized needs during reentry.

- Coordination between the judiciary, correctional reentry services, community-based programs, and parole/probation agencies is often insufficient, leading to gaps in reintegration strategies.
    - Community partners must expand outreach and awareness efforts to engage agents who can provide referrals and ensure effective use of available resources.
    - Without access to reentry plans, parole and probation agents are unable to review release plans and medical records to support supervisees.

Opportunities:

- Courts can enhance continuity of care by imposing special conditions on release that empower supervision agents to verify adherence to reentry plans. This can improve collaboration and accountability across agencies.
- Providing education on the role of parole and probation agents in §8-507 commitments, and offering clear guidance on responding to decompensating problem-solving court participants, can create immediate alignment across sectors and strengthen continuity of care.
- Regular multidisciplinary meetings that involve the individual and all relevant parties can enhance coordination of services and support.

- Legal counsel is not permitted to accompany clients to supervision intake appointments, and there is inconsistent family engagement in the reentry planning process. This creates barriers, particularly when individuals struggle to understand complex legal language or supervision conditions, leading to unintentional violations.

Opportunity: Peers can play a crucial role in bridging this gap by helping clients understand their supervision conditions. Additionally, pre-parole investigations that involve family members in explaining conditions and incorporating them into the reentry process can promote stability and reduce violations.

Community Reentry Services

- Without centralized communication methods, community-based reentry organizations often lack regular updates from coordinating entities and partner agencies regarding collaborative efforts, resource alignment, and new developments. This impedes collaboration and can foster a competitive mindset when securing limited funding.

Opportunities:

- Creating a shared communication platform for key community partners can facilitate stronger collaborations, reducing competition and promoting resource-sharing. Many grant programs prioritize or award additional points for projects that demonstrate collaborative partnerships. This can foster long-term strategic planning and cross-sector alignment.
- Reentry partners can leverage local 211 Maryland (211) call centers to create or access digital directories that are updated in real time and regularly reviewed.

Behavioral Health Services

- As discussed in the Gaps and Opportunities section of Intercepts 0-1, shortages in the behavioral health workforce, especially peers embedded in this sphere, limit timely access to evidence-based, culturally competent care.
- Individuals convicted of sexual offenses face significant barriers to accessing treatment, largely due to a lack of trained professionals willing to work with this population.

Opportunity: The Maryland Sexual Offender Advisory Board (MSOAB) has recommended the development of a statewide plan to identify and train professionals capable of delivering specialized care for this population. The MSOAB's *2021 Report to the Maryland General Assembly* outlines these critical recommendations.

- As noted in the "Corrections Reentry Services" section, individuals released on probation who are still receiving treatment often face disruptions in health insurance coverage, complicating access to necessary services.
- Inconsistent availability of community-based wraparound services across the state leaves many individuals without adequate access to case management support, which is crucial for successful reentry.

Professional Development

- Navigating employment resources is often complicated by varying eligibility requirements, which are typically tied to specific funding sources, making it difficult for individuals to access needed services.
- Budget reductions have limited the availability of Workforce Innovation and Opportunity Act (WIOA) services administered across the state, which impacts individuals' ability to access workforce development programs.

- Efforts to identify and foster recovery-friendly or second-chance-friendly workplaces remain fragmented, creating siloed information and missed opportunities for individuals seeking employment post-incarceration.

Housing

- A statewide shortage of adequate, affordable permanent housing disproportionately affects formerly incarcerated individuals, creating a significant barrier to successful reentry.
- While securing housing is a universal need for reentry individuals, the emphasis on high-risk individuals (e.g., those with serious mental illness or active addiction) creates a gap in available housing for lower-risk individuals.
    - Placing low-risk individuals in more structured programs can lead to higher failure rates, as it disrupts pro-social networks, increases exposure to higher-risk individuals, and focuses on non-criminogenic needs instead of criminogenic ones.
- The limited availability of transitional housing increases reliance on informal living arrangements, further exacerbating instability during the critical reentry period.
- Individuals in recovery face a shortage of recovery residences, and the high costs associated with sober living facilities further limit housing options. Reportedly, problem-solving court participants are particularly impacted by this gap.
- Individuals with sexual offense convictions encounter additional housing barriers due to exclusion zones and restrictive regulations imposed by landlords, housing authorities, and programs, severely limiting their options. Similarly, individuals with arson convictions have historically been denied access to housing.

Opportunity: Proposed legislation, such as Maryland's Fair Chance in Housing Act ("Act"), presents a promising opportunity to reduce housing barriers for individuals with criminal histories. The Act aims to reform the tenant screening process by prohibiting criminal history inquiries on initial rental applications, allowing them only after a conditional offer is made. Other provisions include a shortened look-back period for arson convictions, mandatory individualized assessments for recent arson cases before rescinding offers, and a structured appeals process for applicants. Although the bill stalled in committee without a vote in 2025, supporters plan to reintroduce it in the next legislative session.

- A lack of housing options for individuals without support post-release, particularly those involved in domestic incidents, contributes to a cycle of reincarceration. Individuals released on personal recognizance after an alleged domestic assault, who cannot return home, are often forced to find short-notice housing or shelter. Some of these individuals

are not stable, but do not meet the criteria for involuntary psychiatric care, and may cycle through the system without adequate support.

Transportation

- Persistent transportation barriers further complicate access to treatment, support services, and employment, creating a feedback loop that limits opportunities for successful reentry and reintegration into the community.

Data Systems & Interagency Collaboration

- While rearrest is the most commonly used and observable measure of recidivism, it does not fully capture the success of an individual's reintegration or ongoing needs.

Opportunity: Expanding the use of measures that assess pro-social activity (e.g., civic engagement, self-control, and employment stability) could provide a more comprehensive understanding of individual well-being. These measures would help identify areas where additional support is needed and offer a better gauge of successful reintegration.

Peer Support Services

- In addition to the needs discussed in the Gaps and Opportunities section of Intercepts 0-1, there is a demand for greater education on the appropriate integration of peer support across the different stages of the reentry continuum. Peer roles are not interchangeable, as each reflects distinct lived experiences, even though the populations they serve often overlap.

Opportunity: Effective peer integration requires tailored approaches to the diverse roles and settings in which peers work. Behavioral health peers provide vital community support, particularly for people in early recovery, while forensic peers offer insights shaped by their legal-system involvement. Justice-impacted individuals with behavioral health needs benefit from the forensic peers in long-term recovery who understand and can support the intersection of these experiences. Jurisdictions looking to expand peer support into parole and probation can draw on the National Council for Wellbeing's *Peer Support Services and Community Supervision Examples*, which outline successful models for incorporating peer recovery support into community supervision.

PRIORITIES		
1.	Enhance communication and collaboration with key stakeholders.	24 votes

2.	Secure guidance from the Office of the Attorney General on information sharing to ensure consistent, compliant, and effective data exchange across agencies.	24 votes
3.	Improve accessibility and support for special populations in reentry, including exploring Medicaid enhancements to expand health care access and continuity of care.	18 votes
4.	Develop a statewide community of practice for reentry to share best practices, foster innovation, and promote cross-agency learning and collaboration.	7 votes
5.	Expand funding and access to vital records for individuals involved in corrections and probation.	6 votes
6.	Enhance collaboration with the Social Security Administration to ensure timely access to SSN cards and benefits, supporting employment and reintegration.	3 votes

PRIORITIES ACROSS INTERCEPTS

Based on a voting process on day two of the Summit, focus groups identified topics that were most important to them. Following the voting process, the Centers of Excellence summarized priorities into a comprehensive chart (*as illustrated below*). Some priorities were mentioned across all intercepts and thus highlighted in an additional category.

Intercepts 0-1	Intercepts 2-3	Intercepts 4-5	Across Intercepts
Establish a statewide standard for basic crisis services and prioritize sustainable funding to develop, maintain, and expand crisis services. (28)	Expand housing options to better serve both general and specialized populations. (26)	Enhance communication and collaboration with key stakeholders. (24)	Strengthen communication, coordination, and collaboration across sectors. (64)
Enhance care coordination between and among law enforcement and providers. (27)	Develop strategies to address lapses in insurance coverage during incarceration. (24)	Secure guidance from the Office of the Attorney General on information sharing. (24)	Secure sustainable funding for essential programming. (29)
Support the integration of 988 and 911 services. (24)	Explore and develop community-based outpatient competency restoration options. (20)	Improve accessibility and support for special populations in reentry. (18)	Develop processes to ensure timely access to benefits in spite of coverage lapses. (27)
Evaluate and improve the emergency petition process. (20)	Strengthen cross-sector collaboration by promoting the sharing of information and resources. (13)	Develop a statewide community of practice for reentry. (7)	
Conduct a review of all regulatory bodies involved in addressing state workforce shortages. (7)	Increase funding dedicated to rural areas for services and infrastructure. (10)	Expand funding and access to vital records for individuals involved in corrections and probation. (6)	

Assess core funding for crisis services. (6)	Enhance pretrial services statewide. (10)	Enhance collaboration with the Social Security Administration to ensure timely access to SSN cards and benefits. (3)	Promote community-wide education to reduce stigma and enhance understanding of behavioral health and justice-related issues. (8)
Expand community health education and outreach. (6)	Identify and implement robust screening and assessment tools. (7)		
Enhance service accessibility across the lifespan. (4)	Offer more behavioral health training for correctional officers, including ongoing refresher courses. (4)		
Revise the criteria for involuntary treatment by clearly defining the dangerousness standard. (2)	Standardize data collection and sharing tools to better serve both providers and users. (3)		
	Increase education and awareness initiatives aimed at reducing stigma associated with behavioral health and/or justice involvement. (2)		

Strengthen Communication, Coordination, and Collaboration Across Sectors

Across all focus rooms, participants emphasized that stronger communication, coordination, and collaboration across sectors are essential to building a more effective and responsive crisis system. While substantial efforts are currently underway within intercepts 0-1 to expand community-based services and strengthen pre-arrest diversion options, participants acknowledged that some individuals will inevitably progress further into the system. This reality underscores the critical need for enhanced coordination and information-sharing with partners further along the criminal legal system, specifically the courts and local detention centers, as well as with reentry services on the other side of the process that support individuals returning to the community.

Stakeholders discussed the challenges that arise when individuals transition between facilities or systems, such as disruptions in access to prescribed medications. For example, defendants

who received morning doses before court often missed their later scheduled medications due to legal constraints that prevent the transfer of medication outside of a facility. These gaps in continuity of care highlight the importance of developing clearer communication protocols and collaborative solutions between correctional health providers, law enforcement, and the courts.

In addition, participants identified the integration of 988 and 911 systems as a priority to strengthen crisis response coordination and ensure that individuals in crisis are connected to the right level of care at the right time. Enhancing collaboration with the judiciary was also seen as a key opportunity. By providing judges and court staff with comprehensive, up-to-date information about available community resources, the system can better support informed decision-making and expand the range of diversion and treatment options available.

Ultimately, participants agreed that effective cross-sector collaboration, grounded in shared information, consistent communication, and a unified vision, will help ensure continuity of care across all intercepts. This approach not only reduces service gaps and duplication but also promotes a more connected system where individuals receive appropriate support no matter where they enter or exit the continuum of care.

Secure Sustainable Funding for Essential Programming

Participants across all focus rooms identified sustainable funding as a foundational need for building and maintaining an effective continuum of care. While many promising initiatives have been launched across intercepts, particularly in crisis response, reentry, and community-based service delivery, stakeholders emphasized that these efforts cannot be sustained or scaled without stable, long-term financial support. Short-term grants and fragmented funding streams have led to service gaps, workforce instability, and inconsistent availability of critical resources, particularly in rural and underserved communities.

A major priority was the need to assess and secure core funding for crisis services, ensuring that essential components such as mobile crisis teams, crisis stabilization units, and 24/7 call centers are consistently available statewide. Participants also highlighted the importance of dedicated funding for rural areas, where infrastructure limitations, workforce shortages, and geographic barriers make it difficult to establish and sustain comparable levels of service. Investing in transportation, telehealth capacity, and cross-county partnerships was identified as crucial to improving access and equity in these regions.

Sustainable funding was also viewed as a key driver of successful reentry. Stakeholders noted the need to expand and streamline funding for reentry programming to maintain a statewide community of practice that supports coordination, peer learning, and consistency in service delivery.

Overall, participants agreed that achieving meaningful systems change depends on the establishment of reliable, sustainable funding mechanisms that go beyond short-term or categorical funding cycles. A coordinated state-level approach to financing essential programming, rooted in equity and continuity across intercepts, will ensure that services remain available, integrated, and responsive to community needs over time.

Develop Processes to Ensure Timely Access to Benefits in Spite of Coverage Lapses

Across multiple focus groups, participants emphasized that disruptions in insurance coverage and delays in securing essential benefits create significant barriers to continuity of care and successful reentry. In Maryland, Medicaid is suspended rather than terminated during incarceration, which in theory should support quicker reinstatement. However, stakeholders in the intercepts 2-3 focus group noted that suspension does not prevent practical gaps: individuals frequently leave detention without active or fully reinstated insurance, limiting immediate access to medications, behavioral health services, and follow-up appointments. Participants also highlighted that although Maryland regulation (COMAR 10.09.79) allows correctional facilities to conduct presumptive eligibility determinations before release, these processes are not used consistently across facilities. Variation in staffing, training, and workflow prevents many individuals from benefiting from available mechanisms intended to reduce lapses.

These gaps were further reflected in conversations in the intercepts 4-5 focus group, where stakeholders described persistent delays in obtaining Social Security documentation and reinstating federal benefits. The Maryland Department of Public Safety and Correctional Services maintains an MOU with the Social Security Administration (SSA) to help individuals obtain Social Security number (SSN) cards before release, yet participants noted that processing delays, appointment bottlenecks, and limited SSA capacity continue to impede timely access. Without SSN cards, individuals struggle to complete Medicaid applications, obtain MVA-issued state ID, or access income supports, which in turn delays housing placements, employment opportunities, and eligibility for treatment programs that require benefit verification. Although the Centers for Medicare and Medicaid Services waiver allows Medicaid-funded pre-release services for certain populations, participants stressed that implementation is uneven, and many individuals fall outside the target groups or are released without having fully completed the necessary steps.

Together, these barriers create a cascade of challenges that undermine stabilization at every intercept. Coverage lapses delay medical and behavioral health care at moments of acute

vulnerability, while delays in securing Social Security documentation prolong periods of housing and income instability. Participants across rooms agreed that successful transition and long-term recovery will remain difficult when benefit processes break down. They emphasized that progress depends on stronger and more consistent coordination among correctional facilities, Maryland Medicaid, and the Social Security Administration, along with improved staffing and clearer procedures for activating or reinstating benefits before release.

Promote Community-wide Education to Reduce Stigma and Enhance Understanding of Behavioral Health and Justice-Related Issues

Community-wide education is essential to reducing stigma, improving engagement with services, and strengthening support for individuals with behavioral health needs who encounter the justice system. Stakeholders from the intercepts 0-1 focus group highlighted the need to expand community health education and outreach efforts to increase understanding of behavioral health conditions, available supports, and the systemic barriers that individuals often face. They noted that many community members, frontline providers, and local partners lack clear information about how behavioral health challenges intersect with crisis response and early points of system contact. This lack of understanding can contribute to stigma, reinforce misconceptions about risk and dangerousness, and limit the willingness of community members to support diversion and treatment-focused strategies.

Discussions in the intercepts 2-3 focus group further underscored the importance of targeted education and awareness initiatives designed specifically to reduce stigma surrounding both behavioral health conditions and justice involvement. Participants described how deeply rooted stigma can shape decisions at early judicial stages, influence perceptions of individuals appearing in court or detention settings, and affect the willingness of agencies to collaborate. They emphasized that without intentional, consistent education efforts, providers and policymakers may continue to underestimate the impact of trauma, housing instability, and health inequities on the populations they serve.

Across the state, these challenges are compounded by Maryland's diverse geography. Participants from rural jurisdictions emphasized that limited service capacity and fewer behavioral health providers often intersect with heightened stigma, making it more difficult for individuals to seek help or for counties to introduce new treatment or housing options. Many jurisdictions reported encountering a persistent "Not in My Backyard" attitude, in which community members oppose the placement of behavioral health programs, treatment facilities, or supportive housing in their neighborhoods. Stakeholders noted that while residents may acknowledge the importance of these services in principle, they often resist seeing the realities

of behavioral health needs within their own communities, which reinforces isolation, fuels misunderstanding, and limits opportunities to expand essential services.

Together, contributions across rooms point to a statewide need for coordinated, ongoing educational campaigns that reach multiple audiences, including community members, law enforcement, court personnel, local leaders, and partner organizations. Participants stressed that improving understanding not only reduces stigma but also builds a shared foundation for more compassionate, effective, and evidence-informed responses across the sequential intercept model.

RECOMMENDATIONS

The 2025 Summit reaffirmed several core principles that have emerged from ongoing discussions on behavioral health and criminal legal system reform. To build on these foundational priorities, the following recommendations offer clear, actionable steps to advance systemic change, with a focus on collaboration, sustainability, and service accessibility.

1. **Promote Community-Wide Efforts to Combat Stigma**
   Ongoing, coordinated education and outreach campaigns must be implemented to reduce the stigma associated with both behavioral health needs and justice system involvement. These efforts should target community members, frontline providers, law enforcement, and policymakers to increase understanding of behavioral health challenges and the importance of diversion and treatment services. Special attention should be given to rural communities where stigma is often more entrenched. Efforts should emphasize social contact, inclusive partnerships, and co-leadership by people with lived experience.

2. **Strengthen Cross-Sector Communication and Data Sharing**
   Establish formalized mechanisms for real-time data sharing and coordinated communication between law enforcement, courts, behavioral health providers, and corrections. Clear protocols should be developed to facilitate timely information exchange, ensuring individuals receive the appropriate level of care at each intercept.

3. **Establish Statewide Standards for Crisis Services**
   Develop and implement uniform standards for basic crisis services across the state, ensuring that residents in every jurisdiction have 24/7 access to someone to contact, someone to respond, and a safe place for help. These services must be adequately funded and tailored to local needs, particularly in underserved rural areas.

4. **Secure Sustainable, Long-Term Funding**
   Core funding for crisis services and dedicated resources for rural areas and reentry services must be secured through state-level policy reforms and funding mechanisms. This includes supporting telehealth infrastructure, expanding community health education, and ensuring financial support for rural jurisdictions that face unique service delivery challenges.

5. **Standardize Screening and Assessment at Initial Points of Contact**
   Develop and mandate the use of standardized screening and assessment tools at all points of entry into the justice system to assess behavioral health needs and inform treatment plans. These tools should be designed to quickly connect individuals to appropriate services and diversion options.

6. **Standardize and Enhance Pretrial Services**
   Establish a statewide framework for pretrial services, including standardized language and uniform guidelines for risk assessment, service referrals, and monitoring. This will help prevent unnecessary detention and ensure timely access to support services while individuals await trial.

7. **Expand Housing and Reentry Support**
   Adequate, affordable housing options must be expanded to support both general and specialized populations (e.g., individuals with behavioral health needs and people involved in the criminal legal system). This will provide critical stability for individuals transitioning back into their communities, reducing the risk of recidivism.

CONCLUSION

The 2025 *State Summit on Behavioral Health and the Justice System* (report) brought together key stakeholders from across Maryland, representing all 24 jurisdictions. Attendees included policymakers, law enforcement officials, mental health professionals, and community advocates, all of whom engaged in meaningful discussions aimed at improving the state's response to individuals with behavioral health needs involved or at risk of involvement with the criminal legal system. The Centers provided a platform for participants to exchange insights, share best practices, and explore innovative solutions, fostering a collaborative, interconnected approach to addressing critical challenges.

This year's Summit illuminated both ongoing challenges and promising opportunities for reform. Participants emphasized the importance of coordinated care, early intervention, and timely access to services in building a more effective, compassionate system. A key takeaway from the discussions was the need for integrated, community-based solutions that address the diverse needs of individuals at every intercept of the criminal legal system. Participants also emphasized the importance of implementing behavioral health services that are accessible across the lifespan and reflect the specific needs of different geographic areas and populations. Particular focus was placed on rural areas, reentry populations, and individuals with complex behavioral health challenges, recognizing significant access barriers.

The recommendations that emerged from the Summit represent a unified call for action, with a strong emphasis on standardizing systems, securing long-term funding, and reducing stigma to ensure individuals receive the support they need at every stage of the criminal legal system. Several key issues also surfaced repeatedly throughout the event, including the challenges posed by unfunded mandates, the need for clarity around legal standards and requirements, and the obstacles to community buy-in.

As the Centers continue to advance their mission, they remain committed to facilitating ongoing dialogue, promoting innovative solutions, and advocating for policies that integrate behavioral health with justice system reform. Building on the momentum generated at the Summit, the Centers will continue to lead efforts to address the complex challenges outlined in this report, working toward a more coordinated, equitable, and compassionate approach to care. Through sustained engagement and collaboration, the Centers are dedicated to improving outcomes for individuals and communities across Maryland.

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