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

STATE SUMMIT ON BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM

Utilizing the Sequential Intercept Model (SIM) Mapping Initiative

October 2023

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

Centers of Excellence

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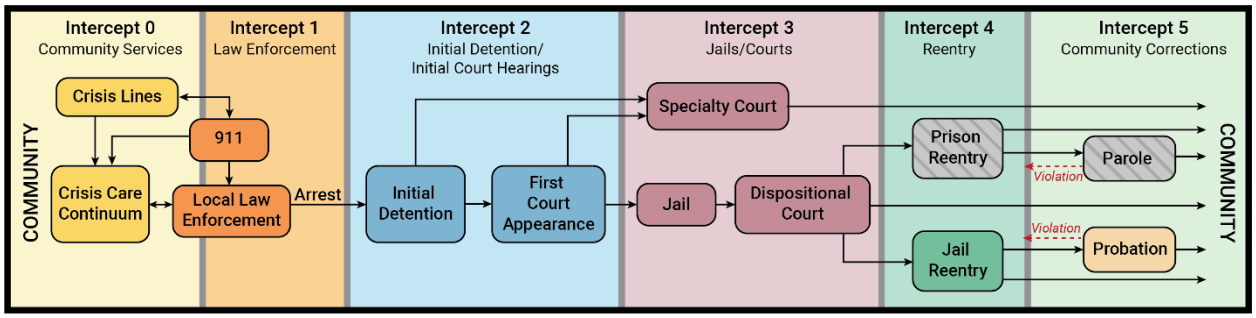
BACKGROUND

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

The SIM illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through a SIM mapping workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system. Additionally, SIM workshops guide communities in connecting individuals with services as they exit the criminal justice system.



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

Maryland's 2023 State Summit on Behavioral Health and the Justice System consisted of a presentation of the SIM and best and evolving practices to:

- prevent individuals with behavioral health disorders from entering the criminal justice system;
- divert individuals from further penetration into the criminal justice system; and
- engage individuals in treatment as they exit the criminal justice system.

Co-facilitated by the Centers of Excellence and Dan Abreu, MS, CRC, LMHC, Senior Project Associate with Policy Research Associates, Inc. (PRA) and senior technical assistance specialist for SAMHSA's GAINS Center, the two-day Summit invited stakeholders from all regions of the State and SIM intercepts to attend. On Day One, there were 75 stakeholders in attendance. Mr. Abreu provided an overview of the SIM, followed by a series of intercept-specific panels that highlighted expert insights, best practices, and innovative solutions. On Day Two, stakeholders participated in one of three focus groups: Intercept 0-1: community services and law enforcement-related diversion; Intercept 2-3: court diversion and jail services; or Intercept 4-5: reentry and community corrections. Each group consisted of two facilitators who were trained through workshops hosted by the Governor's Office of Crime Prevention, Youth, and Victim Services in coordination with SAMHSA's GAINS Center. The facilitators of each focus group led discussions that identified resources statewide, identified gaps in planning or programs within their specific focus group, and prioritized the identified gaps through a voting process. The work from these focus groups informed the recommendations listed later in this report.

INTRODUCTION

Senate Bill 857 (Chapter 68 of 2021) created the Maryland Behavioral Health and Public Safety Center of Excellence (Center) within the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS) to increase treatment, prevent harm, and reduce detention of people with behavioral health disorders. The law established the Center as a statewide hub for the following domains: behavioral health treatment and diversion resources, including model diversion policies for law enforcement agencies; recommendations for behavioral health interventions driven by, assisted by, or without law enforcement involvement; interagency data-sharing procedures; training and technical assistance; and other programs at the intersection of behavioral health and criminal justice.

Much of what the law requires was already underway through various GOCPYVS programs. The Law Enforcement-Assisted Diversion (LEAD) program, the Justice Reinvestment Act (JRA) program, the Crisis Intervention Team Center of Excellence (CITCE), and the Violence Intervention and Prevention Program (VIPP) predate sections 13–4201 through 13–4206 of the Health Article and overlap with the Center's mandate. Through LEAD, established in 2019, the GOCPYVS supports jurisdictions that want to improve law enforcement responses to behavioral health crises through diversion programs. LEAD facilitates connection between law enforcement and behavioral health professionals to increase treatment and minimize involvement with the criminal justice system. The Center coordinates LEAD and is working through the program to develop a statewide model for law-enforcement-assisted diversion. The Center is working with the Maryland Statistical Analysis Center (MSAC) within GOCPYVS to develop a platform for sharing data collected by MSAC related to LEAD and VIPP (which supports data-driven public health approaches to reducing violent crime).

In addition, the Crisis Intervention Team Center of Excellence (CITCE)–which provides technical assistance related to behavioral health crisis intervention to local agencies–guides much of the work to develop a statewide model for community crisis intervention services other than law enforcement. The CITCE page houses best practices including logic models, strategic plans, data statistics, crisis intervention team models, toolkits, training/conferences, and relevant academic entities. To reduce duplication of efforts, GOCPYVS recognizes the Maryland Behavioral Health and Public Safety Center of Excellence and the Crisis Intervention Team Center of Excellence as an integrated entity, the Centers of Excellence (COE).

The Centers of Excellence develops and expands cross-agency partnerships in order to meet its objectives. The Centers of Excellence is represented on the Commission of Behavioral Health Care Treatment and Access; the Standing Advisory Committee on Opioid-Associated Disease Prevention and Outreach Programs; and the Behavioral Health Advisory Council. COE staff

engage regularly with the Maryland Department of Health Behavioral Health Crisis System Program Director and members of the Maryland Crisis System Workgroup and the Bay Bridge Partnership; additionally, COE staff participate in Behavioral Health Equity Listening Sessions and BHA Regional Stakeholder Meetings. At the request of the Crisis Intervention Team (CIT) Subcommittee of the Maryland Mental Health and Criminal Justice Partnership (MMHCJP), the Centers of Excellence has created a CIT Coordinators Group to convene certified CIT coordinators across the State to discuss successes and limitations in crisis intervention services. One objective of this group is to assist in the development of a model crisis intervention program; the group also collaborates with the Crisis Intervention Team-Collaborative Planning and Implementation Committee–which oversees CITCE. The Centers of Excellence continuously seeks to establish and strengthen partnerships to identify and obtain diversion-related outcome data that may support better deployment of behavioral healthcare resources and advance public safety.

Unlike efforts within and across state agencies, sequential intercept model (SIM) facilitator training and SIM mapping workshops are uniquely within the purview of the Centers of Excellence. In collaboration with SAMHSA's GAINS Center, the Centers of Excellence hosted two SIM facilitator training events (August 2022 and March 2023), producing 40 trained facilitators across the State to assist in regional and local mapping workshops. COE staff conducted two jurisdiction-specific SIM mapping workshops with two more scheduled for early 2024. In an attempt to improve technical assistance efforts, the Centers of Excellence developed a General Information Request Form and a SIM Mapping Request Form (both located on the COE webpage) and created a planning kit to streamline regional and jurisdictional SIM mapping workshops. These efforts support the target of providing each local jurisdiction with a mapping or remapping every two years, upon request.

The Centers of Excellence hosted the first in-person State Summit on Behavioral Health and the Justice System in November 2022, which presented recommendations to improve access to housing, peer support specialists, and crisis intervention training. Discussion also led to recommendations for cultivating the behavioral health workforce, expanding mental health courts, and creating a shared data system; facilitation of cross-agency collaboration, detailed above, has been a COE priority in order to meet such recommendations. The Centers of Excellence has also been working to address objectives and priorities identified in the Maryland Behavioral Health and Public Safety Center of Excellence multi-year strategic plan presented at last year's summit. This report is available on the Governor's Office of Crime Prevention, Youth, and Victim Services' website, at: http://goccp.maryland.gov/reports-and-publications/.

Finally, the Centers of Excellence hosted its third annual SIM Summit in October 2023 to share promising behavioral health interventions that improve public safety and health. This *State*

Summit on Behavioral Health and the Justice System (report) summarizes the discussions held at the 2023 Summit to further inform efforts in Maryland.

SUMMIT GOALS

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

Summit participants represented multiple stakeholder systems, including mental health, substance use treatment, health care, human services, corrections, advocacy, law enforcement, health care (emergency department and inpatient acute psychiatric care), academia, and the courts. 75 stakeholders were recorded as present at the Maryland Summit in 2023.

SUMMIT DAY ONE

Welcoming and Opening Remarks: Dorothy Lennig, Esq., Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services, opened the State Summit on Behavioral Health and the Justice System by welcoming participants and highlighting the creation of the Commission to Study Mental and Behavioral Health in Maryland (Executive Order 01.01.2019.02), which focused on examining access to mental health services and the link between mental health issues and substance use disorders. Ms. Lennig spoke about the increasing need for mental health professionals. She described a discussion in which a friend who is a provider in a rural area detailed how difficult it is to provide adequate treatment to those in desperate need when faced with a lack of resources and a shortage of essential staff. Ms. Lennig expanded on a comment made by a local sheriff regarding the challenges officers face as they work with the tools being provided within the existing parameters; she stated that if law enforcement officers are aware of which resources are available, then they can effectively connect individuals in crisis with services and divert them from further penetration into the justice system. Ms. Lennig detailed the advancements completed by the Centers of Excellence this year and the ongoing collaboration with the Maryland Statistical Analysis Center (MSAC) in the preliminary development of a data-sharing platform for SIM mapping. She applauded the attendees for participating in the SIM summit to drive changes to the laws, policies, and funding

streams to increase behavioral health services and divert individuals from the criminal justice system. To conclude her remarks, Ms. Lennig affirmed the progress that has been made while emphasizing the need for sustained cooperation to realize the shared vision of a Maryland that leaves no one behind.

James Rhoden, Assistant Director of the Centers of Excellence (COE) at the Governor's Office of Crime Prevention, Youth, and Victim Services, introduced current staff members and recent COE projects. He concluded his remarks by introducing Dan Abreu, MS, CRC, LMHC, Senior Project Associate with Policy Research Associates, Inc. (PRA) and senior technical assistance specialist for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.

Dan Abreu greeted the participants and delivered a presentation on the sequential intercept model (SIM). He began by addressing major themes: the transition of behavioral health crisis calls from law enforcement to civilian-led mobile crisis teams, the expansion of telehealth services as a result of the COVID-19 pandemic, the building of relationships between 9-1-1 call centers and 9-8-8 lifelines, and criminal justice reform initiatives. Mr. Abreu urged participants to consider the impact of trauma and the importance of diversion, inclusion, and equity while identifying existing resources and gaps during the Summit; he emphasized the current impact of racial disparities across systems, highlighting data to support both the behavioral health disparities that exist in treatment access and cultural competency and the criminal justice disparities that exist in referrals to diversion programs, pretrial incarceration, bail determination, admission to and graduation from drug courts, and probation revocation. Mr. Abreu then elaborated on each of the six intercepts and clarified examples of existing resources and potential opportunities across all intercepts in Maryland; this included certified community behavioral health clinics (CCBHCs) and other community crisis response programs, law enforcement and pretrial diversion strategies, screening and continuity of care within jails, reentry care coordination, and specialized correctional supervision caseloads. Following these remarks, panel presentations highlighting existing state resources across intercepts commenced with moderation by Mr. Rhoden.

Intercept 0/1 Panel Presentation: The intercept 0/1 panel was composed of Lucy Bill Moore, John Moses, and Cory Eslick. Lucy Bill Moore, LCSW-C, Crisis System Program Manager at the Behavioral Health Administration (BHA), Maryland Department of Health (MDH), initiated the discussion by explaining the current shift occurring within the State's crisis response model and its connection to first responders; she maintained that law enforcement is essential to the crisis response system and the intention would never be to eliminate the partnerships but instead to deepen them. She detailed her prior experience with implementing and overseeing the mobile crisis services and law enforcement-assisted diversion (LEAD) programming for Washington County. Ms. Bill Moore then explained her current efforts at a state level to move the Maryland

crisis system into sustainable implementation of regulated and standardized crisis response services. She discussed how the State, with federal guidance from the Office of Medicaid and Medicare and feedback from the Maryland BHA, will adopt a fee-for-service model to ensure sustainability along the crisis care continuum. Ms. Bill Moore emphasized the importance of continued collaboration to determine when a law enforcement presence is appropriate to ensure the safety of all parties involved while providing the best response for the individual experiencing a crisis. Ms. Bill Moore noted that while the sustainability of this transition must be a priority, the state must also increase access for individuals seeking crisis services, minimize wait times, and increase provider availability. She concluded by advising that in regard to the diversion and deflection of individuals experiencing behavioral health crises, Maryland is working simultaneously within the system that exists while working toward a system that is still being developed.

John Moses, Director of Criminal Justice at Wor-Wic Community College and the Eastern Shore Criminal Justice Academy, discussed the importance of crisis intervention training for law enforcement and correctional officers. Mr. Moses recounted observing numerous instances during his law enforcement career of fellow officers responding ineffectively to a person in crisis due to a training deficit. Mr. Moses indicated that his organization currently provides training for a 32-person law enforcement agency in addition to seven correctional facilities, all of which can hold individuals with mental health diagnoses. Mr. Moses' remarks focused on the intricacies of training law enforcement to ensure proper situational response. He indicated that training is the essential element that allows officers to switch mentalities between, for example, active shooter situations and behavioral health calls; training also supports officers in rapid psychomotor (i.e., conscious movement) decision-making. However, he emphasized that training must not simply teach concepts such as when and how to involve someone else on a call, but also explain the process and the impact to individuals to ensure that officers maintain an appropriate mindset. Mr. Moses provided insight into the value of Integration Communication Assessment Tactics (ICAT), an evidence-based approach to use-of-force training for situations involving persons in crisis and those who are unarmed or armed with weapons other than firearms. Mr. Moses then reminded the audience that there is not a standardized approach to training because each agency's needs are in some ways unique. He contrasted the drastic seasonal population shift of the Eastern Shore, which requires reliance on neighboring agencies to support the influx of visitors, with communities that have small, stable populations who are more likely to present to departments with historical knowledge in person to request assistance. He underscored the importance of not over-promising and under-delivering when training law enforcement on deflection and diversion, a point that highlighted the value of local SIM mapping workshops to identify resources and gaps and to improve access to resources statewide. Mr. Moses concluded his remarks by emphasizing his organization's dedication to

achieving long-term system-wide progress in officer attitudes and beliefs about behavioral health.

Corporal Cory Eslick, a Peer Support Coordinator for Anne Arundel County Police Department (AACPD) and member of the AACPD Crisis Response Unit described Anne Arundel County's unique jurisdictional approach of embedding a Crisis Intervention Team (CIT) Unit within the Crisis Response System (CRS), a nonprofit agency. In this arrangement, law enforcement officers are partnered with licensed clinicians to co-respond to behavioral health crisis calls, serving approximately 80-100 unique clients and their families to ensure the provision of clinically appropriate crisis responses. Cpl. Eslick provided his opinion that the success of Anne Arundel's process could be attributed to the system being maintained outside police responsibility with an emphasis on behavioral health. He described this co-response in which a clinician and officer in "soft uniform" travel together to calls, providing time to build rapport and to cooperatively create a response plan for each call to ensure effective, safe service provision. According to Cpl. Eslick, trust has proven an essential element in the program: because officers have developed trust in clinicians, officers have learned to remain in a support role while more precisely delineating which calls truly require law enforcement action; because individuals have developed trust in CIT officers through these positive interactions outside the context of a law enforcement response, they have become more willing to request and accept officer intervention when warranted. In this jurisdictional model, the relationships developed between officers and the community have continued through the conclusion of calls when officers collaborate with a CRS care coordinator to identify any needs associated with potential future calls for assistance. Cpl. Eslick added that in his department, all officers have been trained in Mental Health First Aid (MHFA), whereas CIT training has remained specialized; both CIT training and assignment to the CIT Unit (which are distinct) have been maintained as completely voluntary and via a selection process to assist with the identification of appropriate candidates for training and long-term tenure in the unit. Cpl. Eslick concluded his remarks by highlighting that the development of uniformity regarding law enforcement responsibilities in crisis response will require deep connection and open communication among stakeholders.

Intercept 2/3 Panel Presentation: The intercept 2/3 panel was composed of Kristie Ardire, Kimberlee "Kimber" Watts, and Richard "Gray" Barton. Kristie Ardire, Pretrial Services Case Manager Supervisor at St. Mary's County Detention and Rehabilitation Center, spoke briefly about the bail reform movement in 2014 which influenced the scope of current pretrial services. Ms. Ardire described the current pretrial process in which eligibility is determined through an interview, risk assessment, and judicial approval. She explained that the risk assessment tool, which has been validated for the population, places individuals in a risk category according to aggravating factors (e.g., current charges, pending open cases, criminal history over the last ten years, and history of failure to appear) and mitigating factors (e.g.,

steady employment, confirmed physical address, and no law enforcement interaction in the past twelve months); she reiterated that final authority rests with the judge and no person is automatically ineligible. Ms. Ardire stated that pretrial supervision is more than providing an individual a GPS monitor and includes connection to beneficial services and programming; she provided a current noncompliance rate of 7% under this model. While the St. Mary's area may be limited in resources, they have learned to build and utilize partnerships to provide clients with referrals to services across the State. For example, Ms. Ardire explained that they have minimal difficulty connecting a client to medication-assisted treatment (MAT)/medications for opioid use disorders (MOUD) because of the partnerships forged between their warden and community partners; however, she indicated that placement of clients into state hospitals is a consistent challenge, characterizing it as "almost impossible." Ms. Ardire concluded her remarks by emphasizing the necessity of partnerships to build or expand these resources to ensure that pretrial individuals do not violate their conditions due to inaccessibility.

Kimberlee "Kimber" Watts, Assistant Public Defender in the Forensic Mental Health Division of the Maryland Office of the Public Defender, noted the importance of providing rehabilitative services to charged individuals with behavioral health diagnoses rather than seeking justice with a punitive response. As an example, Ms. Watts mentioned a Frederick County pilot program called "Safe Baby Court" in which family and infant behavioral health needs are addressed for family-oriented cases to ensure that parents' needs are addressed as part of the process of addressing children's needs. Ms. Watts stated that the Office of the Public Defender's emphasis on access to services includes connecting clients to their Peer Recovery Support Specialists within their Social Work Division; she explained that the focus on services continues as attorneys collaborate with the judges to provide community services to an individual who requires behavioral health assistance rather than incarceration. She added that insufficient resources have been a long-documented challenge to supporting these individuals and that while Certified Community Behavioral Health Clinics (CCBHCs) are precisely suited for rapid, flexible, and responsive services, they require time and funding to develop. Ms. Watts stated that while training is frequent and essential at every level, the most significant training occurs while working alongside social workers in a multi-layered, applied approach.

Richard "Gray" Barton, Executive Director of Maryland's Problem-Solving Courts, stated that there are 65 unique specialty courts within 23 of Maryland's 24 jurisdictions based on the self-identified needs of the communities; Garrett County, the only jurisdiction without a problem-solving court, has been exploring the establishment of an Adult Drug Court. Relying on his background first as a law enforcement officer, then as a clinician, and now within the judicial system, Mr. Barton has been encouraging and supporting the collaborative philosophy of specialty courts. He explained that the first step in the implementation of a problem-solving court is the compilation of data to justify the need and ensure support from judges,

prosecutors, and defense attorneys. Mr. Barton noted the drastic perception shift in the courts; while decisions were once based on charges alone, there is now an acknowledgment of the factors that bring individuals into court and the resources that could support those individuals and prevent future court involvement. When discussing evaluation tools utilized, Mr. Barton went on to add that all adult mental health and drug treatment courts use a risk-needs evaluation tool, with risk defined as the potential to recidivate without intervention and the needs defined as those supports an individual might require, ranging from mental health or substance use treatment to the basic needs of transportation and housing. Mr. Barton described a federally-funded pilot program recently undertaken to intervene as a court to screen and refer individuals as early in the criminal justice process and as close to intercept 0 as possible with no guarantee of acceptance into treatment court; the program has anticipated that earliest intervention will be particularly beneficial for improving access for women and people of color. Mr. Barton agreed that many jurisdictions lack sufficient community health resources and that the courts have been ordering individuals to resources that are unavailable as a means to document gaps and hold the system accountable. Mr. Barton concluded his remarks by highlighting the additional behavioral health training that problem-solving court judges receive and reminding the audience that behavioral health-driven issues will continue to present in the courts, requiring the entire judiciary (including but not limited to problem-solving courts) to recognize and respond appropriately.

Intercept 4/5 Panel Presentation: The intercept 4/5 panel was composed of Amanda Cram, Katie Rouse, and Martha Danner. Amanda Cram, LCSW-C, Director of Social Work at the Maryland Department of Public Safety and Correctional Services, discussed the current reentry landscape. She explained that a focus has been directed toward the need for an assessment tool to assist in identifying clients' reentry needs given that individual circumstances necessitate unique reentry plans. The implementation of these unique reentry plans has been hindered by the unpredictable nature of the release process; this uncertainty has necessitated facilitating initiating reentry plans as early as state and federal policy allow, e.g., ordering birth certificates upon entry. However, Ms. Cram expanded on three significant policies that create barriers to reentering individuals: 1) Social Security cards cannot more ordered more than 90 days before release, 2) cards for individuals who are unable to provide an accurate Social Security number cannot be ordered before reentry and therefore require an in-person request after release, and 3) reentering individuals cannot initiate Medicare/Medicaid enrollment until after release. Ms. Cram indicated that her agency's 16 social workers serve over 16,000 incarcerated individuals at a time; the agency has trained staff to assess individuals as needed and has seen recent increases in both the use of telehealth and the inclusion of peer recovery specialists in the reentry process. She reported that eight of the 18 facilities statewide have certified or prospective-certified peer recovery specialists for on-site and post-release services thanks to grant funding through the Maryland Department of Labor that supports stable reentry

employment. In addition to assisting with medication noncompliance and other issues, these peer professionals have also facilitated groups in high demand that address topics such as financial literacy, SMART recovery, and resilience. Ms. Cram concluded by emphasizing the importance of fostering connections for individuals before release as a means of supporting successful reentry.

Martha Danner, Director of the Parole and Probation Division with the Maryland Department of Public Safety and Correctional Services, expanded on the value of telehealth for promoting accessibility and reducing barriers in this intercept; accordingly, telehealth sites have been made available at all 36 division locations throughout the State. She noted that the majority of the population she serves is composed of individuals on probation with sentences of 25 years or more. To meet the needs of the population, Ms. Danner reported collaborating with 390 service providers across the State, 75% of which provide mental health services. She concluded her remarks by underscoring the value of state and local coordination to strengthen the reentry process for individuals.

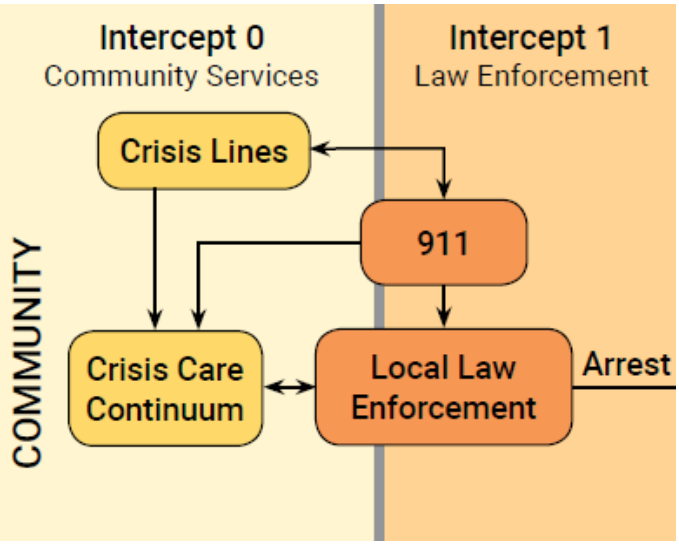
Katie Rouse, Executive Director of the Community Engagement Department for On Our Own of Maryland, Inc., continued the discussion regarding peer professionals across the intercepts by reminding the audience that peers demonstrate a path to recovery and success. She discussed the ethical use of peer professionals with a mnemonic of three “c’s” about the peer’s requirements [credibility, connection, and credentials] and three “r’s” reflecting the agency or system requirements [recruitment, relationship, and retention]. She explained that credibility is determined by an adequate shared common experience to be viewed as a peer, while a connection is built and serves as the foundation for trust. The credentialing process, which exists in Maryland, was developed with the intent of creating mutual expectations of shared foundational experiences and knowledge; while there have been barriers such as cost and academic requirements, Ms. Rouse’s agency has been offering credentialing training at no cost to address this need. She went on to address system-level needs: clear roles for successful recruitment, a culture of wellness for healthy professional relationships, and paths for career advancement to maximize retention. Ms. Rouse summarized peer support as moving through wellness at an individual level together; she added that the work is a trust-based, voluntary, and professional discipline that deserves to be a recognized, paid career opportunity. She illustrated areas for improvement and expansion, including the possibility of training that provides academic credit in addition to continuing professional education credit. She concluded her remarks with a call to envision a system of care wherein the community respects the individual’s wishes for recovery and does not engage someone immediately in a medical or criminal system but instead in a community system including community-based peer-operated support services.

Closing Remarks: Dan Abreu provided closing remarks for day one of the summit by illuminating the importance of collaboration across intercepts to gain a deeper understanding of how behavioral health and criminal justice are intertwined. He provided the integration of peer support programs in the corrections intercept using the relationship model over the medical model of peer respite as an example of cross-intercept collaboration eliciting system-level progress. Mr. Abreu noted that the housing crisis, not explicitly discussed during day one, has been regularly interpreted as complex enough to warrant distinct attention and deeper discussion; he shared that Policy Research Associates, Inc. (PRA) maintains a national Homeless and Housing Resource Center that provides high-quality, no-cost training for health and housing professionals in evidence-based practices to promote housing stability, recovery, and an end to homelessness. Key concepts consistent across all the intercepts from day one included the following needs: ongoing partnerships to improve cross-system communication and data sharing; expansion of services to increase access; and development of a recovery-oriented approach to care.

SUMMIT DAY TWO

Welcoming and Focus Groups: On day two of the summit, Mr. Rhoden greeted participants and Mr. Abreu proceeded with a brief explanation of the process for SIM mapping workshops and the importance of participation in capturing an accurate depiction of the current resources and gaps within Maryland's behavioral health and justice systems. Following the welcoming remarks, participants were divided into focus groups based on their respective intercepts. After these breakout sessions, priorities for change were reviewed across intercepts. This information can be found below.

Intercepts 0 and 1



Resources

- 211 Maryland (211) is a free, confidential resource line that operates 24/7 with a statewide reach that connects individuals with referral specialists.
- The National Suicide and Crisis Lifeline (988) can be accessed 24/7 by call, text, or chat with a goal of live response within 25 seconds; an option for video chat is available for individuals who communicate through sign language. 988 can transfer to local warmlines as appropriate.
- The Human Sex Trafficking Hotline (888-373-7888) is available 24/7 by call, text, or chat with interpreters available (call only). Additionally, tips can be submitted online through an anonymous online reporting form.
- The National Domestic Violence Hotline (800-799-7233) is available 24/7 by call, text, or chat.
    - The Maryland Network Against Domestic Violence maintains a directory of programs that offer 24-hour hotlines, access to shelter, counseling, and advocacy; these services are available for every jurisdiction in the State.
    - The Domestic Violence and Sexual Assault Center at UM Capital Region Medical Center in Prince George's County offers a range of free services including a 24/7 hotline (240-677-2337), professional counseling, victim advocacy, community education presentations, and sexual assault forensic exams. While grant-funded to support victims in Prince George's County, the Center generally attempts to

serve all victims and patients who present due to the complexity of the geographic region and jurisdictions.

- The Department of Social Service can connect consumers to shelters, crisis care, health insurance, food, and more; this resource is available statewide.
- Peer support services are available through non-profit agencies such as On Our Own of Maryland, Inc. and Maryland Coalition of Families.
- LGBTQ+ support centers can be found throughout the State.
- Recovery support can be found through community-based wellness and recovery centers (such as those operated by On Our Own of Maryland, Inc.) and through faith-based recovery housing (such as the combined recovery/homeless shelters in Washington County).
- Every jurisdiction has a health department. Some agencies have developed techniques to increase access to programs and services such as Carroll County's mobile services (Health on Wheels) and Howard County's mobile app (CAREAPP); these strategies encourage the use of existing programs for food, health, housing, transportation, education, employment assistance, and more.
- Jurisdictions are creatively attempting to reduce stigma using art in public spaces; Carroll County received two park benches from Josh's Benches for Awareness (a non-profit dedicated to reducing behavioral health stigma).
- The Brain Injury Association of Maryland provides advocacy, education, and research in support of individuals, families, and professionals.
- Schools provide unique access to families and often serve as community hubs. The Kirwan Commission's *Blueprint for Maryland's Future* is being implemented to address some known gaps such as staffing shortages.
    - Some counties have additional community resources specifically for at-risk youth; for example, Wicomico County has a youth drop-in center through Fenix Youth Project for youth experiencing or at risk of experiencing homelessness.
- Given the multifaceted role that a library plays in a community, many libraries are providing naloxone and mental health first aid training for employees.
- Safe Stations programs are operating in the following counties: Anne Arundel, Caroline, Talbot, Wicomico, and Worcester. Of note, some jurisdictions have successfully expanded the program by including fire stations in addition to police stations.
- Resources for assisted living are being expanded to meet demand statewide.
- Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based approach to identify individuals who use substances at risky levels, is widely used in hospitals throughout the State; in some jurisdictions, it is also used by peers, nurses, case managers, and other professionals to perform a quick screening for needs. Of note,

other states have integrated a brief traumatic brain injury (TBI)/acquired brain injury (ABI) section into the SBIRT and the opportunity for a pilot exists in Maryland.

- Behavioral health urgent care/walk-in services are reportedly available in 18 jurisdictions; days and hours of operation vary by location.
- Crisis stabilization centers are reportedly available in 3 jurisdictions.
- Many hospitals employ patient navigators, and some behavioral health navigators are also located in community settings.
- Mobile Crisis Teams operate in 22 jurisdictions with varying days and hours of operation.
- There are 14 active LEAD programs.
- Dispatchers can access both crisis intervention and Mental Health First Aid training when available.
- P.R.O.T.E.C.T. (Public Resources Organizing to End Crime Together) was established in Senate Bill 929, 2020/Chapter 20, 2021 to combat neighborhood decline throughout the State, support comprehensive strategies to reduce crime and fear in those communities and ensure that local law enforcement is utilized in direct public safety roles. There are currently four P.R.O.T.E.C.T. Coordinators across the State.
- Community policing efforts continue across the State through events such as National Night Out and Citizens Police Academy. Existing voluntary arrangements to embed clergy within police departments provide additional community connection in participating jurisdictions.
- Officer wellness:
    - Harbor of Grace provides a separate section of the facility for first responders.
    - Maryland State Police is identifying public safety-fluent providers in each jurisdiction.
    - Officer assessments can be used as a touchpoint and opportunity to mention resources one-on-one.
    - Safe Call Now (206-459-3020) is a confidential, comprehensive, 24/7 crisis referral service for all public safety employees, all emergency services personnel, and their family members nationwide.
    - The Bureau of Justice Assistance has announced an upcoming study on first responders living with brain injuries.
- Law enforcement is provided continuing education to address current needs. In Carroll County, officers participated in a training by the Columbia Lighthouse Project on the use of the Columbia-Suicide Severity Rating Scale (C-SSRS) for petitions for emergency evaluation.

Gaps

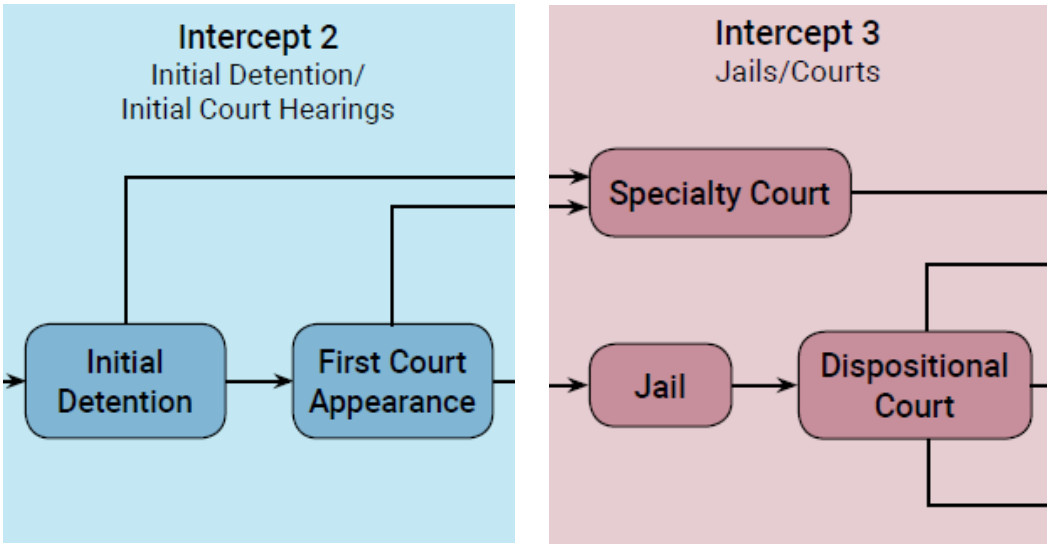
- Integration and coordination of crisis hotlines continues. However, 988 does not have the same universal device connectivity as 911, nor does it have 911's GPS capability; target wait times require additional staffing.
- There is a lack of adequate respite care for adults, youth, and seniors across the State.
- While cross-agency relationships are a resource, the lack of a statewide resource dashboard, directory, or map is a significant gap.
- Lack of transportation (especially public transportation) is a barrier in many jurisdictions.
- Workforce shortages continue to impact the behavioral health and law enforcement fields. Call response wait times are disproportionately impacted by agencies with shortages, particularly small jurisdictions.
- Stigma:
    - Stigma surrounding behavioral health negatively impacts the availability and use of available resources while often excluding individuals with lived experience from decision-making discussions.
    - Stigma surrounding law enforcement deters individuals from requesting and accepting law enforcement assistance.
    - Officers face stigma when seeking resources for themselves; in some jurisdictions, there is a need for improvements to protect officer privacy by limiting the sharing of confidential information with command staff.
- Standardization:
    - Data sharing and program evaluation are stymied by a lack of technical infrastructure and varied metrics; however, these issues are complicated by cross-jurisdictional differences. For example, the Central Maryland Regional Crisis System (formerly called the GBRICS Partnership), a network of behavioral health crisis response services supported by the Greater Baltimore Regional Integrated Crisis System (GBRICS) Partnership project, is not needed or utilized uniformly across the region it serves. These differences exist at the county, region, and state levels.
    - There is a lack of standardization of training and language across law enforcement agencies and between law enforcement and outside agencies such as medical and behavioral health partners.
- The availability of mobile crisis teams varies. Rural communities struggle to find behavioral health professionals to serve in this capacity.
- The availability of behavioral health urgent care facilities varies; not all facilities accept walk-ins, and not all facilities are available 24/7.

- There is a need for improved cross-system coordination and communication to improve the transition of care.
- CIT standards are not uniform across the State. There are barriers for small departments to train an adequate number of officers for coverage. There are few CIT-trained Maryland State Police officers due to staffing constraints.
- Several jurisdictions lack LEAD programs.
- The process for petitions for emergency evaluation (EP) lacks an evidence-based standard statewide; the current process is a source of frustration for law enforcement professionals who cite outdated forms, unclear regulations, and confusion regarding the use of force.
- Police accountability legislation can be difficult for law enforcement officers to interpret; state-level clarification would aid in guiding officers.

Intercept 0-1 Priorities

1.	Sustainable funding for programs and services	14 votes
2.	Workforce development and compensation	10 votes
3.	Housing and unhoused/homelessness services	10 votes
4.	Paradigm shift among decision makers to prioritize health and safety	7 votes
5.	Continuity and integration of care	7 votes
6.	Standardized data sharing across behavioral health and law enforcement systems	4 votes
7.	Expansion of 24/7 services	4 votes
8.	Comprehensive, updated, real-time statewide resource database	2 votes
9.	Access to and accessibility of services	2 votes

Intercepts 2 and 3



Resources

- There are 65 problem-solving courts in 23 of the 24 jurisdictions in Maryland.
    - This includes Adult Drug Court, Mental Health Court, Veterans Treatment Court, reentry Court, Truancy Court, Family Recovery Court, Juvenile Drug Court, and Back On Track Court.
    - The courts' coordinators directory can be found here. However, please note that some of the 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.
    - Some jurisdictions without formalized courts have established informal dockets to manage specific cases (e.g., a Mental Health Docket).
    - The time between identifying possible participants for drug courts and entering drug court varies, but the best practice statewide is 7-14 days.
- Pretrial services are available in all jurisdictions.
- Risk and Need Triage (RANT) is an evidence-based program with supervision and clinical services recommendations.
- Assertive Community Treatment (ACT) programs serve adults 18 or older with severe and persistent mental illness.

    - Programs are available in communities such as Baltimore City, Frederick County, Harford County, Howard County, and Washington County as indicated on Sheppard Pratt's webpage.
- Diversion linkages programs: The Maryland Office of the Public Defender receives referral requests from prosecutors for diversion at bond-review hearings.
- WellPath is contracted by many facilities for medical and mental healthcare, but vendors for prescription services differ across jurisdictions.
- Correctional facilities are using outpatient treatment programs.
- Trauma-informed care training is provided for problem-solving courts.
- Mental health and substance use screening is available at-booking in select counties but is often done independently.
- Validated risk assessment tools are available for the booking process.
- House Bill 116 (2019): Correctional facilities must assess the mental health and substance use status of each incarcerated individual using evidence-based screenings and assessments.
    - Facilities provide FDA-approved medications for opioid use in conjunction with counseling services and reentry planning while incarcerated.
    - 19 out of 24 jurisdictions have met compliance as of December 2023.
- Correctional officers receive CIT training, but percentages vary in every jurisdiction.
- Peer support specialists are available in select facilities.
- Jail-based wellness services vary by facility, but some services include AA/NA groups, GED programs, parenting courses, anger management programs, and trauma-specific counseling. Jail-based substance use programs are also available in select counties.
- CRISP (Chesapeake Regional Information System for our Patients): Maryland's designated Health Information Exchange (HIE) is used along the Mid-Shore to track medication and avoid pharmacy hopping/shopping.
- Facilities offer remote hearings following the COVID-19 pandemic, but select counties have encouraged in-person hearings.
- Crisis intervention team (CIT) training and mental health first aid (MHFA) training is available for personnel.
- Facilities vary in resources but generally include the following programs/services:
    - General Education Development (GED) courses
    - Counseling services
    - Professional development services
    - Drug and Alcohol classes
    - Faith-based services
- Access to peer support varies across the State, but is a service in many jurisdictions.
- Task forces and Commissions include:

    - Commission on Correctional Standards (DPSCS)
    - Correctional Training Commission (DPSCS)
    - Opioid Operational Command Center
    - Local Government Justice Reinvestment Commission
    - Task Force to Study Transparency Standards for State's Attorneys
- Councils and Boards include:
    - Correctional Education Council (DL)
    - Judges, Masters & Juvenile Justice Committee
    - Heroin and Opioid Coordinating Council
    - Maryland Correctional Enterprises Management Council (DPSCS)
    - Justice Reinvestment Oversight Board
    - State's Attorney's Coordination Council

Gaps

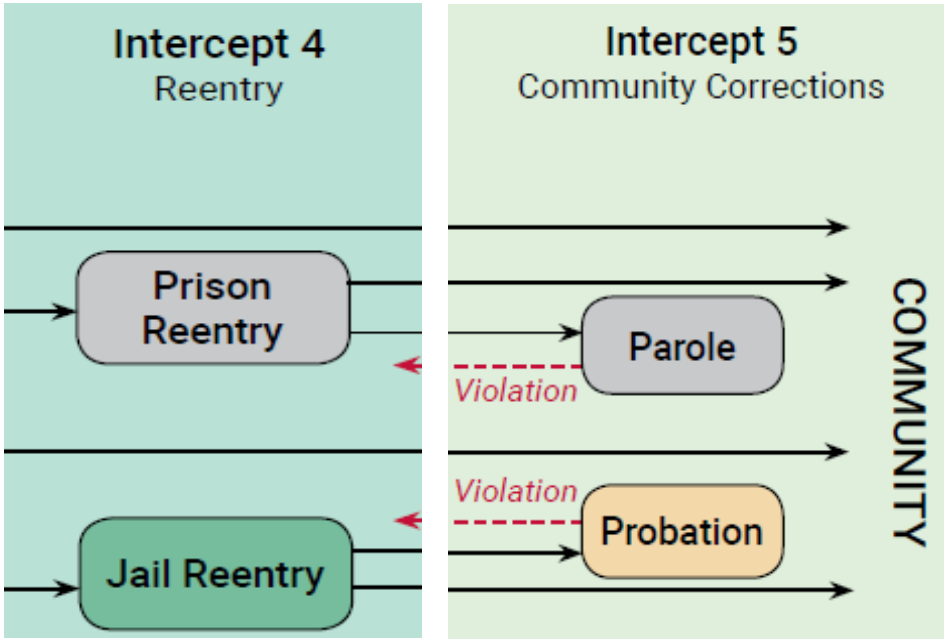
- Cross-systems coordination and communication is needed.
- Pretrial does not have a state entity that supervises pretrial in all jurisdictions.
- There is a need for a shared data system to keep track of services including routinely tracked data on racial and ethnic disparities and longitudinal data.
- Outcome measures and definitions of measures may vary across agencies and assessments.
- Assessments should include measures for change in quality of life.
- Incarcerated individuals are sentenced to conditional releases, but cannot fulfill obligations due to a lack of housing options.
- There is a lack of transportation for care and services.
- Gender-specific screening tools and services needed.
- Pretrial screening tools and processes are inconsistent across jurisdictions.
- Identification of frequent utilizers varies across jurisdictions, and many jurisdictions utilize various informal identifying processes.
- Uniform screening for Veteran status is absent, but Commissioners are now allowed to ask individuals for Veteran status which assists with response and referrals.
- Problem-solving courts do not include individuals with co-occurring disorders and only take individuals with certain levels of risk.
- There is a lack of formally established mental health courts; currently established court services have limited diversion for individuals with serious mental illness.
- Mental health and substance use screening tools and processes are inconsistent across jurisdictions.

    - Differentiating between individuals with mental health problems and those with serious mental illness would improve service effectiveness.
    - Assessments face time limitations (i.e. substance use assessments are invalid after 30 days).
- Regarding space limitations in jails for programming, both population needs and therapeutic space requirements need to be considered when creating the design of new facilities.
- Early reentry support services within detention centers are needed.
- Many peer support positions are grant-funded and not self-sustaining.
- Releases from jail outside of business hours create barriers to connecting individuals to resources.
- There are disruptions regarding the distribution of medications in jails despite preventative measures taken by staff for medication to be available on time and for 30 days; medications are not always maintained for those returning from a state hospital to jail because individuals can refuse medications and providers cannot force medication compliance.
- Support with case management for individuals released and sentenced is needed.
- High turnover and transition of roles contributes to staffing shortages.
- Language services, including sign language interpreters, are lacking.
- Need for family support services across intercepts.

Intercept 2-3 Priorities

1.	Implement reskilling and upskilling initiatives to combat staff shortages (i.e. training, awareness of staff needs, etc)	8 votes
2.	Establish a centralized and consistent data system to track services and identify racial and ethnic disparities	7 votes
3.	Standardize screening tools within all courts across jurisdictions to combat eligibility restrictions for entering problem-solving courts	7 votes
4.	Enhance early reentry services within facilities	4 votes
5.	Improve collaboration between entities	4 votes
6.	Develop implementation strategies for specialized units within facilities (i.e. substance use unit)	2 votes
7.	Expand trauma-informed care efforts	1 vote

Intercepts 4 and 5



Resources

- Progress has been made regarding collaboration between jurisdictions with the launch of 988, mobile response teams, behavioral healthcare centers, etc.
- Health departments across the State have increased their interest and involvement in the reentry process.
- Funding is available to facilitate the implementation of peer professional roles.
- There is a strong relationship between the Maryland Office of the Public Defender and the Maryland Department of Public Safety and Correctional Services.
- United Way offers a variety of services, including providing individuals with a free laptop/tablet.
- Parole and Probation offices offer services such as:
    - Naloxone administration training
    - Telehealth accessibility
- Safe Stations and One Stop Shops have expanded.
- New policies are being designed to increase staff in every county to assist with the mental health caseload.
- Peer support is increasing with help from the American Society of Addiction Medicine.
- Educational opportunities for individuals have increased.

- SSI/SSDI Outreach, Access, and Recovery (SOAR) specialists are utilized throughout the State.
- The use of resource fairs improves consumer access.
- Programs are available to assist with expungements such as Lawyers in the Library.
- Task forces and Commissions include:
    - Maryland Statewide Alliance for Returning Citizens (MSARC)
    - Maryland Parole Commission
- An increasing number of nonprofit organizations have become involved with the facilitation of assisting individuals reentering society.

Gaps

- Although grant funding dedicated to reentry initiatives exists, there are challenges associated with acquiring these funds.
    - Nonprofit organizations often require expertise; their passionate, experienced staff need assistance with obtaining funding and locating resources.
- There is a lack of housing for the following populations:
    - Individuals with severe mental illness
    - Sex offenders and sex offenders with disabilities
    - Individuals utilizing addiction medication(s)
    - Individuals seeking sober living options
- Reentry services require additional funding.
- Workforce development efforts are needed to address staffing needs.
- There is a lack of communication and information sharing between reentry systems.
- Access to transportation is necessary to assist individuals in obtaining services.
- There are substantial obstacles to accessing individuals' vital records (medical, social security, etc).
- Warm handoffs should be improved for increased safety among individuals and the community.
- The physical address associated with an individual can limit reentry services. For example, funding and treatment qualifications may be restricted for individuals whose counties/states of residency and prior incarceration do not align. This can occur when individuals live with friends or family members outside the local area following incarceration.
- Improvements to trauma-informed care are needed.
- Resources and programs for assisting the Veteran and older adult population are lacking.
- Technology

    - Individuals do not always have access to or knowledge about internet use, creating obstacles to checking email, accessing documents, etc.
    - Organizations are coping with lagging technology, which has negatively impacted productivity and even led to full system outages.
- Individuals reentering society encounter banking-related challenges.
- Correctional officers require additional crisis intervention team (CIT) training and education regarding co-occurring disorders.
- Improved access to mental health care medication upon release from state prisons.
- More transitional peers are needed for adequate coverage.

Intercept 4-5 Priorities

1.	Housing accessibility	16 votes
2.	Enhance communication and collaboration among agencies	10 votes
3.	Workforce development to address staffing concerns	10 votes
4.	Policy Barriers	5 votes
6.	Transportation	4 votes
7.	Prevent the recurrence of overdoses upon reentry	4 votes

Priorities Across Intercepts

Based on a voting process, which occurred 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 intercepts and thus highlighted in an additional category.

Intercept 0/1	**Intercept 2/3**	**Intercept 4/5**	**Total**
Sustainable funding for programs and services (14)	Workforce Development (8)	Housing accessibility (16)	**Workforce development and compensation (28)**
Workforce development and compensation (10)	Shared data system (7)	Communication and Collaboration (10)	**Housing (26)**
Housing and unhoused/homeless services (10)	Standardized screening tools (7)	Workforce Development (10)	**Cross-system collaboration and coordination (21)**
Paradigm shift among decision-makers to prioritize health and safety (7)	Reentry support (4)	Policy Barriers (5)	**Standardization of data collection and sharing (13)**
Continuity and integration of care (7)	Cross-system coordination (4)	Transportation (4)	
Standardized data sharing across systems (4)	Specialized units within facilities (2)	Prevent the recurrence of overdoses upon reentry (4)	
Expansion of 24/7 services (4)	Trauma-informed care efforts (1)		
Comprehensive, updated, real-time statewide resource database (2)			
Access and accessibility of services (2)			

Cultivating the Behavioral Health Workforce

Cultivating the workforce in the behavioral health field is crucial for several reasons, each contributing to a more resilient, effective, and sustainable industry. The need to foster and grow the workforce due to significant burnout and staff turnover is acknowledged by participants across all intercepts. High turnover rates can be detrimental to the continuity and quality of care in behavioral health settings, producing a loss of institutional knowledge and a disruption to provider-client relationships. Investment in ongoing training, mentorship programming, and career development opportunities can enhance employee satisfaction, reducing the likelihood of turnover. Longevity in the field is essential for developing expertise, deepening understanding of client needs, and building meaningful therapeutic relationships. Supporting the maintenance of a healthy work-life balance, offering stress management resources, and fostering a positive work environment can contribute to the well-being and longevity of behavioral health professionals; such investment is a crucial step in addressing shortages of qualified professionals and attracting new talent. In summary, cultivating the workforce in the behavioral health field is not only a strategic investment in the well-being of professionals but also a critical step in ensuring the stability, effectiveness, and sustainability of mental health and substance abuse services for individuals and communities. Participants in all focus groups noted the need for workforce development (28 votes). Below are some resources relating to the cultivation of the behavioral health workforce:

- Health Management Associates. (2021). *Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States*. healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf
- Maryland Hospital Association. (2022). *2022 State of Maryland's Health Care Workforce Report*. mhaonline.org/docs/default-source/default-document-library/2022-state-of-maryland-s-health-care-workforce-report.pdf
- Maryland General Assembly. (2023). Mental Health Workforce Development Fund Established (SB283/CH286). https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0283?ys=2023RS
- National Institute for Health Care Management Foundation. (2023). The Behavioral Health Care Workforce. https://nihcm.org/publications/the-behavioral-health-care-workforce-shortages-solutions
- Speicher, L. L., & Francis, D. (2023). Improving Employee Experience: Reducing Burnout, Decreasing Turnover and Building Well-being. Clinical gastroenterology and hepatology:

the official clinical practice journal of the American Gastroenterological Association, 21(1), 11–14. https://doi.org/10.1016/j.cgh.2022.09.020

- Substance Abuse and Mental Health Services Association. (2022). *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies* (Publication No. PEP22-06-02-005). store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf
- USM Healthcare Workforce Working Group. (2018). *Strengthening Maryland's Healthcare Workforce.* https://www.nursing.umaryland.edu/media/umb/umson-mnwc/Health-Care-Workforce-Report-FINAL-Jan-2019.pdf

Increase Access to Housing

The availability of affordable and accessible housing is a significant social determinant of health that all intercepts recognize in conversation as a resource gap (26 votes). The cycle of homelessness and incarceration has been a well-documented obstacle facing individuals within the intersection of behavioral health and the criminal justice system. In this cycle, over-enforcement and criminalization of homelessness lead to increased police contact and citations, frequently followed by unpaid fines and missed court appearances that trigger warrants and arrests. Once within the system, these individuals face a higher likelihood of pretrial incarceration, harsher sentencing, and challenges navigating the terms of probation, all of which create obstacles for securing employment, housing, and overall stability upon release, leaving individuals with few to no realistic options for avoiding homelessness; the cycle then begins anew. Research has provided evidence that housing solutions reduce incarceration; further, housing solutions produce tremendous cost savings within both the criminal justice and medical systems. The resources in the CARES Act and the American Rescue Plan provide a once-in-a-generation opportunity to address homelessness. The following examples are programs, resources, and research relating to preventing and ending homelessness.

- Brown, M., Perez, J., Eldridge, M., and Walsh, K. (2021, November). *Funding housing solutions to reduce jail incarceration.* Urban Institute. https://safetyandjusticechallenge.org/wp-content/uploads/2021/12/funding-housing-solutions-to-reduce-jail-incarceration.pdf
- Center for Housing and Health. (2024). *Better health through housing*. https://housingforhealth.org/bhh/
- Luken, S. (2021). Policy Recommendations to Address Housing Shortages for People with Severe Mental Illness. *Psychiatric Services, 73*(3), 329-334. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202100158

- NAMI [National Alliance on Mental Illness] Maryland. (n.d.). *Housing.* http://namimd.org/resource_center_draft/benefits_and_insurance_/housing
- United States Interagency Council on Homelessness. (2023, November 30). *USICH releases first federal homelessness research agenda in more than a decade.* *https://usich.gov/news-events/news/usich-releases-first-federal-homelessness-research-agenda-more-decade*

Increase Cross-System Collaboration and Coordination

Facilitating collaboration and coordination between behavioral health and public safety agencies is essential for promoting community well-being, addressing complex issues, and ensuring the safety and recovery of individuals with behavioral health needs. Collaborative efforts allow for a more comprehensive and holistic approach to public safety that considers both the immediate safety concerns and the underlying behavioral health issues contributing to certain behaviors. Collaboration also enables early identification and preventative intervention for individuals at risk of mental or behavioral health crises to address issues before they escalate, reducing the likelihood of crises and emergencies. Coordination between behavioral health and public safety professionals promotes mutual understanding, dispelling stereotypes and reducing stigma surrounding mental health issues to foster a more empathetic and informed response to individuals in crisis.

Behavioral health expertise is invaluable in training public safety professionals to recognize and respond effectively to individuals experiencing mental health crises. This collaboration enhances de-escalation techniques, reduces the use of force, and ensures that individuals receive appropriate care during crises. By working together, behavioral health and public safety agencies can also optimize the use of resources. This includes shared training programs, joint initiatives, and coordinated service delivery, leading to more efficient and effective responses to the needs of individuals with behavioral health issues. The Centers of Excellence is working to enhance such collaboration through jurisdictional and regional SIM mapping workshops which continue to gather stakeholders to work together and identify diversion and deflection strategies. Additionally, the Maryland Behavioral Health and Public Safety Center of Excellence Strategic Plan includes recommendations, objectives, and priorities related to cross-system collaboration. Participants in all intercepts underscore the importance of collaboration and coordination between agencies involved across behavioral health and public safety fields (21 votes) Below are some resources relating to the importance of collaboration and coordination between agencies working toward the same goal.

- Maryland Crime Research and Innovation Center. (2023). *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan*.

https://goccp.maryland.gov/wp-content/uploads/Maryland%E2%80%99s-Behavioral-Health-and-Public-Safety-Center-of-Excellence-Strategic-Plan-7-24-23.pdf
- Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. Medicine, 101(52), e32554. https://doi.org/10.1097/MD.0000000000032554
- Bunger, A.C., Chuang, E., Girth, A. et al. (2020). Establishing cross-systems collaborations for implementation: protocol for a longitudinal mixed methods study. Implementation Sci 15, 55. https://doi.org/10.1186/s13012-020-01016-9
- The Council of State Governments Justice Center. (n.d.). *Police-Mental Health Collaboration Programs: Checklist for Behavioral Health Agency Leaders*. https://csgjusticecenter.org/wp-content/uploads/2020/02/Checklist_BH-Agency-Leaders.pdf
- Substance Abuse and Mental Health Services Administration. (n.d.). *Care Coordination for Certified Community Behavioral Health Clinics (CCBHCs)*. https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination

Establish a Shared Data System

While law enforcement, behavioral health care, and state and local mental health agencies are complex and distinct systems, all share an important goal: the reduction of people with behavioral health care needs having repeated contact with the criminal justice system. To achieve this shared goal, coordinated practices such as sharing information, collaborative training, and data collection are essential. Information sharing per federal and state laws between law enforcement and behavioral health care providers can help identify people at risk of having frequent contact with the criminal justice system, ensure those individuals are linked to community-based services, and maintain continuity of care if someone is arrested; additionally, an effective system for tracking and sharing existing resources statewide improves consumer access. To help each system better understand the perspectives and protocols of their counterparts, criminal justice, and behavioral health care practitioners should coordinate with each other when developing and delivering training and educational programs; the involvement of individuals with lived experience can be particularly effective. Collecting and analyzing program performance data is necessary to inform decisions regarding resource allocation, crisis response practices, and treatment and recovery planning; standardized data collection may require adjustments to intake forms and other data collection tools. Ultimately, comprehensive and consistent data analysis is essential for evaluating program outcomes and impacts, promoting fiscal accountability, and informing policy. Participants across intercepts have acknowledged a desire to continue with efforts to create a statewide data-sharing system (13

votes). The Maryland Behavioral Health and Public Safety Center of Excellence Strategic Plan includes recommendations, objectives, and priorities related to the promotion of comprehensive and consistent data collection, management, and integration. The following are resources that can be used for expanding data-driven strategies across intercepts statewide:

- Governor's Office of Crime Prevention, Youth, and Victim Services. *Data Dashboards*. http://goccp.maryland.gov/data-dashboards/
- Governor's Office of Crime Prevention, Youth, and Victim Services. *Grants Interactive Map.* https://goccp.maryland.gov/grants/
- Maryland Crime Research and Innovation Center. (2023). *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan*. https://goccp.maryland.gov/wp-content/uploads/Maryland%E2%80%99s-Behavioral-Health-and-Public-Safety-Center-of-Excellence-Strategic-Plan-7-24-23.pdf
- Opioid Operational Command Center. *Maryland Overdose Data Dashboard*. https://stopoverdose.maryland.gov/dashboard/
- US Department of Justice (DOJ) Bureau of Justice Assistance (BJA). (n.d.). *Delivering behavioral health.* https://bja.ojp.gov/program/pmhc/behavioral-health#information_sharing

RECOMMENDATIONS

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

Trauma-Informed Care

Trauma-informed care is a critical approach in the criminal justice field that recognizes the widespread impact of trauma on individuals and emphasizes creating an environment that fosters understanding, empathy, and support for those who have experienced trauma. Many individuals within the criminal justice system, including victims, witnesses, and even offenders, have a history of trauma that can significantly influence their overall wellness. Trauma-informed care in criminal justice shifts the focus from punitive measures to a more compassionate and holistic approach. By integrating trauma-informed, resilience-oriented principles, the criminal justice system can become a catalyst for growth, healing, and recovery for individuals affected by trauma.

Per Chapters 722 and 723 of 2021 (House Bill 548 / Senate Bill 299) and coordinated by GOCPYVS, the Commission on Trauma-Informed Care (Commission) is charged with coordinating a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults and with reporting its findings and recommendations to the Governor and the General Assembly. The Commission published the *Commission on Trauma-Informed Care: Findings and Recommendations 2023 Annual Report*, which includes information on the findings and recommendations of the Commission as it relates to the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults. Additionally, this report includes the reports submitted by 15 state agencies detailing the trauma-informed, resilience-oriented services and programs happening at each respective agency. It also provides recommendations to improve related existing laws. To further its progress in achieving the goals outlined in legislation, the Commission formed workgroups to address specific focus areas:

- The Organizational Implementation & Technical Assistance workgroup, in partnership with other workgroup chairs, created a framework to serve as a foundation for the

continued work of the Commission. This framework, titled *The Maryland Way: Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)*, was approved by the Commission as a foundational document for its work.

- The Metrics & Assessment workgroup conducted a thorough search of assessment tools to capture each principle of *The Maryland Way*; the workgroup created a resource hub to capture a list of assessment tools and the workgroup's evaluation of each tool.
- The Definitions & Core Values workgroup compiled a set of unified definitions for specific terms identified by the Commission to facilitate the development of a statewide strategy; the Final Definitions Adopted by the Commission on Trauma-Informed Care have been adopted by the Commission and recommended for use across State agencies.
- The Training workgroup has created a trauma-informed care training to meet the objectives and guidelines outlined in legislation; the workgroup is working with FrameWorks Institute through their contract with the Maryland Department of Health (MDH) to plan introductory training for agency representatives and Commissioners.
- The Public Awareness workgroup is working with FrameWorks Institute and other workgroups to create a plan to promote public awareness of state government's efforts in making a culture shift in State government toward a trauma-informed resilience-oriented State government.
- The ACEs Aware workgroup submitted *Findings and Recommendations on the Development and Implementation of the ACEs Aware Program* to the Governor and the General Assembly. This workgroup has been working closely with colleagues from the ACESs Aware program in California, gaining operational knowledge and advice for the creation of a similar program for Maryland.

Since 2018, GOCPYVS has also been coordinating Handle With Care Maryland. Handle With Care is a trauma-informed response to child maltreatment and children's exposure to violence. This partnership between education and first responders increases trauma-informed approaches and addresses adverse childhood experiences to prevent future victimization or criminality.

Racial Equity and Disparity

Racial disparity within the criminal justice system refers to the unequal treatment and outcomes experienced by individuals of different racial and ethnic backgrounds. This pervasive issue highlights systemic biases and structural inequalities that contribute to an uneven distribution of resources, opportunities, and justice itself. Understanding and addressing these disparities is crucial for developing effective and fair policies within the criminal justice system.

One significant aspect of racial disparity in the criminal justice system is evident in the arrest, prosecution, and sentencing phases. Research consistently demonstrates that individuals from minority communities, particularly Black and Hispanic populations, face higher rates of arrest

and are more likely to be charged with offenses compared to their white counterparts for similar behaviors. Once in the system, racial and ethnic minorities often receive harsher sentences, contributing to the overrepresentation of these groups in prisons.

Addressing racial equity and disparity in the criminal justice system requires a multi-faceted and sustained effort, involving collaboration between policymakers, law enforcement agencies, community organizations, and the public. By acknowledging and actively working to eliminate systemic biases, society can move towards a more just and equitable criminal justice system.

While the annual SIM Summits focuses on the adult population, racial and ethnic disparities also exist within the youth justice system. Maryland is a participating state and formula grant recipient under the Juvenile Justice and Delinquency Prevention (the Act) of 1974, reauthorized in 2018. One of four 'core requirements' of the Act, participating states must identify and reduce racial and ethnic disparities at five (5), critical contact points within the youth justice system[2]:

1. Arrest
2. Diversion (filing of charges)
3. Pre-trial detention (both secure and nonsecure)
4. Disposition commitments (secure and nonsecure)
5. Adult transfer

In partnership with our community-based, public safety, and state and local government partners, The Office plans and implements evidence-based jurisdictional and statewide efforts to prevent youth from becoming system-involved. Some of these efforts include:

- Implementing front-diversion opportunities (community-based and law-enforcement);
- Supporting holistic programming to combat the contributing factors that lead to system involvement; and
- Expanding evidence-informed youth development and community-based programming in targeted jurisdictions that exhibit high rates of R/ED.

As detailed above, Maryland's Commission on Trauma-Informed Care adopted the principles, definitions, and implementation domains within *The Maryland Way: Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)*. That framework includes the commitment to uphold the principles of anti-racism and anti-bias across all state institutions including those within the domains and intersection of behavioral health and criminal justice.

[2] Juvenile Justice and Delinquency Prevention Act. (2018) *State Plans, Sec. 223 (a)(15) 34 U.S.C.* https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/media/document/JJDPA-of-1974-as-Amended-12-21-18.pdf

- Health Disparities Reduction Initiative. https://health.maryland.gov/mhhd/Pages/Health-Disparities-Reduction-Initiative.aspx
- Implicit Bias Training for Healthcare Professionals. https://health.maryland.gov/mhhd/Pages/Implicit-Bias-Resources.aspx
- Maryland Commission on Health Equity. https://health.maryland.gov/mche/Pages/default.aspx
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CONCLUSION

The 2023 State Summit on Behavioral Health and the Justice System (report) summarizes information gathered at this year's State Summit on Behavioral Health and the Justice System. Last year's summit marked a significant step forward in fostering collaboration and understanding between key stakeholders in addressing the complex intersection of behavioral health needs and the criminal justice system. Throughout the 2022 panelist discussions, presentations, and interactive focus groups, it became evident that a holistic and compassionate approach would be essential to reducing interactions between individuals with behavioral health needs and preventing further penetration of these individuals into the criminal justice system.

This year, 20 of the 24 jurisdictions in Maryland were represented at the event. The Centers of Excellence provided a platform for experts, policymakers, law enforcement officials, mental health professionals, and community advocates to share insights, best practices, and innovative solutions. The multifaceted nature of the topics was underscored, in turn emphasizing the importance of integrating mental health services, crisis intervention training, and community-based initiatives into the criminal justice framework.

One key takeaway from the summit is the need for increased investment in mental health resources and services, both within and outside of the criminal justice system. By prioritizing preventive measures, early intervention, and treatment options, we can create a more supportive environment that addresses the root causes of behavioral health issues rather than relying solely on punitive measures. In addition, standardization of processes and data collection and sharing is crucial for organizations seeking efficiency, consistency, and accuracy in their operations. By establishing uniform procedures and methods, jurisdictions statewide can improve preventative measures, early intervention, and treatment options.

Collaboration emerged as a central theme, with participants recognizing the importance of partnerships between mental health professionals, law enforcement agencies, social services, and community organizations. Developing comprehensive, cross-sectoral strategies will be crucial in breaking down silos and ensuring a coordinated response to the challenges at hand. The summit also highlighted the significance of education and destigmatization efforts to promote a better understanding of behavioral health issues within the criminal justice system and the broader community. By cooperatively fostering empathy and awareness, we can work toward creating a society that prioritizes rehabilitation, recovery, and the overall well-being of individuals with behavioral health needs.

Through its mission, the Centers of Excellence strives to assist, support, and facilitate conversation and program development related to behavioral health and criminal justice efforts across the state of Maryland. The Centers of Excellence will continue to work with local, state, and federal partners to organize and implement SIM mapping workshops, at the request of local jurisdictions, and conduct an annual report using this model. As we move forward from this summit, the momentum generated must translate into actionable policies, reforms, and sustained commitment from all stakeholders involved. The shared vision of a system that prioritizes compassion, prevention, and rehabilitation can only be realized through continued collaboration and a steadfast dedication to the principles discussed during this transformative event. The summit has set the stage for a more collaborative approach to behavioral health within the criminal justice system, and it is now incumbent upon all involved to convert these discussions into meaningful, lasting change.

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Brooke Sisson	Case Manager	Carroll County Health Department
Captain Bonnie Payne	Community Corrections Captain	St. Mary's County Detention and Rehabilitation Center
Caroline Baker	Captain	Charles County Sheriff's Office
Cher Rivers	Community Health Outreach Worker	Frederick County Behavioral Health Services
Christian Koontz	Master Deputy	Washington County Sheriff's Office
Cory Eslick	Corporal	Crisis Response Unit, Anne Arundel County Police Department
Dan Abreu	Senior Project Associate	Policy Research Associates
Dan Davis	CIT Liaison	Howard County Police Department
Daron Brodie	Peer Recovery Specialist (LEAD/QRT)	Carroll County Health Department
Darren McGregor	Director of Crisis and Criminal Justice Services	Behavioral Health Administration, Maryland Department of Health

David Taylor	Clinical Coordinator	Behavioral Health Systems of Baltimore
Erica Carlson	Clinical Officer / LCSW-C	Maryland State Police
Genevieve LaPorte	CIT Coordinator	Howard County Police Department
Gillian Tonkin	Special Assistant to the Chief Judge	District Court of Maryland
Honorable Marina Sabett	Judge	District Court of Maryland
Ignatious Zakrjewski	Officer	Montgomery County Police Department
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Jennifer Clark	Clinical Program Supervisor, Washington County Mobile Crisis Services	Sheppard Pratt
Jennifer Loring	Assistant Regional Director - Region1	Juvenile Services
Jennifer Maffucci	Field Supervisor 1	Division of Parole and Probation
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John Moses	Director of Criminal Justice	Wor-Wic Community College / Eastern Shore Criminal Justice Academy
Judith Brown	Regional Social Work Supervisor	Maryland Department of Public Safety and Correctional Services

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Kelly Mosher	Assistant State's Attorney	Frederick County State's Attorney's Office
Kevin Nock	Forensic Peer Specialist	Maryland Office of the Public Defender
Kimber Watts	Assistant Public Defender	Forensic Mental Health Division, Maryland Office of the Public Defender
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Tiffinee Scott	Executive Director, Maryland Peer Advisory Council	Maryland Peer Advisory Council

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Veronica Dietz	Director of Crisis Services	Carroll County Health Department
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